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Critical care nurses: thriving or striving through workplace adversity

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Abstract

Aim: Nursing workforce levels are becoming critical, with evidence that highlights that more nurses are leaving the profession than are being trained. This situation is, exacerbated by an aging workforce, levels of staff retiring, and the effect of COVID-19. Critical Care (CC) is not immune to this situation. However, some seasoned nurses continue to work in CC for many years; little is known about why they stay and if they strive or thrive in a place renowned as having unhealthy work conditions. The study explores and describes the lived experiences of registered Critical Care nurses (CCNs), working in the CC environment who strive or thrive against adversity.

Method: Whittemore and Knafl's (2005) integrative review underpinned the research questions, enabling exploration of what is already known about the CCN workforce and their associated longevity. An explorative, descriptive methodology, framed on Husserl's (1859-1938) descriptive phenomenology approach (Beck, 2021) utilised semi-structured interviews to explore sixteen CCNs experiences. Data was collected using a two-staged approach of purposive and theoretical convergent interviews.

Results: Using Colaizzi's (1978) seven stages of method analysis, findings revealed sixty-seven themes which were sub-divided into seven emergent themes, with sub-themes including belonging and labour of love. It is hoped that these findings will be beneficial in the development of retention strategies to stem the flow of CCNs who leave the specialism, their organisation and ultimately, the profession.

Contribution of new knowledge: Focusing on the newly developed CCN Intent to Remain model, incorporating sense of belonging, the work-family, ensuring safety to thrive, a culture of support (mothering) and psychological well-being (recognition and value) may positively influence the retention of those CCNs remaining in CC and promote a sense of thriving.

Key words: Critical care, critical care nurse, lived experience, longevity, intent to remain, descriptive phenomenology

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Glossary of Terms

Band 5	Newly registered nurses.
Band 6	Band 6 nursing roles typically include senior staff nurses, deputy ward managers and various specialist nurses.
Band 7	At this level the nurse is highly specialised and is typically a clinical lead.
Band 8	Typically, a ward manager or in a specialist role such as Advanced Critical Care Practitioners/ Lead Critical Care Outreach Nurse.
Cat B's	Term used to define Registered nurses with no Critical Care skills, who were redeployed to Critical Care in response to COVID-19 (NHSE, 2020)
CC	CC provides specialist care for the vulnerable, complex patients whose conditions are life threatening, require constant monitoring and is staffed with specially trained healthcare professionals (ICS, 2022).
CCN(s)	Registered nurse working in acute environment including critical care, high dependency or intensive care.
Community of Practice	A group of people who share a common interest or set of problems, coming together to fulfil group and individual goals. The focus is to share best practice and create new knowledge to advance a domain of professional practice (Wenger, 1998).
Emotional wellbeing	Successful handling life's stressors and adapting to difficult times, in a constructive way. This includes accepting and managing emotions and having a sense of purpose, meaning and supportive relationships.
Intention to leave (ITL)	Nurse turnover intention is defined as an individual's perceived probability of permanently leaving the employing organisation soon (Falatah, 2021).

Intention to remain (ITR)	Nurse intention to stay in clinical practice. Determinants have been identified which relate to personal and professional; organisational profile; work environment and patient related.
Longevity	Long service
Moral distress	When a nurse feels compelled to act against their own moral judgements. When the nurse knows the right thing to do, but constraints, typically institutional make it impossible to pursue the right cause of action.
Psychological wellbeing	Multidimensional construct which encompasses and individuals' sense of happiness, satisfaction, mental and emotional health. This also includes accomplishment.
Qualification in Specialism (QIS)	The QIS is the specialist Critical Care education programme for registered nurses. This programme is based on the National Standards for Adult CC Nurse Education (CC3N, 2023). It is studied at Degree or Masters level in Higher Education.
Supernumerary status	Students, in practice or a work-based learning environment that are supported to learn without being counted as part of the workforce numbers, required for safe and effective care in that setting (NMC, 2019).
Thrive [ing]	The psychological, cognitive, emotional and social wellbeing of an individual. This positive psychological state is characterised by a sense of vitality and sense of learning (Spreitzer at al., 2015). Having the range of mental, physical, social functioning and wellbeing (Su et al., 2014).

Acknowledgements

Living is a process of developing oneself…

The ultimate measure of a (wo)man is not where

(s)he stands in moments of comfort and convenience,

But where (s)he stands at times of challenge and controversy.

(Martin Luther King (Junior), 1963)

The purpose of this phenomenological study was to describe why seasoned critical care nurses (CCNs) remain working in Critical Care (CC) against adversity, so that we can discover ways to support CCNs to continue to deliver that care, whilst caring for themselves.

During this period of learning, there has been a period of great loss, of sacrifice, and yet such reward and for that I need to give thanks:

To the CCNs: to all those that care for the seriously-ill, even when we know that this can come at personal sacrifice. I especially want to thank those that were actively involved in sharing their experiences so that I could explore and share their stories with the aim to make a difference.

To my supervisors, especially Professor Julie Green and Doctor Ivan McGlen. For those that know me, my lack of confidence is hidden by an external façade; Julie and Ivan your

encouragement, positivity, and belief provided me with sheer surprise, tenacity, and perseverance to complete this research. Your insight and understanding of nursing workforce issues and your belief that I had recognised something new, was often the rock that supported me to persevere; thank you.

And my family, to whom I am forever grateful. For all those missed Sundays, when I locked myself away; to procrastinate, read and occasionally write, thank you for your undoubting confidence and support, believing that I could achieve this. Bethany and Ellenor; never give up, do what you want to do, but do it well, do it with your heart, and you will not go far wrong. To Alex, thank you; I could not have completed this without your unquestioning support, I thank you with all that I have.

To Mom and Dad, I know you never really understood my role as a CCN, CC educator, academic or researcher; however, you were always so proud. Thank you; I am what I am because of your love and support.

And lastly to Mom, during your extended stay in CC, you believed in me, encouraging me to continue to study, insisting you were fine. I wish that the final part of your journey, had been different, however, if you had to be cared for by any nurses, I am so proud it was with those that I associate myself with and am so proud to be one of. I miss you so much and I dedicate this to you Mom, with all my love.

Contextualising the Thesis

Introduction

This chapter outlines key points about the style and language convention used within this study.

i: Structure

This section provides an overview of each of the forthcoming eleven chapters.

Abstract

Here, the key points of the study are presented, providing sufficient detail to classify the thesis when published, as relevant or not to readers' expertise, and research interest.

Chapter 1: Introduction, and so it begins

Chapter 1, presents a personal biography, relating to the social context, early years, clinical and academic professional journey which correlate to the rationale for the study and research design. This sets the scene following personal reflection for the field of investigation.

Chapter 2: The Context – Setting the Scene.

This chapter positions the thesis in the context of the CC workforce and provides the rationale for the study. An overview of the political and social context of nursing workforce over the last two decades is provided, from a national, and international

perspective demonstrating how CC has not been immune to these influences. This highlights the exodus of staff from the CC environment, which conflicts with a personal reflection on longevity in this intense area of work whilst remaining highly motivated.

Chapter 3: Literature Review

Here, the integrative review findings relating to CCNs and their intent to remain (ITR) in CC are presented. Using a systematic integrative approach enabled empirical and non-empirical evidence to be included. Quality assurance of the process is demonstrated using Hawker et al. (2002) scoring approach. Seven themes reveal what is currently understood and highlights an emerging need for research on CCNs ITR in CC.

Chapter 4: Theoretical Framework

Here, the research epistemology and ontological position are presented, grounding the research in its philosophical design. This includes, defining and describing the methodology, descriptive phenomenology, and disclosure of the personal standpoint.

Chapter 5: Feasibility Study (FS)

Within this chapter the rationale and justification for the FS are offered. The similarities and differences to phases one and two are defined, including sampling, data collection, and analysis. The FS findings identified the worthiness of further exploration into why CCN remain in CC.

Chapter 6: Methods

Here the data generation methods, aligned to the descriptive phenomenological approach, are presented. The intention was to gain an understanding of the CCNs lived experience of ITR by answering the research question:

> *Why do some CCNs, exhibit longevity and remain highly motivated in an emotive and intense area of work, whilst others leave early in their career?*

Chapter 7: Presentation of Findings

This chapter presents the findings as described by sixteen CCNs in response to the research questions, using semi-structured interviews. The data was analysed using Colaizzi's (1978) systematic approach and presented as textual patterns. Seven themes emerged from the findings: constructs of a CCN; emotions; organisation (including the effect of COVID; leadership; knowledge; rewards, and frustrations, each having several sub-themes.

Chapter 8: Discussion

CCNs unique experiences are synthesised revealing eight concepts: belonging, labour of love, work-family, psychological safety, identity, quality of work-life, intent to remain, and the psychological effect of COVID. These concepts provide the rationale of why CCNs remain working in this emotional charged environment.

Chapter 9: Recommendations

This chapter shares the recommendations including how mobilisation of this unique knowledge will be disseminated to the CC community.

Chapter 10: Reflexivity

A previous investigative study piqued curiosity and supported the plethora of evidence on CCNs exodus from CC. This contradicted a personal assumption and highlighted a relatively unexplored area of evidence. This chapter shares experiences during the research journey. Here, strengths and limitations of the study are detailed.

Chapter 11: Conclusion

This chapter summarises the contribution of new knowledge in the field of CCN.

ii: Style and Language

The thesis has been written in the academic style of the third person; however, on occasion, personal pronouns (e.g., I/me) have been used, typically to present assumptions and personal reflection. This emphasises the role of the researcher, whilst ensuring assumptions are transparent within this phenomenological approach.

Aiming to find a balance between writing in an emotional style that might detract from the logical argument, objectivity and rigor has been maintained whilst ensuring personal investment is disclosed (Knox, 2006). This aligns with the phenomenological design of active participation rather than passive positioning (Beck, 2021).

To ensure clarity of expression, consistency and to improve flow for the reader (Enago Academy, 2021), the following abbreviations represent Critical Care (CC) and Critical Care nurse (CCN). Rather than using the interchangeable terms Intensive Care (ITU), High Dependency (HDU), and Critical Care, CC has been used throughout. Four acronyms

have been commonly used: work environment (WE), intent to leave (ITL), intent to remain (ITR) and feasibility study (FS).

Participant quotes have been edited, removing repetition, to assist with reading flow, e.g., um, oh, etc. The following transcript conventions maintain the original intent of the dialogue; a detailed rationale for this is presented in chapter 5 (Willis, 1977, pg. viiii). Participant quotations are presented in inverted comas, denoting the participant unique reference number in brackets.

Reference to COVID aligns to Public Health England's definition of both the disease name (COVID-19) and SARS-CoC-2 the virus name (Public Health England, 2020).

Table 1: Key Transcripts Convention (Chapters 5 & 7)

Symbol	Meaning
[ ]	Background information to make the context, meaning or dialect clear
....	Words of phrases have been edited out
( )	Pause

P. E. Willis Ethnographic text (1977) pg. viiii

Footnotes, denoted by number (1) etc., provide context, or a citation regarding key concepts. These provide clarity and definition without detracting the flow of discussion.

iii: Summary

This chapter outlines the key style functions used throughout the study, to provide clarity for the reader.

Chapter 1: Introduction and so it begins

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1. Introduction

The chapter presents a personal biography of my life trajectory, using a reflective approach. This thesis has permitted me to reflect on where I have come from and travelled to, through an educational, political and sociological perspective. Using critical reflection points and a selection of lenses, the departure from my early years in the working-class domain is described, my career development as a Professional Development Nurse in the National Health Service (NHS) and ultimately, my current destination as a nurse academic in Higher Education (HE).

1.2. Personal Background

1.2.1 Early Years

Born in the late 1960's, in typical white working class, middle England town. The majority of townsfolk had moved from the inner-city to affordable housing, benefitted from the welfare state and comprehensive school system.

In the early years, at a time when women's roles were being challenged (David, 2003), I was growing up in an emancipated household, with a 'hands on Dad', due to my Mother's ill health, living with a chronic illness, it was, a very untraditional nuclear family. My Mother's ill-health led to a modern style of living with equal partnership in both child and household management. Both parents were working to share the financial burden, rather than the traditional female working 'for pin money' for family

extras; this was no ‘bookish introduction to life’. Although sympathetic to the feminist perspective (Oakley, 1974), my upbringing was not so much as emancipation for my mother but a way to cope in a nuclear family whilst living with a chronic illness with three young children. This biological disruption, as defined by Bury (1982), to the household meant that my primary socialisation included frequent visitations to the healthcare environment; this then became a milieu that I felt both comfortable and safe within. Nurses became a familiar part of my extended family providing warmth, security, and mutual support.

As a child schooled between 1972-83, it is important to recognise this was not a period that spent time and energy on improving the educational input (Elliot, 1996 in Ball, 2013). My comprehensive school period saw the re-emergence of the political dominance of neo-conservatism with the privatisation of public services. There was no expectation of great achievement, merely an expectation and norm, that children would enter comparable employment to their parents; reinforcing the pattern of the working classes pre-1990. As a product of the comprehensive style of education, and with a lack of school or parental guidance and too young to enter nursing, but with financial stability secured with my elder siblings already in employment, I was empowered to make the personal choice to attend Further Education College. A pre-nursing programme added to my O-level qualifications, resulting in an uneconomic academic achievement rather than being guided towards A-levels, and certainly no mention of HE. On reflection, this prolonged my secondary education with no academic gain, however, on completion I was a motivated, confident seventeen-year-old; I left the family home

to commence my professional nursing career and personal journey, never returning to the family home.

1.2.2 Professional role: Clinical Practice History

With work as an economic necessity, I saw a departure from the working class as a specialist practitioner. My journey began in 1985-1988, in the School of Nursing on an apprentice-style training programme. Living away from home, in a nearly inner-city area, I become familiar with the wider ethnic diversity and cultural perspectives, poles apart from my personal history.

Recognising that my decision to select the speciality of CC once registered, was without doubt one of the most influential choices of my professional career and one atypical of a new registrant in 1988. Exposure to the specialism of CC was one that I had not experienced during 'training', however, CC became and remains a passion. CC is defined as specialist care for vulnerable, complex patients whose conditions are life threatening, who require constant monitoring and are staffed with specially trained healthcare professionals (ICS, 2022). This environment is rich in autonomous nursing practice, oblivious to the traditional organisation and culture of medical hierarchy. Due to patient acuity, the stressful environment CC is disproportionally affected by high vacancy and turnover (Ulrich et al., 2019), but despite these challenges, I found this professional community intrinsically and extrinsically rewarding. Free from commitments, I was in the fortunate position of entering the empowering world of role extension, decision-making and educational opportunity. Employed as a Staff Nurse, my investment and scope for knowledge steered me to the early accomplishment of my qualification in

specialism (QIS), embodying an emphasis on lifelong learning and an introduction into HE. I was the first and only person in our nuclear family to be university-educated, and only then as a part of my nursing working-life.

With this came an escalation in social positioning and further opportunities to undertake a diploma, degree and post-graduate diploma in HE. My undergraduate degree dissertation was a descriptive exploratory study examining the role of the preceptor for a new CC programme[1]. In the early 1990's this was a relatively under-explored area, with a small sample size and findings that were not generalisable, however, this provided a valuable insight into the role and support required for both the learner and mentor.

On reflection, the decision to practice in CC was the foundation that shaped my professional identity lasting over two decades as a practitioner, with no career break when married or following the birth of my children. Intending to remain in employment, mirroring the current social expectations of women having a family and returning to work, this experience was that of a 'working mom' highlighted by David (2003); in contrast, this was in a stable married relationship. The investment and acquisition of knowledge and skill enabled growth in my professional identity; to a senior position and no longer a shift worker; the balance of personal and professional behaviour was accomplished. To enable my career, as a mother of two, the extended family, the Grandparents, became active members of our childcare arrangements.

[1] Preceptor, meaning tutor or instructor, was defined as unit-based nurse who teaches and assesses in addition to regular duties, in attempt to bridge the practice theory gap (Kramer, 1974).

The acquisition of educational capital and a commitment towards quality and safety through education, led to my appointment as the first Professional Development Nurse within the local NHS Trust. In 2000, the Department of Health published 'Comprehensive CC'; this presented the first and most significant political focus on CC, prior to the COVID Pandemic (2020), with generous investment for the expansion of services due to the public outcry in the lack of CC services nationwide (Department of Health, 2000). This political investment facilitated a recruitment drive, bed capacity expansion and investment in in-house education. The conjuncture between the political awareness of resources, risk, capacity, and my professional role had a positive outcome, which led to a wider organisational recognition in an advisory capacity for education and the development of the first educational framework for nurses recruited from overseas.

Locally, the development of a training need-analysis and competency-based programmes further immersed my professional identity in education. The development of new approaches, aligned within HE, elevated my career to a regional level with a sharing of educational principles and networking. Educational programmes delivered in-house, that linked theory to practice, were accredited by HE establishments, providing academic credit value for practitioners (Bologna Declaration, 1999). This advancement ensured educational currency, increased learner engagement, and provided organisational value-for-money.

The next challenge, in 2004, was to undertake a post-graduate degree. My Master's in Arts (Education) had the additional recordable qualification of Practice Educator (Nursing & Midwifery Council, (NMC)), however, an interruption at the dissertation

juncture, due to personal circumstance and then my departure from practice, forced a hiatus in Master's level study.

1.2.3 The Move to Higher Education: Complexity and tension

Over the last four decades, nurse education has undergone a period of reform in an attempt to provide an academic base and align nurse education with other healthcare professions. The United Kingdom Central Council for Nursing and Midwifery, (UKCC) [latterly the NMC] were receiving criticism for the apprenticeship model of training with a lack of adequate supervision and high attrition rates. Project 2000 (UKCC, 1987) was pioneered with the location of nurse training in HE, (a year post my completion of Registered General Nurse (RGN) training), with new diploma level accreditation, placing nursing as a distinct discipline and raising its professional identity. This was steered by the Thatcherite neoliberal induction of internal marketing, placing the NHS in a purchaser/provider relationship with HE. Nursing became a discipline taught within this larger community of learning; a forerunner to the advent of an all-degree approach to nurse education in 2012-2013.

For a nurse there is a responsibility to view caring through multiple perspectives; as a scientist, a care provider, and from the perspective of the patient, carer and/or society. Each perspective offers a differing lens; for the educator this potentially adds an additional layer, for the learner an additional challenge. Nursing epistemology shifted focus not only to what nurses do, such as their technical skills, but also on what they know. Without an understanding of our own discipline, which includes the knowledge that underpins thoughts and actions, practice, research and education will continue to

be hindered in its efforts to gain recognition as a scientific discipline and its distinctness of professional identity.

As a specialist nurse there was apprehension entering, HE in 2008; this related to a perception of the apparent forfeiting of clinical credibility when entering academia (Diekelmann, 2004; Kenny et al., 2004; McArthur-Rouse, 2007). Commencing in academia was challenging and complex, even with rich clinical expertise aligned with educational practice, it was a culture shock. Nurses now describing themselves as teachers, often found the professional-academic challenges significantly harder than those seen in other professions; typically due to this being atypical of their educational experience (Findlow, 2012). Nurse lecturers highlighted uncertainty relating to both identity and status, whilst sharing the same problems as other lecturers they considered themselves as ‘‘far from accepted as equals and proper academics’’ (Findlow 2012, p.128). Boyd (2010, p.155) also draws attention to such tension with new lecturers ‘‘holding onto their existing identity as a practitioner’’. These findings were highlighted when Boyd examined two worlds, nursing, and those new to HE; both worlds rich in audit, inspection and regulation, and having a dialogue on the community of practice as the ‘newcomer interacting with the old timer’ (Wenger, 1998; Boyd, 2010). By investigating workplace identity, Boyd identified that the experienced professional had a perceived loss of status within the new community, in contrast to their previous community where they were perceived as experts. This resonated (Andrew, 2012, p.847), having a wealth of clinical knowledge, holding a post-graduate Diploma in Education, however personal feelings identified as ‘not [being] in possession of the wealth of educational capita that institution peers have’. The feeling of ‘small fish, big

pond' was aggravated by the lack of induction, differing terminology and expectations to teach from day one. Prior experience included a plethora of moderately sized teaching activities, however, with no formal induction into the 'local' HE community, my experience was one of 'fend for yourself'.

The speed at which lecturers were required and eased into the classroom and the preparation for teaching consuming scholarly activity conveys workplace tension. Additionally, the 'reconstructing pedagogy' theme identified by Boyd, (2010) highlighted the keenness of new academics to develop new practitioners rather than contributing to new pedagogy through research. This contributed to the difficulty in embracing new identities in scholarship, such as active research. Indeed, suggesting that experience aligned with the evidence recognising a lack of socialisation into HE, valuing professional currency whilst accepting that the new academic identity is left exposed.

The following discourse relates to scholarship and research credibility. The departure from clinical practice related to self-actualisation within CC, and the organisation. My professional identity in practice was unquestioned; I excelled, in a position of authority, advisor and in possession of the credential capita, but I sought a change and challenge. The appointment into HE was based upon being a credible practitioner with a teaching qualification. As a lecturer, for fifteen years, my pedagogical role encompasses a teaching portfolio spanning across the pre-and post-registration programmes from Level 4 to Level 7, a developer of nursing curricula, aware of creative thought and the complex healthcare world whilst being undaunted by change. It has been relatively easy to be involved and make enhancing changes to existing and new programmes. This was

aided by the resilience afforded by previously working in a fast pacing, stressful ever changing work environment (WE).

My initial research activity had been biased towards the small sampled qualitative domain, rich in thick description. However, in 2015 at a chance meeting, my induction into leading research began; as a Chief Investigator for an international study focusing on the CC WE, and specifically moral distress (MD), I entered the quantitative domain, challenging my prior experience and intellectual comfort zone. This study explored the WE, MD and its relationship with ITR within Adult CC across CC units in the Midlands, UK and Canada. Using a cross-sectional survey design, data was collected using Lake's Practice Environment scale as the measurement of the Nurse Work index (PES-NWI, Lake, 2002) and MD Revised (MDS-R, Hamrich, Borchers and Epstein, 2012) as the measurement tool for MD. Age and MD were significantly positively correlated with ITR, indicating older nurses were more likely to remain on their unit. MD was negatively correlated with ITR with their current employer and nurses were more likely to leave. The overall research findings were co-presented at the World Federation of CCNs in Serbia (2018) and in 2019, I presented the outcomes relating to MD at the national CC conference. These findings formulated the initial intelligence gathering work for this study; and widening personal membership to research networks within the local and external community. While, in addition, enhancing my academic role to have a more critical perspective and wholesome identity.

Clinical credibility has been maintained with continued association with National and Regional CC networks, membership of CC National Nurse Network Education Forum; (CC3N), national policy developments (2015, 2022, 2023); co-author of the National

Competency Frameworks for Registered Nurses in Adult CC, Step 1 (2015, 2022), Step 2/3 (2015); lead author for the CC Maternal (2018, 2024) and Cardiac (2021) competencies, and as the lead for the National Competency Frameworks for Registered Nursing Associates in Adult CC (2021, 2024). Presenting these developments at several multidisciplinary CC national conferences (2010, 2015, 2019a, 2019b, 2021, 2023, 2024).

More recently clinical credibility was demonstrated with a return to clinical practice working at the 'coalface', in CC, during the COVID pandemic (2020). CC was the front line in response to COVID; the NHS took unprecedented action to increase CC capacity to cope with the pandemic. The political decision to commence lockdown in England aimed to prevent CC services being overwhelmed and with an awareness of the fact that delivering sufficient CC capacity went beyond the physical infrastructure, beds and equipment, this level of expansion also required enough trained and available staff (Kings Fund, 2020). The Kings Fund (2020) reported that even with changes to clinical staffing ratios, there were simply not enough staff to make use of the additional physical resources the NHS had invested in. Whilst evidence on the extent of the pandemic and the substantial toll on the staff was unavailable at that time, a request to return to clinical practice to support CC colleagues, was supported by my education establishment; an act which enhanced my clinical role and credibility.

1.3 Rationale for the Study

This sharing of social circumstance, personal and professional trajectory has demonstrated that an early decision to work within CC has aligned my professional identity and professional expertise for thirty-six years within one specialism, CC. This is during a time when nursing has experienced a workforce shortage driven by the escalating demands for healthcare and the aging population. This piqued my curiosity when reflecting on my longevity in practice; why do some CCNs have longevity and remain highly motivated in an emotive and intensive area of work, whilst others leave early in their CC career? In fact, why are we experiencing this exodus from CC practice when some nurses have remained in CC their entire work-life? Do we know what these reasons are? This relatively unexplored area demonstrated an emerging need for research on the CCNs decision to stay in CC. The overall aim in advancing this area of knowledge was to develop strategies to inform education, political and practical decision-making policies to enhance retention strategies and, to assist in the response to the CC nursing workforce crisis.

1.4 Research Question

This phenomenological study will answer the following question:

> *Why do some CCNs, exhibit longevity and remain highly motivated in an emotive and intense area of work, whilst others leave early in their career?*

Sub- question:

> *Are CCNs thriving or striving whilst working within CC?*

1.5 Chapter Summary

In summary, the approach of selecting critical events to hang personal biographical accounts has become commonplace in social and educational ethnographies. Living in a world of complexity and conundrums, we are not isolated, and we are affected by our environment. The rational deconstruction of my personal and professional life course can be seen as a frame of reference that has led to this Professional Doctorate. I do not see my past as a struggle or feel that I was entrenched in some social or political landscape, indeed, my reflections have been shared to give insight into my professional and education trajectory. However, this refection has added clarity, through various lenses, to that journey and has strengthened my personal aspiration to achieve equilibrium in the professional world and unite with the community of researchers.

Being a CCN is unique to each nurse, although similarities may occur. This thesis is the storytelling of my research and is representative of myself, my thinking, and my writing. As an academic working within HE, a teacher of acute and CC subjects, I remain a nurse, a CCN.

Chapter 2: Setting the Scene

2.1 Introduction

Within this chapter, CC nursing is situated in terms of CCN workforce and positioned within an international, national, and regional context. The political and policy context is considered including reference to the first white paper for CC, Comprehensive CC (Department of Health (DH), 2000), and more recently reference to the impact of COVID-19[2] (Public Health England, 2020) and how this global pandemic impacted on CCNs. Finally, the National Standards for Adult CC Education and their alignment to HE in England, Wales and Northern Ireland (CC National Network Nurse Leads Forum, CC3N, 2023)[3] are presented.

2.2 Critical Care

CC is an umbrella term defined by the Intensive Care Society[4] (2009) encompassing all areas that provide Level 2 (High Dependency) and/or Level 3 (Intensive Care) provision (FICM & ICS, 2022, Fig.1). In 2020, the 3rd CC and Outreach Workforce survey identified that there were 282 CC units in England, Wales, and Northern Ireland, with the majority

[2] COVID-19 represents the disease name and SARS-CoV-2, the virus name (Public Health England, 2020), for the purpose of this work, COVID-19 will used to refer to both the virus and bacterial condition.

[3] CC3N, an organisation, not a professional body, were established in 2003 as part of the NHS Modernisation programme, represent the Operational Delivery Networks developing guidelines and standards for CC in England, Wales and Northern Ireland.

[4] The Intensive Care Society (ICS) is the UK's largest multi-professional intensive care membership organisation for doctors, nurses, psychologists, physiotherapists, and other allied healthcare professionals from across the world working in CC. This group provides education, standards, and guidance development, supports CC research, and develops wellbeing resources to ensure that members can deliver quality care to the sickest patients.

being combined general Level 2 (High Dependency) and Level 3 type (Intensive Care) facilities (CC3N, 2020). The Faculty of Intensive Care Medicine[5] (FICM) and Intensive Care Society (ICS) within the Guidelines for the Provision of Intensive Care Services 2[6] (GPICS2, FICM, 2022) defines the Intensive Care Unit as a specially staffed and equipped, self-contained area of a hospital that dedicated to the management and monitoring of critically-ill patients with life threatening conditions (FICM & ICS, 2022).

Level 0	Patients whose needs can be met through normal ward care in an acute hospital.
Level 1	Enhanced care, for patients where increased interventions are required, at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the CC team.
Level 2	Patients requiring more detailed observation or intervention including support from a single failing organ system, postoperative care, those with uncorrected physiological abnormalities and those 'stepping down' from higher levels of care.
Level 3	Patients requiring advanced monitoring, respiratory support (such as ventilation) alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support from multi-organ failure. Typically provided in Intensive Care.

Fig.1: Classification of Level of Care for Patients in Hospital (FICM & ICS, 2022)

[5] The Faculty of Intensive Care Medicine (FICM) a professional and statutory body for Intensive Care Medicine, including doctors, Advanced CC Practitioners (ACCP) and CC pharmacists. FICM influences education and standards to define national policy and improve outcomes for patients and families within CC.

[6] GPICS2 is a collaborative authoritative reference for the planning and delivery of Intensive Care services between ICS & FICM (2022); aiming to improve standards and reduce geographical variation within CC services. The Quality Care Commission (CQC) use GPICS to benchmark and assess local services. https://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services

Intensive Care is an area where care can be provided timely, safely and with quality that cannot be provided in a ward environment and includes management of patients with high levels of dependency, requiring advanced pain relief, palliative care support, and management of organ failure (ICS, 2020).

Kayambankadzanja et al. (2022) state that there is lack of a consensus definition for critical illness, which relates to the acuity of the patient rather than the disease. They refer to critical illness as a state of ill health with vital organ dysfunction with a high risk of imminent death if care is not provided. In 2021, the definition of the level of patient acuity was redefined to reflect clinical need regardless of location (FICM & ICS, Fig.1).

CC Outreach Teams (CCOT) are part of the CC workforce, with 136 of the 282 CC units in England, Wales, and Northern Ireland providing an CC Outreach service (CC3N, 2020). The CCOT service was introduced following the publication of the first white paper, Comprehensive CC (DH, 2000), (discussed in 2.7, policy context section). This team of practitioners are typically nurse-led, whilst supported by the CC medical team; they provide CC knowledge and skills to patients with, or at risk, of critical illness in environments outside of the Intensive Care environment. CCOT are a responsive emergency service, supporting the recognition of deteriorating patients, managing conditions such as sepsis, treatment and escalation planning, providing education and support for clinical areas and providing continuing care for recently critically-ill patients who have stepped down from CC to a ward environment. Outside of the UK, they may be referred to as Rapid Response teams (RRT's) or Medical Emergency Teams (MET's). CC is aptly defined as "a skill set not a geography" (ICS, 2020).

2.3 International View of Nursing

The World Health Organisation (WHO, 2020) uses the International Standard Classification of Occupation (International Labour Organisation, 2008) for defining nursing[7]. The global nursing workforce represents 27.9 million, with a global shortage of nearly 6 million, who are mainly from the low-middle income countries (WHO, 2020). 1:8 nurses work outside of their country of origin, with higher income countries relying on foreign-born and foreign-educated nurses, 15% more than other countries (WHO, 2020). Island states have difficulty in retaining health workers, when those key workers are financially more secure when working in higher income countries (WHO, 2016).

The WHO's Global Strategy for Human Resources identified a potential workforce deficit of 18 million, with many countries either lacking the technical and financial resource or not having the social or economic demand to produce this workforce (WHO, 2016). The disparity in supply and demand of healthcare labour resulted in the United Nations adopting the WHO's Global Health Strategy, 2030, with a response advocating for investment into education, job creation, and social sectors for economic growth (2016). Recommendations include efforts to create 40 million jobs in health and social sectors. They recognised that 70% of healthcare careers were held by women, and the economic empowerment of women and youth were recognised as key factors to be addressed. The 2020 International Year of the Nurse, increased momentum on how to invest in the

[7] ISCO (2008) definition of nursing "Nursing professionals provide treatment, support and care services for people who need nursing care due to ageing, injury, illness or other physical or mental impairment, or potential risks to health. Nurses assume responsibility for the planning and management of the care, supervise other health care workers, whilst working autonomously or in teams in the application of preventive and curative measures".

nursing workforce to best address national health priorities, 'unparalleled advocacy and data reporting contributed the first State of the World's Nursing report', (WHO,2020). This was also at a time of unprecedented health challenges and socio-economic disruption due to COVID-19, with its impact discussed in section 2.8.

The WHO's (2020) prioritisation of policy summarised a broad understanding of worker shortages and surplus, skill-mix and geographical imbalance; the supporting actions related to education, jobs, leadership, and service delivery. Within the international nurse education remit, the inconsistency of degree level entry and the shortage of suitably qualified faculty to educate nurses to degree level was highlighted as a concern (West et al., 2016, Bvumbwe & Mtshali, 2018). Recruitment, infrastructure, and clinical practice availability are cited as the main casual factors in preventing an increase in education capacity for nurses and midwives to meet healthcare demand. When capacity was available, the perception of the nursing role was highlighted as the issue. Investment in technology, learning design, digital learning and culturally sensitive care, were cited as essential for successful increase of student numbers (WHO, 2020).

Resource mobilisation was considered key to meeting the need for the 6 million positions required in most countries with existing national funding; this would be more challenging for the lower income countries (WHO, 2020). 'Attract, recruit and retain', was the statement of intent, (WHO, 2020), with stakeholders identifying concerns that the expected growth would be in the upper middle to high income countries (WHO, 2020).

2.4 National View of Nursing Workforce

Growth in NHS was seen in the early 2000's, during both new Labour budgets, but has been in decline since 2012, as the conservative government attempts to reduce the UK's budget deficit at a time of austerity. The NHS is the largest employer in England, with 1.27 million full-time equivalent staff working within the primary and secondary care provision (gov.uk, 2023). Within the NHS, nurses are the largest workforce of healthcare providers, with the Organisation for Economic Co-operation and Development recording the total number of nurses in 2021 as 692,800 (OECD. Stat, 2022). Of these, 563,555 were domestically trained, and approximately 129,225 were trained outside the UK (OECD. Stat, 2022); highlighting a 6% increase in internationally trained nurses from 11.25% in 2010 to 17.9% in 2021 (OECD. Stat, 2022).

The Kings Fund (2022) reveals a worrying picture of continuing poor workforce planning, weak policy and an endemic of staff shortages (Kings Fund, 2022); reporting one in ten vacancies are unfilled equating to nearly forty thousand nursing staff vacancies across NHS trusts, mental health services and community providers (Kings Fund, 2022). Positively, the 2019 Conservative manifesto cited extra funding for 50,000 additional nurses in the NHS by 2024/25. Whilst recognising that any benefits will take time, and that the retention of the existing nursing workforce remains an important factor; a significant number of the nursing workforce are experiencing ill-health, burnout and demonstrate intent to leave (ITL) the nursing profession (Peate, 2022).

Work-life balance and the reported lack of value of nurses within the UK has been cited by the Royal College of Nursing as another significant factor for the ITL the profession

(2023). The OECD's Health Europe 2022 report compared nurses pay across Europe, highlighting countries such as Luxemburg and Belgium pay almost double what a nurse in the UK receives. The Netherlands pay equated to £43,580; Iceland £40,650; and Germany £37,980 in comparison to £29,710 in the UK. This comparison not only reveals a reduction in the national earnings but a failure to keep up with day to day living, resulting in remedial strike action within the UK in 2022/23.

2.5 National View of Non-Nursing CC Workforce

The definitive source which outlines planning and delivery for all CC services within the UK is GPICS2 (FICM, 2022). These key standards refer to the expected workforce, including the medical team, who unlike other physicians manage patients of all genders, from healthy to terminally ill, from neonates to the very elderly, pre, peri and post-operatively including pain management (Zacharowski et al., 2022). The report presents the expected pattern of work for the medical team referring to patient ratios, immediate access to advanced airway skills, a designated Clinical Director, assured 24/7 consultant attendance within thirty minutes, and rotas that are cognisant of wellbeing such as fatigue and burnout.

A more recent addition to the CC workforce is the Advanced CC Practitioner (ACCP's)[8], this newer role are advanced practitioners, from a variety of professional backgrounds including nursing, physiotherapy, and operating department practitioners. The ACCP, is

[8] ACCP's work within the code of their professional regulatory body. A FICM-associated ACCP with supervision from an CC Consultant works within the definition of an CC resident, providing 24/7 immediate clinical/medical cover for patients. ACCP's follow a two-year education programme identified by FICM, which includes non-medical prescribing and competency-based assessments.

‘a registered practitioner with an expert knowledge base, with complex decision-making skills and clinical competence for expanded autonomous scope of practice. The characteristics of which are shaped by the context in which the individual practices, demonstrable at Masters level and meets the education, training and CPD requirements for Advanced Clinical Practice as identified within the Advanced Clinical Practice framework’ (HEE, 2017). The ICS and FICM reported that there are over 100 ACCP’s registered nationwide who have successfully completed their specific post-graduate education programme (FICM, 2022).

Integral to the CC workforce are members of the multidisciplinary team who provide professional support to optimise care and clinical management. GPICS2 (FICM, 2022), supports that there must be a designated pharmacist, dietician, speech and language therapists, occupational therapists, psychologists, and physiotherapists for each unit, with recommendations made for access, involvement in decision-making and a minimum level of competence for each role.

In addition to the professional workforce, CC is contingent on its non-registered staff whose functions are essential in providing supportive care with the multi-disciplinary team. This includes second-level registered nurses (Nursing Associates), healthcare support workers, domestics, ward clerks, data analysts and administrative staff. Together these are the CC workforce that support the needs of patients and their families within the confines of the CC environment.

2.6 National View of a CCN

CCNs work in an environment with a higher number of nursing registrants and within a wider community of healthcare professionals, primarily because CC admissions span the whole of the healthcare community, not specifically relating to age or disease. The acuity of the patient group requires that the nursing workforce work within an environment that is fast paced (FICM, 2022), they are frequently presented with stressful situations, ethical and moral decisions and increased exposure to end-of-life care (Witton, et al., 2022). As with other specialised units in hospitals, CC has its own culture (Currey et al., 2019), a specific knowledge base (CC3N, 2023) and its own workforce, specifically CCNs (CC3N, 2020, ICS, FICM & UK CC Nursing Alliance, 2022). These CCNs align to GPICS2 (FICM, 2022) and CC3N (2022) definitions of registered nurses that provide constant care delivery to critically-ill patients and their families at a patient to nurse ratio of 1:1 for a Level 3 patient and 1:2 for Level 2.

The National Workforce survey asserts that from the 282 UK CC units, the total number of CCN whole-time equivalents, between band 5-8, was 16986.6, a reduction from 17836, in the 2017 workforce survey (CC3N, 2020). Staff turnover has increased to 11% with 18 of the CC units reporting a nurse turnover of more than 20% (CC3N, 2020). At the time of the survey, 1453 CCN vacancies were reported, representing 8.87% of the CCN workforce; this demonstrates a slight increase from the previous report. The data demonstrates that more nurses are leaving CC than joining (CC3N, 2018), presenting a similar picture to that of the national and international nursing workforce data.

In 2010, this nursing shortage was perpetuated by an aging workforce (Lavoie-Tremblay et al., 2010), however, the national average of the CC workforce over 50 years of age reduced to 11% in 2019 (CC3N, 2020) with only one unit having 20% of the workforce over the age of 50 years (CC3N, 2020). This does, however, represent a loss of CC experience over the last three workforce reports.

GPICS2 (FICM, 2022) advocates for each CC unit to have one Lead Nurse and a supervisory shift coordinator for the 24-hour period, increasing in numbers as the bed capacity increases; these additional supernumerary nurses hold the CC post-registration qualification.

The career trajectory for the CCN is a continuum from band 5 as the newly registered nurse, to band 8, the ACCP and Nurse Manager (Matron). Alternatively, CCNs can remain on a clinical nursing route as part of the CCOT, professional band 6-7.

2.7 Policy Context

In 2000, the Department of Health published Comprehensive CC which saw the first significant political attention to CC, with generous investment for the expansion of services due to the public outcry in the lack of CC services nationwide (DH, 2000). The political investment leant towards a significant recruitment drive, bed capacity expansion, investment in in-house education and the introduction of CCOT. The conjuncture between the political awareness of resources, risk and capacity had not been replicated until 2020, with the publication of Intensive Care-2020 and Beyond (ICS, 2020) and the COVID-19 pandemic, where local, national, and international resources for CC were once again high on the political landscape.

2.8 COVID-19 and its impact on CC

COVID-19 was a global healthcare emergency, first presenting in Wuhan, China in late 2019 (WHO), 2020), with the first cases in the UK in late January 2020 (Huang et al., 2020). In March 2020, the WHO declared a severe acute respiratory syndrome Coronavirus 2 (SARS-COV-2) pandemic (WHO, 2020), capable of spreading from person to person primarily by aerosol and direct contact causing respiratory illness ranging from mild to severe life-threatening illness, organ failure and death (Rhéaume et al., 2021). The high transmissibility indicated that stringent physical distancing and early quarantine were needed to control the viral spread.

Admissions to CC were at unprecedented levels with up to 400 critically-ill patients being admitted in England, Wales and Northern Ireland every day (Fig.2, ICNARC, 2021).

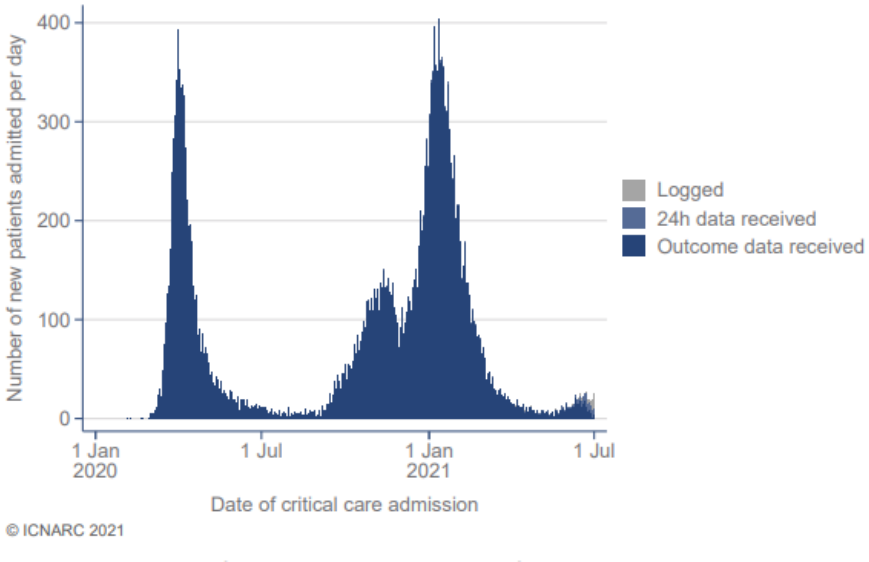


Fig.2: Admission of Critically-Ill Patients with COVID-19 to CC

Clinical data verified that in England, Wales and Northern Ireland, 10,953 patients with confirmed COVID-19 were admitted to CC up to 31.08.20, with 26,550 admitted after 01.09.20 to 01.01.21 (Fig.3, ICNARC, 2021). Within the Midlands region, there was a staggering increase of 275% CC admissions in the second-wave of the pandemic (Fig.4, ICNARC, 2022).

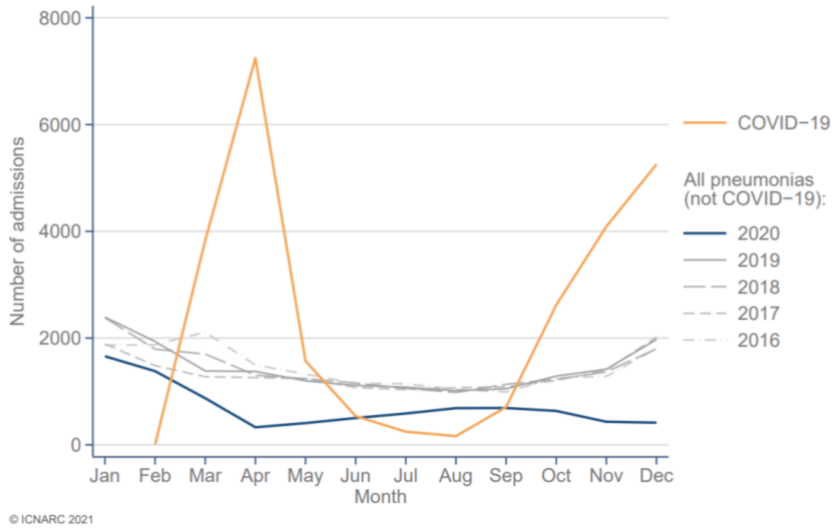


Fig.3: Admission Numbers: Pneumonia over 5 years compared with confirmed COVID-19 during 2020

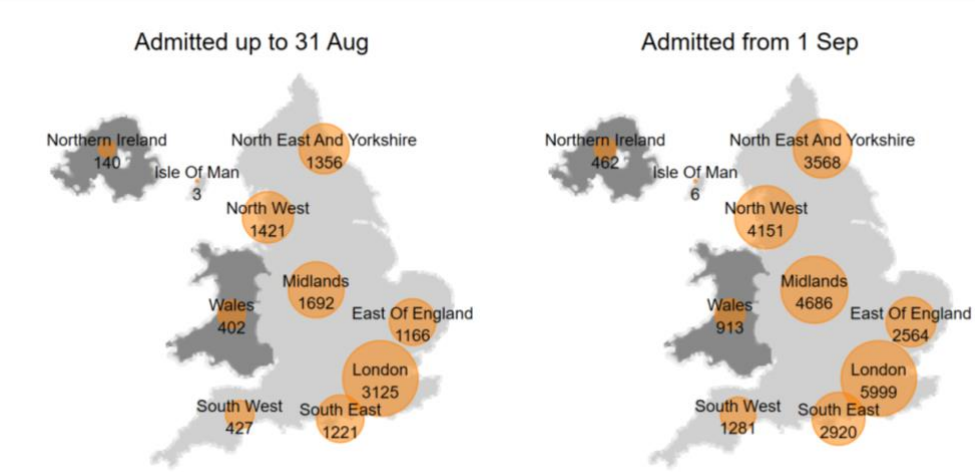


Fig.4: Geographical distribution of CC Admissions with COVID-19 in 2020 (ICNARC, 2021).

The requirement for CC services in the UK, and the World, was well above CC capacity, with the highest number of patients receiving mechanical ventilation on January 24th, 2021, with 4,077 patients being ventilated nationally. Therefore, a different approach was required by the CC workforce to respond to the increased capacity requirements. In March 2020, the UK witnessed a culture change of redeployment, with ward nurses and allied health workers recruited to undertake the same job role as CCNs, to sustain workforce numbers during the COVID-19 pandemic (Armstrong, et al., 2020).

During this unprecedented time, further untraditional responses were required. CCNs were required to change their working processes from a 1:1 patient-to-staff ratio to a 4:1; or 6:1, with those deployed providing support. CCNs were required to work to this new diluted patient ratio to provide a minimum level of CC to as many patients as possible (UKCCNA, 2022 in CC3N, 2022), whilst supporting this new team approach to non-CC workforce in terms of their knowledge, skills and welfare (EFN, EfCCNa & European Society of Emergency Nurses, 2020 in CC3n, 2020). Such actions were necessary to respond to the emergency level 4 national incident (NHS England, 2021). Although precarious, responses were unavoidable and to date unquantified as to the adverse impact on patient outcome, staff wellbeing, recruitment, and retention (UKCCNA, 2022).

CC had already been identified as an environment that is stressful to work in, with 86% experiencing one of the three classic symptoms of stress, exhaustion, depersonalisation and reduced personal accomplishment; COVID-19 exacerbated this issue (British Association of CCNs (BACCN), 2020). Reports on the mental health of CCNs during the pandemic noted that up to 20% of staff had thoughts of self-harm, 45% recognised

symptoms of PTSD and 50% highlighted psychological distress (Greenburg et al., 2021; Ezzat et al., 2021; Roberts et al., 2021). Staff wellbeing, recruitment and retention are now key foci to narrow the nursing workforce gaps noted before the pandemic and ensure flexibility for future emergencies (UKCCNA, 2022). The return to safer staffing to patient ratios were also advised (UKCCNA, 2022).

The effect of COVID-19 caused a temporary halt on the research study due to governance policy and personal needs[9].

2.9 Regional view on CC workforce and study sites

There are 18 CC Operational Delivery Networks across England, Wales and Northern Ireland (Fig.5). Within the Midlands there are thirty-three hospitals, which are distributed into three divisional networks: Birmingham Black County, Hereford and Worcester, Central England and Northwest Midlands and North Wales (acprc.org, 2023). This study focused on two Trusts within the Midlands network across two divisional sites.

[9] In March 2020, due to extreme pressures within CC, research ethics committees informed all researchers that all research was to be halted unless this related specifically to COVID-19. In addition, due to the experience of the inquirer I returned to clinical practice to work within CC during the first-wave of the pandemic. This impacted on data collection and continuation of the research study.

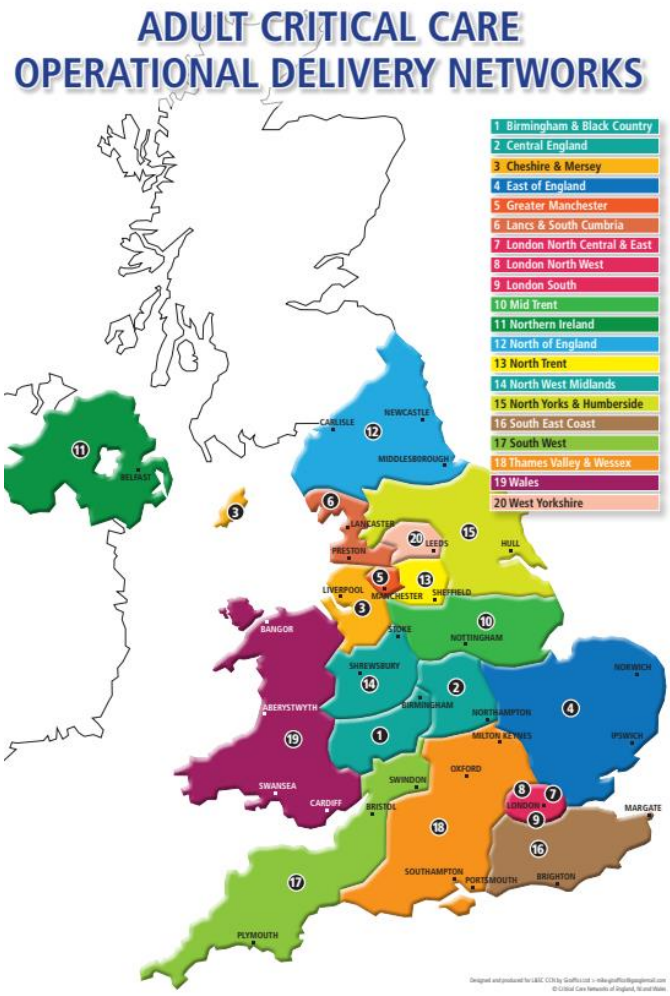


Fig.5: Operational Delivery Networks across England, Wales and Northern Ireland (acprc.org, 2023)

2.10 CC Education and Affiliation to Higher Education

CCNs demonstrate a prominent level of clinical competence when delivering complex care to critically-ill patients and their significant others. To achieve this high-quality, safe, and equitable care delivery, the nursing workforce requires the right level of knowledge and associated skills. All nurses hold the principal knowledge traits of their profession; however, the pre-registration nurse programme does not fully prepare a novice nurse to work within CC. A new registrant, on commencing practice in CC, would

return to supernumerary status; this is atypical of a new registrant who has successfully achieved a post within the acute or primary sector, where they would inaugurate their professional registration status. A registered nurse with post-registration experience, joining CC, would also be awarded supernumerary status, with the length dependent on the nature of their experience. This period of socialisation is where the CCN embarks on the acquisition of their esoteric knowledge of theory and skills which are not shared by the wider community of nurses. As an agent, they differ in level of responsibility and autonomy sometimes only awarded to a ward nurse in a specialised or advanced role.

The National Standards for Adult CC Education (CC3N, 2023) is now in its third revision since its introduction in 2012. This was developed following the demise of the English National Board, with varying standards of CC education, issues associated with transferability across the workforce and programmes not being fit for purpose. As one of the document founders, I am supportive of its recommendations for a framework of education for practitioners new to CC and those undertaking their qualification in specialism (QIS) at post-graduate level.

The supporting suite of clinical competencies enable a CCN to work through the 'steps of competence' from foundation to independence, facing complex decisions with supervision and leadership responsibilities within their CC environment. The foundation level, Step 1, is provided in-house, supporting the supernumerary period of education and the first twelve months of experience. Steps 2 and 3 are aligned to programmes facilitated within HE with successful practitioners achieving 60 credits at levels 6 or 7. Course delivery should be responsive to service delivery, flexible in design, aligned to GPICS2 (FICM, 2022) standards and follow the suggested course curriculum within the

standards. This common framework assists practitioners with geographic mobility as employers have assurance of the knowledge gained and competence achieved.

In support of this standardised education framework, GPICS2 (FICM, 2022) and the National Standards of Adult CC Education (CC3N, 2023) advocate that a minimum of 50% of the nursing workforce should be in possession of a CC post-registration QIS. To support the education attainment and application in clinical practice GPICS2 recommends that each CC unit should have a Lead Clinical Educator, who possess appropriate post-graduate study in education and one Clinical Educator per seventy-five members of nursing staff (FICM, 2022).

2.11 Chapter summary and findings

In summary, there are nearly 17,000 CCNs in England, Wales, and Northern Ireland (Cutler, et al., 2020), working in an environment that is highly technical, fast paced, stressful, and emotionally challenging, as patients balance between life and death. The international and national picture presents a shortage of workforce within the healthcare sector and nursing workforce and CC has not been immune to this.

CC is an area which has recently gained media attention and national interest due to the COVID-19 pandemic and the impact of this is only just surfacing; indeed, the initial and preliminary effect to the CCN appears to have been one of negativity. This provided a rationale to include narrative of the CCN lived experience of COVID during data collection.

Chapter 3: Literature Review

3.1 Introduction

It is a fundamental assumption that CCNs experience of working in CC is a challenging one (Rhéaume & Breau, 2022), requiring enhanced scope of practice to care, both technically and emotionally, for the most acutely unwell patients and their families in the healthcare environment. Healthy WE positively impacts on nurse outcomes, including psychological health, job satisfaction and ITL (Ulrich et al., 2019).

In accordance with descriptive phenomenological methodology, Van Manen (2014) suggests that researchers should assert their philosophical stance; as such, the personal philosophical assumption is that some CCNs remain in CC for their entire career. This reflective, rather than scientific, belief is based on the observation of a variety of national CC working parties, including CC3N's Education Forum, and observation in clinical practice. However, the belief that some CCNs demonstrate longevity in this highly acute speciality has been challenged during the investigation of CCNs and their WE, its relationship to MD and association with ITL (Witton, et al., 2022). The findings were of similar orientation to others (Dodek et al., 2016), that older nurses were more likely to remain in CC.

This internal conflict provided the rationale to explore and gain a greater understanding of the phenomenon:

> *Why do some CCNs, exhibit longevity and remain highly motivated in an emotive and intense area of work, whilst others leave early in their career?*
>
> *and are they thriving during this time*?

3.2 Introduction to the review

This chapter comprehensively presents literature that explores the influences on the CCN workforce, specifically relating to the research question and CCNs ITR in the speciality. It explores whether they are thriving or striving in their WE. This literature review follows a systematic approach to appraise the research and related material and, demonstrates what is known and unknown about the topic under review.

3.3 Aim

The aim was to locate, analyse and synthesise a range of source materials that were relevant to the research question. Using an integrative review method, originally developed by Whittemore and Knafl (2005), enabled the incorporation of findings from both qualitative and quantitative research, (Aveyard, et al.,2016; Oermann & Knafl, 2021). The rationale for selecting an integrative review approach was a pragmatic one; based on the initial review undertaken for the feasibility study. Here, it was evident that various research methodologies had been utilised within studies which related to CCNs and their experiences, and any restriction to a single method could potentially exclude other findings. An integrative approach allowed the inclusion of a diverse range of non-

research studies, widening the search approach (Whittemore & Knafl, 2005; Aveyard, et al., 2016), leading to an enhanced understanding of complex concepts and theories (Oermann & Knafl, 2021).

3.4 Review question

The literature review question was defined in terms of population, intervention, comparators, outcomes and study designs (Table 2).

Table 2: PICOS, Centre for Reviews & Dissemination (CRD) (2008)

Research Question	
Population	Studies with first level CCNs working in CC
Intervention	Any intervention or combination of interventions that relate to physical, psychological or social influences on the CCNs intent to remain or leave the CC WE
Comparators	Intent to remain, or intent to leave
Outcomes	Any outcome, including but not restricted to well-being, organisational support, professional development
Study Design	Qualitative, quantitative, mixed method approaches

The main research question using PICOS was framed as: *What factors influence CCNs' decision to continue to work in CC?* As an empirical study, it was supported by several review questions as suggested by Aveyard, et al., (2016). In addition to what is known about ITR, and ITL, common concepts such as WE and the psychological impact of working in CC were also reviewed.

3.5 Method

Gaining an understanding of what is already known, using an integrative review approach, was a significant component of the research process; it was therefore important to assert the search strategy (Aveyard, et al., 2016). This section will focus on presenting the methods of locating the evidence relating to CCNs' experiences of working within CC and how this effects their ITR within the speciality. Transparency of this process enables replication and critique of the processes used (Silverman, 2020). Ganong (1987), as the first researcher to use integrative reviews in nursing and healthcare research, identified that the methodological rigor of this stage should meet the same standard as primary research, (Silverman, 2020).

Whittemore and Knafl, (2005), modified Cooper's (1998) framework in order to address precise matters of an integrative method. The framework (Table 3 below) outlines the initial problem, the purpose of the review, search stage, evaluation, and presentation. The search stage included a computer assisted search using key words in the Cumulative Index of Nursing and Allied Health Literature (CINAHL), combined with identification of 'grey' literature and, if relevant, conference presentations, texts and white papers. In the data evaluation stage, specific methodological principles to evaluate the overall quality were used. There is no gold standard for identifying quality papers; indeed, evaluating the quality of integrative reviews with assorted sources increases this complexity. Kirkevold (1997) suggests in such instances calculating quality scores based on authenticity, methodological quality, information value and representativeness should be considered (Hawker, et al., 2002).

Table 3: Integrative Review Process (adapted from Whittemore and Knafl, 2005)

Stage of Review	Illustration of Decisions and Issues
Problem Identification	Empirical and theoretical work since 2000 relating to the concept of CCNs, and their experiences of working in CC, focuses on the WE intent to leave and psychological stress such as moral injury. The problem is: *why some CCNs remain in CC for long periods and potentially a significant part of their professional career*. Greater understanding of the concept of longevity in CC practice for CCNs was proposed. Therefore, the aim of this integrative review was to analyse the concept of longevity in CC practice and are CCNs thriving or striving in CC.
Literature search	Specific focus on CCNs experience of working in CC, related to longevity of working in the speciality, and decision to remain. CCNs, CC and WE were key words in the CINAHL database. Excluded articles pre-2000, restricted to the English language and required full paper access. By focusing the review, potentially relevant sources identified were reduced from 188,4113 to 32 reports.
Data evaluation	The integrative review final sample included empirical and non-empirical reports. Empirical reports included a varied spread of methods. This diverse range of studies were then scored using Hawker et al. (2002) scoring tool. Those scoring fair and good were included as their rigour and transparency of methods were clear. Those scoring poor and very poor were read, included in the data extraction table but were less representative in the analysis process and not presented in the data. The non-empirical reports included professional body and organisation reports.
Presentation	Synthesis of the findings were portrayed in a thematic manner, which supported the rationale to investigate why some CCNs remain in CC as opposed to the plethora of findings which highlight why they leave.

Primary and non-empirical sources were ordered, categorised and summarised providing an integrated conclusion of the research problem. Hawker et al. (2002) allows the option to retain any source that meets the inclusion criteria, regardless of the quality score (Table 4). However, in this instance, and due to the plethora of sources (twenty-one) which achieved a score of fair and good in the quality assessment, those scoring poor or very poor using the Hawker et al. (2002) scoring tool were not included in the presentation of the data.

To strengthen the data analysis process further, multiple individuals were part of the data review, with initial quality scoring completed followed by consensus of accuracy and completeness of the 'scoring' process by the lead supervisor (JG).

Table 4: Methodological Scoring Tool (Hawker et al., 2002)

Author and Title	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
Abstract and Title					
Introduction and Aims					
Method and Data					
Sampling					
Data Analysis					
Ethics and Bias					
Findings / Results					
Transferability / Reliability					
Implications and Usefulness					
Total Score					

3.5.1 Article inclusion and exclusion criteria

The key to integrative reviews lies in their purpose, not only their size, with an aim to respond to the question and lessen bias in selection and inclusion of studies, irrespective of their paradigm (Hawker, et al., (2002); Aveyard et al., (2016). This is partially accomplished with diligence to the predetermined transparent selection criteria which narrows the focus.

Inclusion and exclusion criteria were determined (Tables 5 & 6), to focus and operationalise the transparency and replicability process. The initial review was limited to studies published after 2000. This date should ideally be meaningful to the topic, however, a pragmatic approach was necessary, with studies prior to this deemed to add little value by comparison. Post the COVID pandemic, the dates for the literature being considered expanded to 2023, to ensure all recent and relevant literature was included.

Table 5: Inclusion Criteria for Primary Studies

Inclusion Criteria
Relating to CC (and similar search terms)
Full text format available through reviewed databases
Articles published in the English language
Abstract and references included
2000-2020, amended to 2023 to add COVID concept (S4)
Published in academic journal
Peer reviewed
Primary reports that utilized any research method (qualitative, quantitative or mixed method)
Secondary reports relevant to the research question

Table 6: Exclusion Criteria

Exclusion Criteria
Concepts relating to other specialities such as Emergency Departments and oncology
Non adult CC units including Paediatric/ Neonatal
Reference to military personnel
Healthcare professionals/members of the muti-disciplinary team (no specific focus on CCNs)
Geographical location (rural CC units in Australia, and other similar healthcare environments)
Focus on patient impact/ outcome (including pressure injuries)

3.5.2 Search Strategy

Electronic searching was the central method of locating pertinent studies, although it is noted that limitations associated with the search terminology and indexing can lead to only 50% of eligible studies being included (Whittemore and Knafl, 2005). To ensure completeness, and in addition to electronic searching, handsearching of the abstracts, reference and citation was conducted and relevant additional material was added to the data extraction table for review. Ideally the review should include all relevant literature, regardless of publication status, to prevent publication bias (CRD, 2008), so a wider review was conducted. The purpose of this wider search strategy was to ensure all relevant literature was identified (Whittemore and Knafl, 2005).

3.5.3 Databases

An extensive electronic search was performed using relevant databases and using the 'All Health Databases' option. The seven databases accessed, each retrieving a collection of material, are summarised below (Table 7).

Table 7: Research Databases Accessed

Database	Description
AMED	The Allied and Complimentary Database. This presents the alternative medicine database for healthcare professionals to review alternative treatments mainly from European journals. AMED is produced by the Health Care Information Service of the British Library.
MEDLINE	Medical Literature Analysis and Retrieval System Online. This is the authoritative database for healthcare fields professionals including veterinary and healthcare services and created by the National Library of Medicine. Medline uses Medical Subject Headings (MeSH), subheading hierarchy to have the capability to search over 5,600 medical journals.
APA PsycINFO	American Psychological Association is the largest resource for scholarly abstracts (books, journals, abstracts and dissertations) relating to peer reviewed mental health and behavioural science. It has a history dating back to the 17th century, international material and the highest DOI corresponding rates.
AgeLine	With a focus on the over fifty age, and issues of aging, this is the foremost source for age-related content, psychology, sociology, economics and public policy.
CINAHL Plus with Full Text	Cumulative Index to Nursing and Allied Health Literature available since the 1930's, is the core nursing and allied health professional database with more than 770 journals.
APA PsycArticles	American Psychological Association is the authoritative source of full text, peer reviewed scholarly articles, spanning from 1894.

Search terms were identified from the research question: *what factors influence CCNs' to continue to work in CC?* and replicated in each search. Boolean operators (AND/OR) and truncation were used for variation of words alongside using the inclusion and exclusion criteria, including nurs*, AND critical care*, OR intensive care* to expand and restrict the search (Table 8) (Polit & Beck, 2021).

Table 8: Search Terms

Search	Search Terms
Search 1 (S1)	CCN/ Intensive Care Nurs*/ ICU Nurs* AND WE AND job satisfaction/ work satisfaction/ employment satisfaction AND intent to remain OR intent to leave
Search 2 (S2)	CCN/ Intensive Care Nurs* AND CC / intensive care/ICU AND Intent to remain/intent to stay
Search 3 (S3)	CCN/ Intensive Care Nurs* AND emotional intelligence OR psychological effects, burnout, stress, MD, moral injury OR organisational support
Search 4 (S4)	CC Nurs*/Intensive Care concepts from S1/S2/S3 AND CCN experience/ perception of COVID 19/ SARS Pandemic/ Coronavirus

3.6 Results, Screening and Selection

Table 9 presents the multiple search findings.

Table 9: Search Findings

Search	Detail
Search 1 (S1)	Initial search (S1) related to the concepts of job satisfaction, CC WE and ITR or ITL, locating a total of 1,870,468 articles. Due to the plethora of literature available limiters and eligibility criterion were used to refine results and further search approaches were added (S2-S5). Of the initial 1,870,468 articles, 1870,385 were removed using limiters such as: date to 2000- 2020, (1097), full text (259), peer reviewed (244) and duplicates (195). These were extracted to file save and the full title was reviewed. 83 articles remained

	following elimination of articles relating to oncology, paediatrics, reference to patient care, management interventions, and those relating to the wider healthcare team. Further refinement continued with the removal of studies with incongruous findings, such as non-human subjects and healthcare environments or those which lacked similarity to the UK, Europe, USA, Canada, and Australia.
Search 2 (S2)	The second search (S2) added the specific concepts of ITR or ITL, longevity in the workplace. This located 1514 'hits'. These were similarly refined linking to full text (302), peer reviewed (281), date 2000-2022 (278) published in academic journal (278), English (278). Equally, these were extracted to file save and the title was reviewed; following the elimination of articles relating to non-relevant concepts such healthcare assistants, dental hospitals, and duplicates, 103 articles remained.
Search 3 (S3)	The third search (S3) added the concepts of stress, burnout, psychological effects and emotional intelligence; locating 69 articles. Emulating the process followed by S1 and S2 led to a final 13 papers. S1, S2 and S3 were then reviewed for duplicates leaving 119.
Search 4 (S4)	The process was repeated for the fourth search (S4), adding the concepts of the CCNs experience, effect of and perception of COVID, SARS and the pandemic; ascertaining 355 articles. Here patient intervention and patient safety were the significant limiters. Resuming the process of limitation achieved 27 articles. As the search reached its final stages, references were reoccurring, and not generating new articles. This process yielded 146 articles. To further refine the search results the title and abstract were read ascertaining their significance to the research question. Conference presentation, editorials and the remaining obscurities, relating to radiology, personal protective equipment and neonatal nursing were eliminated. The remaining 108 were subjected to full text reading. Full text reading directed the exclusion of scoping reviews, organisation achievement which may have a positive effect on the individual, this included those relating to Beacon status, and preceptorship programmes for new starters to CC.

Outcome	Thirty-two papers were identified as definitive papers from the electronic database search. In addition, during the process of full text reading, citation searching elicited sixteen publications, opinion pieces, reviews and seminal literature relating to the concept of what factors influence CCNs' to continue to work in CC.

The PRISMA flowchart (Fig.6) presents the multi-method search approach.

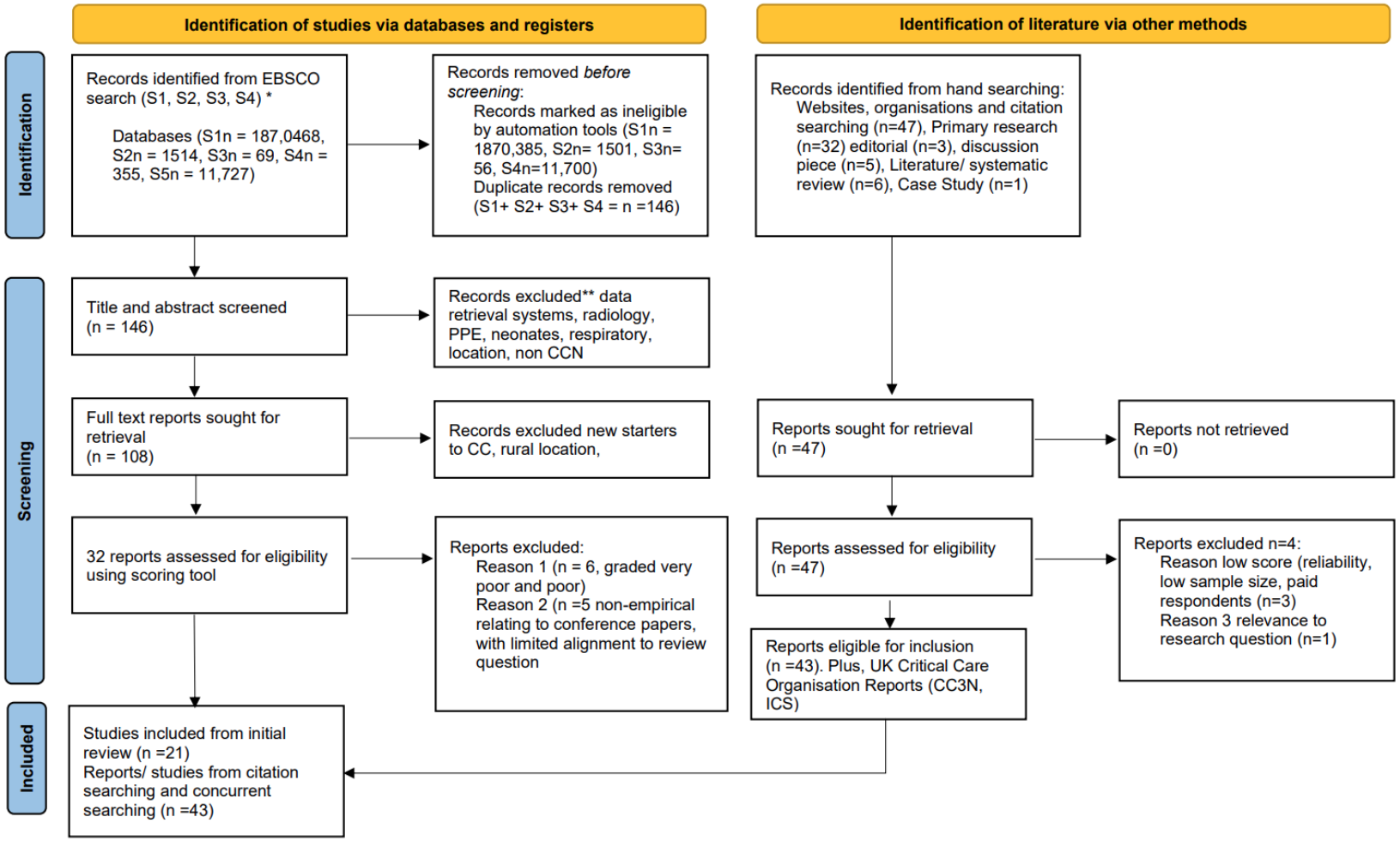


Fig.6: PRISMA 2020 Flow Diagram for Integrative Review

3.7 Article review

The source material spanned across the paradigms, quantitative, qualitative and mixed method designs. To ensure that these were robustly evaluated they were systematically reviewed using a staged approach. This commenced with consideration of relevance by reading and re-reading the full text, scrutiny for relevance to the research question, situation of study, data source and nature of study; comparable to the method purported by Hawker et al., (2002). This was followed by a data extraction stage (appendix 1), where study design features were considered for reliability and validity (Aveyard, et al., 2016); this stage frequently demonstrated that reference to ethical procedure and method of analysis were limited or unclear. The final stage, scoring for methodological rigor, involved the grading of each empirical study using Hawker et al. (2002) scoring tool (Table 10). The rationale for selecting this tool was that, unlike other tools, it calculates an overall score using a Likert scale (ranging from 40 'good' to 10 'poor') to indicate the methodological rigor of each study; the alternative, leaving a descriptor, could be open to interpretation, thus, reducing reliability. The articles were scored independently by the researcher followed by peer review, which demonstrated congruence in scoring (appendix 2).

Table 10: Summary of Quality Appraisal (Hawker et al., 2002)

Author	Good	Fair
O'Brien et al. (2022)	Good	
Rhéaume et al. (2022)	Good	
Rushton et al. (2015)	Good	
Roney et al. (2022)	Good	
Fitzpatrick et al. (2010)		Fair
Celik et al. (2021)	Good	
Ulrich et al. (2019)		Fair
Guttormson et al. (2022)		Fair
Kelly et al. (2017)	Good	
Kagan et al. (2022)	Good	
Kester et al. (2021)		Fair
Sung-Heui (2021)	Good	
Yoon et al. (2022)	Good	
Elpern et al. (2005)		Fair
Stone et al. (2007)	Good	
Rivaz et al. (2021)	Good	
Levi et al. (2021)		Fair
Ndlovu et al. (2022)	Good	
Bergman et al. (2021)	Good	
Currey et al. (2019)	Good	
Breau et al. (2014)	Good	
Total	**15**	**6**

3.8 Synthesis/ overview

Consideration was given to the undertaking of a meta-analysis as part of the quality process, however, due to the lack of homogeneity and diverse nature of the quantitative studies, the data was deemed to be more suitable as a narrative synthesis. The synthesis

overview involved the collation and summary of the empirical primary studies, discussion papers and policy. The drawing together formulated seven key themes:

Fig.7: Integrative Review Findings: Key Themes

3.8.1 Work Environment (WE)

A healthy WE is defined as "…a practice setting that maximizes the health and well-being of nurses, quality of patient outcomes and organisational system performance" (The Association of Ontario, RNAO, 2013, p.13). Optimal WEs are also associated with positive recruitment and retention of nurses (Alspach, 2009), an increase in work satisfaction and a decrease healthcare costs (Dimino, et al., 2021).

Our international colleagues demonstrated early commitment to publishing WE guidelines, with the Standards for Establishing and Sustaining Heathy WE (AACN, 2005). Recognition of collaboration, communication, decision making, appropriate staffing and leadership were highlighted as essential. A decade later, the UK published the Core Standards for Intensive Care (2013; 2016) and, subsequently, GPICS outlining guidelines for CC services (FICM & ICS, 2016; 2019; 2022; 2024). Since publication, these standards

have aligned with an increasing body of knowledge which highlights the relationship between heathy WE, nurse well-being, organisation and patient outcomes (Ulrich et al., 2019).

CCNs identified a sense of control, which is akin to structural empowerment, as a positive influencing factor on their working role (Ulrich et al., 2019). Empowerment is defined as the extent to which nurses have access to key organisational resources and having empowerment over one's WE. This has been linked to 'work effectiveness' and positive patient outcome (Ulrich et al., 2019). CCNs typically experience autonomy within CC, however when this is not experienced, there is an association with decreased job satisfaction, characterised as reduced engagement and burnout (Rahman et al., 2017). Burnout is defined as an individual's response to work-related stress that is not successfully managed (WHO, 2020).

Breau and Rhéaume (2014) reviewed the relationship between empowerment, job satisfaction, ITL and quality of care; they identified an inverse relationship between ITL and empowerment, with those attaining lower empowerment scores indicating a higher ITL. Suggesting that empowerment is fundamental for CCNs to work efficiently and effectively whilst attributing positively to their well-being.

Psychosocial WE (PWE) is dependent on factors that include job demand, autonomy, decision-making, work social-support and the effort-reward balance (Lavoie-Tremblay et al., 2008). Participation is the coming together of healthcare workers to share in the decision-making about mutual concerns, relationships between participation and stress; with decreased levels of stress observed as the level of nurse participation increased.

Papathanassoglou et al.'s (2012) exploration of professional autonomy, suggests that CCNs negatively perceived their contribution in decision-making regarding patient care, increasing their feeling of being undervalued. Whilst recognising that involvement with positive contributions is identified with reducing negative behavioural alterations such as irritability, apathy and absenteeism (Rahman, et al. 2017).

Papathanassoglou et al. (2012) identified a positive association between the CCN and physician interaction, highlighting how supportive interactions reduce adverse psychological reactions and improve wellbeing. Albeit a mild association, collaboration and effective communication maybe a pre-requisite for an HWE and increased job satisfaction (Papathanassoglou et al., 2012). Rivaz, et al. (2021) stated that improving the WE factors, in terms of professional collaboration and resource adequacy decreased CCN burnout and ITL.

Adverse working conditions are recognised as a primary factor contributing to CCNs leaving the CC environment (Ulrich et al., 2019; Roney et al., 2022). Workplace adversity can be defined as a "negative, stressful or episode of hardship encountered in a workplace setting" (Jackson et al., 2007, p.3). CCNs are exposed to workplace adversity due to the frequency of bearing witness to tragedy and anguish, whilst caring for others including families/carers (Stokes-Parish, et al., 2023). Woo, et al. (2020), systematic review highlighted the unique, yet intense, patient characteristics predisposes CCNs to burnout more than other HC professionals.

Aiken et al. (2013) in their large European study of 33,659 nurses, identified that one in five CCNs are dissatisfied with the WE. Similarly, Heinman et al. (2013) highlighted WE

characteristics such as leadership, professional relationships, and career development were related to ITL. Similarity here can also be drawn to human factors, which are commonly overlooked (Dimino, et al., 2021).

3.8.2 Psychological Well-being

CCNs work in a highly intensive setting, delivering life-sustaining and end-of-life care, with additional demands relating to, often, unrealistic expectations from relatives. The related physical and psychological strain of this challenging patient-family centred care is known to have a negative impact on the CCNs' health (Rhéaume et al., 2021).

Stressors and trauma caused from caring for such complex, high acuity patients over time, was highlighted as a cause for one in five CCNs suffering from psychological distress (Karanikola et al., 2015). This alarmingly high figure is consistent internationally (Shen et al., 2020); with 38% of CCNs in British Columbia experiencing significant symptoms of PTSD, mild to severe depression (57%), anxiety (67%) and stress (54%) (Crowe et al., 2022) and 19-27% of CCNs in Holland suffering from symptoms ranging from anxiety and depression to PTSD (Heesakkers et al., 2021). PTSD is defined as direct or indirect exposure to a single or repetitive episodes that result in symptoms and stress responses that last over one month (American Psychiatric Association, 2013).

Levi et al. (2021) identified that 33% of CCNs have symptoms of PTSD, and 23% align to the diagnostic criteria of PTSD in comparison to 18% of ward nurses and 10% of the general population. Symptoms of re-experiencing, avoidance and alterations in mood can lead to the provision of poor-quality care, medication errors and a lack of empathy.

Levi et al. (2021) relates this to poor WE, which leads to decreased job satisfaction and ITL.

Rushton (2015) noted a strong association between burnout and resilience, reporting that those with greater resilience were protected from emotional exhaustion whilst also contributing to personal accomplishment. The increased levels of resilience were also associated with hope and a reduction in stress (Rushton, 2015).

3.8.2.1 Moral Distress

Elevated levels of stress has been linked to MD (Rhéaume & Breau, 2022). MD is defined as the conflict between knowing the right course of action, believed to be morally correct, and having little ability to impact on the situation (Jameton, 1984; 1993), described further as feeling powerless and not being heard (Hamric, 2014).

Henrich et al. (2016) highlighted quality of care, extent of care provided, inconsistent care plans, poor communication, end-of-life decision making, interaction and conflict with families, recommendations for patient care being ignored, lack of support and resourcing as causes for MD in CC. MD is also linked with an imbalance in perceived power, such as nurse-physician relationships, and organisational conflicts (Choe et al., 2015).

MD has an active relationship between the practitioner and the WE, with the inability to sustain moral integrity which leads to frustration, anguish and despair (Carse & Rushton, 2018). Similarly, Hiler, et al. (2018), in their study of 328 nurses, found a significant correlation between MD and the WE; they highlighted decreasing levels of

MD as nurses participated in hospital affairs and that MD intensified as dissatisfaction with the WE increased. These issues were associated with increased staff turnover, decreased quality of care and were identified as causative factors leading to premature departure from the nursing profession (Dodek et al., 2016).

To improve understanding of the relationship between WE and MD, Witton, et al. (2022), in a cross-sectional survey, of 266 CCNs, highlighted the principle causes of MD as being influenced by end-of-life decision making, avoiding acting when errors are observed and continuation of care that is seen as futile, when no-one will make the decision to withdraw care. Furthermore, the dilemma of working with nurses and healthcare professionals who were unsafe ranked the third highest on the MD scale. Similarly, an awareness of CCNs perceived as incompetent in delivering care to the critically-ill patient was ranked fifth in contributing to MD distress (Witton et al., 2022). CCNs highlighted the distress of working with such healthcare workers and raised concerns regarding incompetence, patient allocation and acuity of patients.

Elpern et al. (2005) identified the provision of care perceived to not be in the best interest of the patient as the most frequent cause of MD. They remarked that MD increases with years of experience, suggesting an accumulative weight of burden, rather than de-sensitisation over time; also supported by Dodek et al (2016). The impact of this relates to job dissatisfaction and loss of CCNs in the workplace with the provision of aggressive care. Rushton (2015) also reports similar findings of MD increasing over time. Rushton (2015) also linked the effects of MD with increased job dissatisfaction with disengagement, and reduced organisation loyalty with increased ITL.

Another key factor in the development of MD is the destabilisation of the CCN workforce typically due to staff shortages (CC3N, 2020). The National CCN Workforce survey (CC3N, 2020) reported 9 % nursing vacancies in CC with an annual turnover of 10-20%. The CCN workforce has been destabilised due to COVID, presenting severe nurse shortages and a reduction in nurse-patient ratio. Credland (2020, no.p.) stated that CCNs "are physically and psychologically exhausted. Many are off sick with significant mental health issues due to their experiences of managing the first COVID-19 surge".

Choe et al. (2015) found that MD, rather than triggering an ITL, led to ambivalence, blaming workload for the nurses' prioritisation of tasks over human dignity or patient advocacy. These nurses describe a feeling of powerless and inability to influence the outcome of ethical dilemmas; defining the cause of their ambivalence as increased feelings of guilt resulting from being unable to protect patients' dignity and act in their best interests (Choe et al., 2015).

Whilst MD and burnout can individually predict turnover intentions (Karakachian & Colbert, 2019), Rushton (2015), Rhéaume and Breau (2022) and Roney et al. (2022) associated MD, with burnout and ITL. Rushton's (2015) cross sectional study on healthy WE, highlighted MD as a significant predictor for emotional exhaustion, depersonalisation (presenting as dulled emotion and detachment) and reduced personal accomplishment; the three characteristics of burnout.

CCNs are considered to have the highest rate of burnout; at over 50%, with 86% demonstrating at least one symptom of burnout such as insomnia, chronic fatigue, increased illness, anxiety or depression (Mealer and Moss, 2016). Others negative

effects of MD and burnout include emotional fatigue, increased job dissatisfaction, and evidence of substance misuse. Cacchionne (2020) also agrees, stating circumstances out of their control, an inability to advocate for their patients and caring for those whose outcomes were considered futile contributed to CCNs MD (Rhéaume, et al., 2021).

In healthcare, there is a disproportionate share of stress (McAllister & McKinnon, 2009), yet there is some evidence to suggest that there is little implementation of self-care, the nurse spends so much time caring for others that they do not care for themselves (Bright, 1997).

3.8.3 Intent to Leave

CCNs are highly skilled and costly to replace; ITL and the subsequent attrition leads to valuable experience being lost and organisations then needing to recruit and retrain, costing 50% of a nursing salary, (Ellison, 2021). ITL CC data has been presented pre-and post-COVID; with Ulrich et al. (2019) presenting one-third of CCNs expressing ITL in next twelve months; albeit a reduction from the American 2013 survey. Rhéaume and Breau (2022), stated Canadian CCNs ITL was 49%, which is significantly higher than Lavoie-Tremblay et al.'s (2021) study in Québec the previous year, which indicated a 30% ITL as their current position, while 22% ITL the profession entirely. This is significantly lower than the reported statistics by Witton, et al. (2022) in their UK study, which highlighted that two-thirds of CCNs had considered leaving in the same period.

The compelling evidence presents the predictors relating to ITL CC as: organisational issues, nurse/physician collaboration, nurse competence, control/ responsibility, and autonomy (Ellison, 2021). Intermediary factors included

engagement, compassion satisfaction, job satisfaction, burnout, with a principle influencing factor relating to control and responsibility (Roney et al., 2022).

Ulrich et al. (2019), in a sample of over eight thousand CCNs, found that 60% of participants highlighted an area of concern relating to the absence of appropriate staffing, which negatively affected their physical and mental well-being. The negative effects of CCN staffing include fatigue, emotional exhaustion, and depersonalisation, and the association with burnout is confirmed by Sung-Heui (2021), in a systematic review examining the relationship of job satisfaction, burnout and ITL.

Albeit a decade ago, and with a response rate of 15%, Fitzpatrick et al.'s (2010) study recruited 6589 CCNs, and examined the association of empowerment, certification and feeling valued. The findings linked the lack of empowerment and support to study with an ITL current position of 41%, and an ITL the profession of 7%, with the younger, ethnic groups and male nurses ever more so. In addition, the older more experienced CCNs were generally more satisfied with their career, which increased their ITR (Fitzpatrick et al., 2010). The association of support to study and ITL was also highlighted by Yoon and Cho (2022), albeit with a small study; 93% did not receive frequent educational updates, and ITR was higher for those that did.

Kester et al. (2021), cited the most frequent cause for leaving was to pursue advanced roles or relocation. This small study, 165 CCNs, presented a significant increase in the workplace healthiness, noting that this is reflected in CCNs staying in their jobs longer, experiencing less MD and an increased satisfaction in the workplace. Breau and Rhéaume (2014), in a larger study of 533 CCNs similarly found low ITL, with the

associated cause relating to career advancement or financial reasons and this being a generational concept for the younger ones. Baby boomers were affiliated as devotional to their employers, whilst generation X and Y desired better professional opportunities and working conditions.

ITL is a global multidimensional concern, that combines social, physical and cultural aspects (Khan, et al., 2018). These findings explore the organisational, department, team cohesiveness and individual's wellbeing factors as causative factors for ITL. Organisational support is identified as a key component to reduce burnout and ITL (Lavoie-Tremblay et al., 2021), and specifically, the workforce want managers to be visible and listen to concerns.

3.8.4 The Meaning of Work and Job Satisfaction

The history and theory of work is embedded within the characteristics of society, fused with personal and societal identity (Fineman, 2012). Work is a relatively new phenomena, dominating since the industrial revolution. Prior to that, history presents a community of 'labouring' securing shelter and gathering sufficient food. Work is influenced by families, education, economy, structural society, and cultural norm (Fineman, 2012). With the kind of work influenced by geography, social class, wealth, education, gender, age and ethnicity (Fineman, 2012).

The theories of motivation to work, are multiple and complex (Fineman, 2012). Here, the intention was to review the CCNs perspective of work, rather than the organisational or management perspective. From a worker perspective, Maslow's (1943) theory of

fulfilment, built on a theory of individual need[10], suggests the most basic need that motivates our behaviour is survival. Job security, with its financial compensation, ensures the meeting of physiological needs. Safety needs are met through the CCN feeling safe at work, in relation to the environment and their job security. The structure of the needs hierarchy motivates the individual to move towards the next level. With the subsequent psychological needs of love and belonging, being satisfied in a work context, when an individual has healthy relationships. This feeling of belonging in the workplace, is in the form of positive relationships with colleagues and supervisors (Alspach, 2009). Belonging is defined as personal involvement with a group which is characterised by feelings of value, need or being accepted (Hagerty & Patusky, 1995). This suggests that belonging, within an organisation, leads to the feeling of fitting in, being appreciated, both, essential for health and wellbeing (Grobecker, 2016). Maslow's (1943) final need refers to self-actualisation, attributed to enabling an individual to grow and be all that they are able.

Similarly, Herzberg's job satisfaction two-factor theory (1959), consists of two continuum, relating to motivation and hygiene concepts. The hygiene factors relate to personal safety, job security and good work-life balance. The motivating factors, relate to job satisfaction, stemming from financial reward, recognition, nature of work, advancement, responsibility, and achievement. Nickerson (2023) surmises that this

[10] Abraham Maslow, a behaviourist psychologist, developed the Hierarchy of Needs, Fulfilment Theory, (1943). Theorising a hierarchy of needs, illustrated as a pyramid with survival needs at the broad-based bottom and self-actualisation needs at the top. The original theory recognised that satisfaction is not an all or nothing phenomenon, suggesting needs may not be fully met before the next need emerges. Habitually individuals are directed towards meeting the next set of needs. Growth needs, and self-actualisation, may continue to be felt and become stronger once they have been engaged.

contradicts the traditional view of job satisfaction, speculating that job satisfaction and dissatisfaction are interdependent. The absence of a good WE, policy and structure, and interaction with colleagues, may lead to the employee being dissatisfied at work. These dissatisfiers may cause dissatisfaction at work, but their presence does not create satisfaction or motivate (Nickerson, 2023).

There is criticism about integrating both Herzberg (1959) and Maslow's (1943) theories, however, it can be recognised that Herzberg motivation–hygiene theory relates to the workplace context and without the balance of personal with professional, located within Maslow's theory, the motivation factors cannot be met in the workplace. Therefore, both theories have been used as a lens here.

Job satisfaction is the fulfilment of desired needs in the workplace and is one of the most frequently mentioned constructs relating to burnout, WE and turnover. Job satisfaction is a behavioural and emotional response which reflects the individual's judgement of their work, working life and WE (Ulrich et al, 2019). Satisfaction is a psychological factor; it cannot be seen or quantified. As an individual, if needs are unmet, a drive is triggered to keep the human mechanism in order. If this fails, an alternative goal is sought, or the individual is left frustrated (Fineman, 2012).

CCNs provide a service for patients and their families; it is important that they are satisfied with their jobs to be productive and efficient, and this is known to improve the quality of the service they provide (Atefi, et al., 2014). Missed care, reportedly leaves a CCN vulnerable to committing errors, feeling demoralised, undervalued, and disempowered and impacts on their physical and mental well-being (Senek et al., 2020).

CC workload, and consistently working at high intensity, can lead to job dissatisfaction and MD (Elpern, et al., 2005). Özden, et al., (2013) found a weak but significant correlation between job satisfaction and burnout, with those identifying with emotional exhaustion and depersonalisation also scoring lower for job satisfaction.

Atefi et al. (2014) related job satisfaction and the importance of working with supportive colleagues, correlating with Roulin, et al.'s (2014) survey on retaining and satisfying personnel. Roulin et al.'s (2014) findings correlated, job dissatisfaction with work-family conflict and burnout. With financial reimbursement and perceived lack of value by managers being a source for dissatisfaction, and an inability to meet physiological and social needs. The lack of autonomy and clinical decision-making, led to CCNs having to wait for medical decisions for simplistic interventions was reported to negatively affect motivational behaviour (Roulin et al., 2014).

Specialist education has been linked to intrinsic reward (nurses' satisfaction and empowerment) and extrinsic reward (retention and patient satisfaction) (Ulrich et al., 2007). Fitzpatrick, et al. (2010) demonstrating that CCNs with the QIS displayed greater satisfaction and personal growth and felt this validated their professional credibility. Currently 46% of UK CCNs hold a QIS, less than reported in 2017 (CC3N, 2020) yet, the National Standards for Adult CC Nurse Education (2023) state that 50% of CCNs should hold a QIS (ACC Service Specification, NHSE, 2019).

3.8.5 Age and Work

Sacco, et al. (2015) highlight a striking feature that CCNs aged 50 years and older, scored higher on the compassion scale and lower on the burnout scale than their younger colleagues, which may be due to life experience and better preparedness to cope with the CC workplace. Kelly and Lefton (2017) review of compassion fatigue, also found that the inexperienced and younger CCNs had heightened compassion fatigue, and the older CCNs demonstrated increased job enjoyment. This related to contribution, value and meaningful recognition, which in turn increased compassion satisfaction and reduced burnout. Similar key findings were highlighted in Witton, et al's. study (2022), which noted a positive correlation between age and ITR. Similarly, Cajanding (2021) found that older nurses were associated with higher resilience scores during COVID. This suggests a link between job satisfaction to age; potentially highlighting that emotional intelligence increases with age, as did the relationship between stress coping mechanisms and age. Mollaoğlu et al. (2003) reported that those nurses with longer careers experienced less exhaustion, affording them greater job satisfaction, and those newer in their careers experience increased depersonalisation.

Contrastingly, Rushton (2015) and Ndlovu, et al. (2022) did not identify differences across the age range. Ndlovu, et al (2022) study of professional quality of life (QoL), measured compassion satisfaction. The findings suggested a low to moderate compassion satisfaction and moderate to high burnout, with compassion fatigue, associated with the high workload during COVID. The variables found to influence QoL were experience, nurse education and nurse-patient ratios; with participants having a mean of 13 years CC experience, and 60% held the QIS.

Overall, suggesting some inconsistency between age and work experience pre and post COVID. Interestingly Rushton (2015) highlighted that resilience remained consistent across the years of experience, suggesting the cultivation of internal resilience to enable nurses to thrive and survive in high intensity settings may be achieved (Rushton, 2015).

Stone et al. (2007) investigated organisation climate and ITL. CCNs experience significantly related to ITL, with those having worked in CC for less than one year or over eleven years less likely to leave. Stone et al. (2007) also suggested organisational features such as involvement in decision-making and leadership linked to ITR, however there was no link to hours of work or financial reward.

Generational cohorts, as defined by birth year (Table 11), are seen as a questionable method to categorise the population into large chunks of people, with Fineman (2012) suggesting that similarities and overlapping can be seen between the age groups. However, acknowledging these differences, similarities can be seen when referencing leisure time between generation X and Y; with the notion of centrality of work in their lives declining and a greater motivation towards status and money, seen with Gen X (Fineman, 2012; Breau and Rhéaume, 2014). Fineman (2012) also suggests the generational effect has a lesser impact on work compared to psychology and personal make-up.

Table 11: Generation Link Definitions

Type	Date of Birth	Work Ethic
Silent Generation	1920's-1930's	Born in a time of economic recession, conservative, conformists, prepared to work hard.
Baby Boomers	1940'-1960's	Part of regeneration and increasing affluence, following WWII. Valuing results, drive, loyal, and give maximum effort.
Generation X- 'latchkey'	1960's-1970's	Valuing informality, and work-life balance, and seen as 'feckless by the baby-boomers'.
Generation Y- the millennials	Mid 1970's-mid 1990's	Digital natives, preference for collaborative working, strong urge for personal development and flexibility, keen to learn new skills.
Generation Z- post millennials	1990's-2012	Digitally connected, fiscally conservative
Generation A	2012-2025+	Wider digital connection, educated virtually, 'expected to be highly educated and wealthy'.

3.8.6 Psychological impact of COVID-19 on CCNs

The global pandemic was described as "mass traumatisation of the nursing workforce", characterised by insufficient staffing, high demands and increased personal risk (Rhéaume & Breau, 2022, p.12). CCNs experienced COVID as frontline healthcare practitioners, with 20% becoming infected and 2,200 nurses dying from the disease (ICN, 2021). CCNs increased risk of exposure was due to working with aerosol generated procedures, typically used in the management of CC patients and unused in other WE (Mokhtari et al., 2020).

CCNs described the physical and mental burden of COVID; their witness of suffering and the 'utter devastation' of feeling helpless, and the sense of professional failure which continues to haunt them like nothing they have experienced before (Kagan et al., 2022; Guttormson et al., 2022). A fear for their families, uncertainness of the disease and the effectiveness of protective clothing, found the CCNs questioning and for some, regretting their role as a CCN (Kagan, et al., 2022; Guttormson et al., 2022).

The fear of working in a COVID CC environment was examined by Celik et al. (2021). This comparative quantitative study used the fear of COVID-19 and DASS- 21 depression scale, to investigate the mental health status between 156 CCNs working in COVID and those working in non-COVID units. CCNs working in COVID units, significantly associated with the fear of the disease and were four times as likely to suffer depression and stress and had twice the level of anxiety (Celik et al., 2021). This demonstrated how COVID adversely affected CCNs mental health status. Similarly, Kagan et al. (2022) exposed the emotional strain of the increased numbers of admissions and deaths, adapting to different WEs, and the negative affects this had on the quality of care and mental fatigue for the CCN.

ICU nurses were significantly more at risk of emotional exhaustion, a core component of burnout, than other nurses who were caring for COVID-19 patients (Bruyneel et al., 2021). The suggested cause for this was, again, related to the increased number of deaths and greater workload. Watching patients die without their family present, working with limited resources, working beyond their scope of practice and concerns over transmission risk to their own family were also highlighted (Cacchionne, 2020; Sriharan et al., 2021).

O'Brien et al.'s, (2022) exploration of the difficulties faced by CCNs during the pandemic, described the additional demands on their workload, with reduced time for what they considered to be important aspects of care, including assessments. This frequently left CCNs with feelings like they were 'treading water' (O'Brien et al., 2022). Similarly, Bergman, et al. (2021) highlighted the transition to 1:3 nurse-patient ratios that led to experienced CC's 'tumbling into chaos', providing 'diminished care' and patient safety being compromised. In addition, there was recognition of the staff redeployed to CC, they were known to have received preparation training, which left them feeling a lack in confidence and competence whilst caring for two to-three patients. Additional hands were not perceived to be the answer to insufficient quality of care, although recognition that care had to be 'good enough' caused psychological challenges. The war-zone analogy related to the lack of resources, space, and increased capacity; indeed the CC workforce perceived managers as unsupportive and unaware of their concerns over workplace issues during this time (González-Gil et al., 2021; Fernandez et al., 2020; Moradi et al., 2021). It must be recognised, however, that similar findings (lack of support, resources etc.) were also highlighted by Mealer and Moss (2016) pre-COVID. The additional demands of working in protective clothing, led to CCNs referring to feeling like 'you might die' (Bergman et al., 2021).

Ethical conflicts due to the enforced COVID restrictions and restricted family visitation rights, left families and CCNs dissatisfied (O'Brien et al., 2022). This additional burden added negative repercussions on the CCNs emotional health, due to the moral challenges of keeping families apart (Guttormson et al., 2022; O'Brien et al., 2022). Lluch-Canut, et al. (2020) highlighted that CCNs remained susceptible to other causes of

ethical conflicts during the pandemic such as end-of-life decisions, inappropriate care, and the availability and management of resources.

Roney et al.'s (2022), descriptive study compared pre and post-COVID data in COVID and non-COVID units using the Maslach Burnout Inventory and similar scales. The findings highlighted that 70% of CCNs described higher levels of stress and significant evidence of burnout during the pandemic, relating this to additional working hours. CCNs working in COVID units demonstrated increased emotional exhaustion and depersonalisation, citing the denial of viral existence, wearing of PPE and the absence of the public (Roney et al., 2022) and organisational support (Guttormson et al., 2022) as the cause for the exodus from the workplace and profession.

Rhéaume and Breau (2022) considered organisational support and the CCN during COVID; their findings demonstrated that increased support reduced burnout and ITL, highlighting the positive effect of healthy WE with supportive management. Organisational support included flexible working patterns and positive regard. Not all CCNs felt supported during the pandemic (Guttormson et al., 2022); with COVID intensifying psychosocial factors, such as the absence of autonomy and being valued, leaving CCNs feeling expendable (Guttormson et al., 2022).

CCNs disclosed negative coping mechanisms heightened by emotional stress with evidence of increased smoking, eating and alcohol intake; findings similar to Rushton (2015) pre-COVID. The amplified stress levels were positively correlated to burnout and cited as a cause for CCNs leaving the CC WE (O'Brien et al., 2022).

More positively, team cohesion and a feeling of pulling together was highlighted alongside the appreciation of public support by both Guttormson et al. (2022) and O'Brien et al. (2022). Breau and Rhéaume (2014) also cited team cohesion as the most important reason to remain in the organisation. Despite this, 'solution finding and companionship' was 'surreal', with CCNs experiencing some of the best times as a nurse (Bergman et al., 2021).

Similarly, Kagan, et al. (2022) speak of the war-zone mentality, with CCNs sharing a narrative of empowerment and the strengthening of professional values, whilst taking pride in nursing. Increased mutual support aligned to the difficult decision making, alongside a recognition for good physical health, rest and distraction during out of work hours was reinforced.

However, it remains to be seen whether CCNs' can effectively bounce back from stressful events lasting over successive waves of the pandemic, and what the impact will be on ITL or ITR.

3.9 Discussion

This integrative review located a plethora of good to fair quality evidence relating to the CC WE and CCN wellbeing. The relationships between WE, professional satisfaction, emotional health (MD and burnout), the effects of COVID and the associated ITL have been explored. Specifically, the feeling of being undervalued, failing to actualise professional values and expectations, were linked to job dissatisfaction, but the deeper understanding of what makes a positive experience, WE, or the CCN decision to remain is less clear. In addition, Jackson et al.'s, (2007) suggestion that characteristics that

enable some CCNs to demonstrate resilience and cope in such adversity, are also not clear.

The researcher's assumption that some CCNs thrive, finding job satisfaction, professionally develop, advancing their careers and/or longevity in practice whilst working in an environment that is frequently cited as adverse, was unfounded. Therefore, the findings did not reveal why some experienced CCNs remain in CC, for most of their professional career, which supports the importance of this study.

3.10 Strengths and limitations

The strengths of this review include the robust, rigour, transparency and replicability of the methods used. This is further supported by findings from a publication relating to MD and ITL CC previously published by the researcher (Witton, et al. 2022).

Constant review throughout the research period, with notifications relating to the initial search terms, detected new emerging evidence. This specifically related to S4 and the focus on COVID and its effects on the CCN.

The limitations of this review included utilising only English language studies, potentially missing some references. It was also beyond the scope of the review to present a deeper description on the extensive literature of each theme relating to emotional wellbeing and ITL, due to word limitation.

3.11 Summary and research implications

In summary, this integrative review focused on a well-designed question, locating and examining the extant literature determining what is already known about CCNs working in CC with acutely-ill patients with intense needs and uncertain outcomes. Both of which have been aligned to unhealthy WEs, emotional well-being, job dissatisfaction, and the CCNs ITL. COVID has exacerbated workplace adversity, with the evidence citing a lack of resources, increased capacity, personal risk, psychological distress and complex ethical issues as additional concerns (Fernandez et al., 2020; Nowicki et al., 2020).

The integrative review findings reveal why CCNs leave CC, the organisation and for some the profession. Rather than repeating the plethora of studies which continue to examine why CCNs leave, this study focuses on the revealed knowledge gap, the lived experience of CCNs that remain in CC. Specifically, how CCNs measure the joy of work and why they remain, demonstrate longevity and whether they are thriving; and underpinning this, whether their decision is a conscious one. A better understanding of these phenomenon, underpins the research question:

> *Why do some CCNs, exhibit longevity and remain highly motivated in an emotive and intense area of work, whilst others leave early in their career?*

The rationale for this, beyond the focus of wellbeing for the CCN, relates to patient safety and the financial instability of recruiting and educating CCNs as a revolving door process; retention is the key. It is hoped the findings and recommendations may lead to the development and implementation of interventions to improve job satisfaction for

CCNs, in order to positively affect work-life-experience and ITR, with positive benefit for patient outcomes and the organisation.

Chapter 4: Theoretical Framework

4.1 Introduction

This chapter focuses on the study's research foundation, its epistemological[11] and ontological[12] framework.

The initial stage was to determine the overall research design and the methodology that was most appropriate, whether qualitative or quantitative. By applying Terry's (2018) decision tree (appendix 3), this clearly identified that a qualitative approach would be most suitable, as there was no correlation or causation to be established. Cohen et al. (2018) support this, stating that to enable an in-depth understanding of a social problem, exploratory and descriptive research requires philosophical underpinnings based on a qualitative approach. Outcomes are intended to add to the understanding of this phenomenon (Silverman, 2020), thus filling a gap in the evidence base, as identified in Chapter 3, relating to CCNs lived experiences and their ITR in CC, thus providing recommendations to best retain and stem the flow of nurses who elect to leave CC.

[11] The word epistemology comes from the Greek word epistémé, the theory of knowledge, (Audi, 2010). The epistemological stance contributes to the judgement of trustworthiness, quality of the findings, and justification of knowledge claims (Creswell & Poth, 2018). The 'researcher task is to understand, describe and explain multiple and differing versions of situations, their distinctiveness, cause and consequence' (Cohen et al., 2018, p.288)

[12]The word ontology relates to the nature of reality (Creswell & Poth, 2018). There are many realities, as seen through many views. Qualitative research observes agents who construct their own meaning of a situation, making sense of their world through interpretative processes (Cohen et al., 2018). Simply, ontology is the study of being, (King, et al., 2019). Meaning ascends through social situations and interactions, and the intent here is to report on these multiple realities.

The study aims of exploring multiple meanings from several participants meant that an individual case study or storytelling approach was rejected (Creswell, 2013), thus, allowing for a common understanding of the problem to be presented. Two of the most frequently used qualitative approaches seen in social, health science and educational research literature are grounded theory (GT) and phenomenology (Creswell & Poth, 2018). Both were initially considered, and the rationale for selecting the distinct qualitative method of descriptive phenomenology as the definitive philosophical framework is explored in this chapter.

4.2 Approaches

An urgent growing problem is the supply of the nursing workforce, with more nurses leaving the profession than joining and trainees failing to compensate for the 'hole in the bucket' that has been identified (Imison et al., 2016). The epistemology, what we know from the findings from the literature review, support this, presenting a picture relating to ITL (Stone, 2007), adverse WE (Alspach, 2009), job dissatisfaction (Breau, Rhéaume, (2014), and more recently, psychological experiences (Ndlovu et al., 2022).

The researcher's prior research experience, from a positivist viewpoint, revealed CCNs ITL CC (Witton et al., 2022). This international multicentred study identified that MD was negatively correlated with ITR. The findings underpinned the necessity to gain a deeper understanding of CCNs experiences by exploring knowledge of a social nature. This viewpoint is typically gained by understanding the subjective meaning of the

phenomenon[13] from a qualitative approach. Additionally, the problem identified had no hypothesis to test, and therefore aligned to an interpretivist viewpoint.

A qualitative objective is to describe what is happening and provide a deeper, richer narrative (Silverman, 2020). These descriptive constructs 'fit' together to describe a phenomenon; this is known as theoretical discovery and is particularly useful when there is little already known and little to compare to. From the relativist perspective society is viewed as the product of engaging with one another rather than a 'pre-existent real entity with objects and structures' (King, 2019, p.9). Relativism is consistent with social practice and interactive explanation (King et al., 2019). Meaning, a qualitative stance enables the research question to be examined, by gaining a richer narrative, describing the experiences of those CCNs who have remained in CC for significant periods and how they exist and live within CC (King et al., 2019). The social structure can be entities at macro, meso or micro level such as the NHS, organisation or CC, situated external to the individual's control (Brofenbrenner, 1974). By advocating for a social and interactive explanation gained by conversing with CCNs, the ontological position is consistently positioned.

By situating the observer in the world, it becomes more visible to them (Creswell & Poth, 2018); chapter one served to also position the researcher's experience. Qualitative researchers collect data in the natural setting, being sensitive to participants and the

[13] A phenomenon is an 'object' of human experience (van Manen, 1990, p.177). In qualitative research a phenomenon is defined as an observable concept, event, or experience that is studied and analysed (Merriam- Webster, 2023). Phenomenon Definition & Meaning - Merriam-Webster Accessed 23.07.2023.

place of study, ascertaining patterns or themes with a purpose of making sense of the identified problem (Beck, 2021). For this study, this enables development of strategies to reduce nursing attrition and improve nurse retention in the CC environment. Both grounded theory and phenomenology initially aligned with these proposals.

4.2.1 Grounded Theory

GT, drawn from a sociological background is the study of process, leads to the generation of theory which is developed by being grounded in field data (Charmaz, 2011).

Classical GT emerged in the 1960's from the work of sociologists, Glaser and Strauss, at a time when positivism was the dominant paradigm of inquiry (Table 12). Positivism stressed that objectivity and generality human experiences could be reduced to quantifiable variables (Charmaz, 2011).

GT is inductive, and as such, is guided at each phase of the journey by a combination of 'involvement and interpretation' (Charmaz, 2011). Rather than a clear endpoint, the design is constructed, and depends on whom the researcher 'interacts with…. hears and how (I) learn and think' (Charmaz, 2011, p.6). Grounded theorists commence with the data; empirical events are studied whilst 'pursuing hunches and potential analytical ideas' (Charmaz, 2011; p3). GT has a lack of ontology to classify the data, and a lack of epistemology, as a philosophy for the research (Glaser, 2005).

Table 12: Components of Classical Grounded Theory (Charmaz, 2011: p6)

Components of Grounded Theory
"Simultaneous involvement in data and analysis
Constructing analytic codes and categories from data, not from preconceived logically deduced hypothesis
Using the constant comparative method, which involves making comparisons during each stage of the analysis
Advancing theory development during each step of the data collection and analysis
Memo -writing to elaborate categories, specify their properties, define relationships between categories and identify gaps
Sampling aimed toward theory construction, not for population representativeness
Conducting the literature review after developing an independent analysis"

The traditionalist's viewpoint suggests that researchers enter this realm of research with no preconceived ideas, with the ideology that this reduces the risk of bias in interpretation (Kriukow, 2022). Glaser (2005) recognised later in his theoretical development that the researcher will always have some knowledge of the area under review which provides 'direction and orientation', whilst acknowledging objectivity must be maintained.

Gallagher et al. (2015), state that GT relates to how the individual responds to their understanding of reality. The emphasis being on the agents' experience defined by them, giving them 'voice' and how to represent their opinion through thick description (Murphy et al., 1998). Strauss's pragmatist background adds to the GT view, that human beings are not passive in their social world; and pivotal to the theory is its method of open-ended study to problem solve and gather that social meaning (Charmaz, 2011).

Pragmatist approaches embraced by Strauss inform symbolic interactionalism, with theoretical perspective, assuming that reality, self and society are constructed through interaction, which relies on language and communication. Grounded theorists do not locate knowledge but make a construction of it: leading to an enhanced understanding for greater discourse (Corbin and Strauss, 2007).

4.2.2 Phenomenology

Phenomenology[14] enables the examination of a phenomenon and what this means to the individual, following a structured approach, to postulate the 'essence' of the meaning (Beck, 2021). As an inductive approach this enables description of the 'heart and soul' of the experience (Beck, 2021, p.2); presenting the characteristics of shared experiences.

Phenomenology is deep-seated in the philosophical tradition, initially developed in the 20th Century by Edmund Husserl. Cohen (1987), positions Husserl's method as the 'naturalism doctrine which denies a strong separation between scientific and philosophical methodologies, and denies positivisms focus on objective observation of external reality' (Shorey, 2022, p.2). Husserl[15] (1988) presents phenomenology as pure

[14] Phenomenology is 'a privileged view of an experience from the perspective of the participant' (Beck, 2021, p.1). It is a source for questioning the meaning of life and how persons live it. Phenomenology seeks to understand and describe the universal essence of a phenomenon (Creswell, 2013).

[15] Husserl (1859-1938) is seen as the father of the philosophy of phenomenology (Beck 2021), first denoted in Ideas, Pertaining to a Pure Phenomenology and Phenomenological Philosophy (1913). His focus is the phenomenon perceived by the individual's consciousness which is central to all human experience (Shorey & Debby-NG, 2022). Asserting that knowledge that comes from immediate experiential evidence can be accepted, pure and transcendental, not a science of facts, a science of essence. Essence is what makes a phenomenon. Meaning is sought through the viewing from varying positions and divergent perspectives (Beck, 2021).

description of a lived experience, the 'what' providing a deep intimate narrative on what individuals have in common relating to their lived experience (Beck, 2021). Objectivity and elimination of bias in descriptive phenomenology means the researcher remains faithful to the participants lived experience, avoiding personal unreflective presuppositions (Beck, 2021; Creswell & Poth, 2018; Van Manen, 2014). Subsequent criticism of Husserl's method resulted in the expansion of phenomenology, to include interpretation of a relevant context, or analysis of an experience as seen in Heidegger[16] and Merleau-Ponty's work (Beck, 2021; Creswell, 2013).

It is this lived experience and being faithful to the participants which is significant in the descriptive phenomenological approach (Van Manen, 2014), with the researcher endeavouring to eliminate bias and avoiding 'tainting' of the study outcomes (Beck, 2021). Husserl's method of situatedness uses epoché[17] and 'bracketing'[18] whilst exploring the commonality of an experience. The researcher understands and puts aside their beliefs, opening to new beliefs, which is the transcendental experience (Beck, 2021). Bracketing creates an awareness between the past and present, causing an apprehension that ensures the researcher is not influenced by their presupposition.

The making sense of one's own experience, outlining of assumptions and preconceptions, is postulated in chapter one. As a CC nurse, a CC educator and CC

[16] Heidegger transcendental hermeneutic phenomenology (1988) draws on Plato and Aristotle, to reformulate the thinking of phenomenology, and the everyday world. The concrete existence of human life, encompassing lived experiences.

[17] Epoché, applied in Husserl's descriptive approach (1981), meaning abstention; to put aside presupposition that can impede researchers being open to the meaning of the phenomena.

[18] Bracketing, the process of achieving reduction. Beck (2021) defines this as Husserl's method of conflict between the researcher's past and present, avoiding interference from their presupposition.

influencer, Husserl's epoché enables an open mindedness to the participants' experiences, the phenomenological essence, whilst suspending personal preconception and increasing the validity of this methodology. More simply the researcher did not have an empty head about the topic, there was a lived experience, exposure to the literature and research activity, and the awareness of this affords a positive tension between what has been known and describing a new common understanding. This has been made easier by the lack of a theoretical evidence base identified in the integrative review.

4.3 Rationale for Selecting Descriptive Phenomenology

The methodological design was selected with the purpose of identifying new theoretical constructs; there are no earlier contemporary theories to 'test' or offer explanation as to why some CCN' remain in CC. Both GT and phenomenology are similar in that they begin with a research problem and use similar data collection tools to gain an understanding of real experiences (Kriukow, 2022). Both approaches are interpretative, with the researcher being close to the participants, yet aiming to control researcher bias and increasing trustworthiness.

However, their differences include the overall presentation of the findings; its output. Phenomenology understands and presents the lived experience of a specific group. This includes how they lived through that experience, reducing it to what they have in common, being the 'essence of the experience'. The purpose of GT is to develop exploratory theory of a dynamic process (Kriukow, 2022). There are structural variances e.g. in the data collection and sampling stage. In phenomenology the primary data collection method is qualitative in-depth interviews, which are frequently 'open ended'

e.g., ‘tell me how you lived through this experience’ (Kriukow, 2022). It uses a relatively small homogeneous sample, typically five to fifteen (Kriukow, 2022). In GT, the aim is to gather data from all sources; ‘everything is data’ including interviewing, observation, diaries, memos (researcher journals) (Charmaz, 2011). The GT sample can be small, but is typically twenty to fifty, (Kriukow, 2022); generally higher than that found in phenomenological studies (King et al. 2019). GT typically commences with purposeful followed by theoretical sampling[19]. Early suspicion is developed by initial analysis, leading to additional recruitment to further explore the theory or understanding; which explains the larger sampling numbers. In addition, from the traditionalist’s viewpoint, GT leans towards a lack of pre-reading, indeed, being cautious about reading the literature of the topic. Traditional GTs do not want to impose previous knowledge on the findings (Glaser,2005). However, researchers post this traditional viewpoint, highlight that this is important in all research studies; it is difficult to declare no knowledge of a subject area.

Both approaches have their own data analysis techniques commonly using thematic analysis approaches. Using specific structure and terminology such as line by line and open coding in GT (Charmaz, 2011), and often presenting the findings as x and y, describing the dynamics of z (Creswell & Poth, 2018). Whereas, a phenomenological approach provides a descriptive relationship of multiple individuals shared experiences, gaining a common deeper understanding.

[19] Theoretical sampling is the selection of participants based on emerging findings to ensure representation of important theoretical categories (Polit & Beck, 2021).

As a research scholar, the question was around the contribution that was needed to add to this field of enquiry. The answer narrows the result for choosing the methodological framework. The study aim was to explore CCNs experience and meaning of working in CC, and their decision to remain; this aligns closer to descriptive phenomenological methodology. Neubauer et al. (2019) recognises that it is phenomenology that allows greater learning from the experiences of others, gathering perceptiveness about a phenomenon which maximises the effectiveness of feedback and workplace learning. Neubauer et al. (2019) also suggest that phenomenology is the 'closest fit' conceptually to clinical nursing, with its exploration of the 'how' and 'what' of the experience affording a new way to interpret the participants individual consciousness.

Phenomenology advocates provision of a privileged view of the meaning of an experience from the perspective of the participants; "readers will be able to walk a mile in the shoes of participants to learn firsthand what that experience is like" (Beck, 2021, p.1). Beck (2021) asserts that based on the discoveries of a phenomenology study, effective interventions can be devised to engender the greatest impact. It is this emphasis on the lived experience, the essence of 'what influenced' their decision to remain, with the aim to be able to make suggestions for future practice which have encouraged utilisation of descriptive phenomenology for the study methodology. This is in comparison to developing a theory from substantive evidence, as seen in a GT approach (Creswell, 2013). In addition, phenomenology provides a defined approach for a novice researcher in the data analysis stages (chapter 4).

4.4 Summary

Descriptive phenomenology is a qualitative research method with a central purpose to explore the exhaustive description of a phenomena, reducing individual lived experiences to describe the universal essence. This supports the researcher's ontological position, which recognises that there can be multiple versions of reality, and common ground has been sought. Using descriptive phenomenology, from the epistemological position, as a relativist, provides rich accounts of this social phenomenon and highlight what is known about the CC journey of an homogeneous group of CCNs and their decision to remain in the CC environment against adversity. This is presented without attempt to explain their narrative following the descriptive phenomenology tradition (Moustakas, 1994).

This descriptive phenomenological study draws on Husserl's key concepts of bracketing, 'epoché', to empower the researcher to 'look beyond what is known in scientific exploration' (Husserl, 1981, p.322), thus acknowledging personal assumptions and presuppositions, to see it afresh whilst recognising that consciousness is not pure but, it connects us to the society we inhabit (King, et al., 2019).

In summary, considering the aim of the research, the social nature of the setting and having no hypothesis to test, this research has been underpinned by a descriptive phenomenological approach. This allowed the novice researcher, an experienced clinician, to present a rich narrative answering the question of

> *Why do some CCNs, exhibit longevity and remain highly motivated in an emotive and intense area of work, whilst others leave early in their career?*

Chapter 5: Feasibility Study (FS)

5.1 Introduction

The terms pilot or FS are used interchangeably, (Doody and Doody, 2015), however, pilot studies are designed to test instruments or be a mini version of a full-scale study and are therefore identified as a crucial element of good study design (Malmqvist, 2019; van Teijlingen & Hundley, 2001). A FS is defined as the preparation stage of a study, to avoid wasting time and finances on larger scale for studies that are unlikely to answer the research question (the National institute for Health and Care Research (NIHR, 2023). A FS is a preliminary exploration of a proposed project, to determine its merits and viability, establishing design parameters to answer the question "Can this study be done?".

The rationale for this FS, originated from personal reflection on longevity in practice and the consideration of how this conflicted with the literature. In addition, peers have demonstrated longevity whilst remaining highly motivated in this emotive and intense area of work, thus this appeared to be an area that warranted further investigation. New evidence relating to the longevity of members of the CCN workforce was sought to investigate why some remain for their entre work-life.

A problem had been identified, which required greater exploration; this provided an opportunity to test specific research techniques. The FS became the precursor for the next phase exploring the CCNs motivation for remaining in CC.

5.2 Initial Review

An initial literature review explored the relationship between the CC WE and ITL; it highlighted the predictors of attrition including MD, burnout, compassion fatigue and absence of fair reward. The following databases were searched: Medline Cinahl, PsychINFO, PubMed publisher, and Google Scholar, accessing studies published between 2005 and 2018 (databases are summarised in Chapter 3).

A summary of this review highlighted the predictors of ITL CC, including job satisfaction, unhealthy WE and lack of opportunities (Cortese, 2012). However, in contrast to the findings, it can be postulated that CCNs often receive more investment for professional development when compared to other nursing specialities. Rahman et al. (2017) identified that the reduction in nursing numbers, heightened work pressures and time constraints, negatively affect specialist nurses to work efficiently and effectively towards task completion. Numerous studies illustrated that CCNs were dissatisfied with their WE (Aiken et al., 2011; Heinen et al.,2013; Van Bogaert et al., 2013), indeed a large European study of 33,659 nurses identified that one in five CCNs were dissatisfied with their job (Aiken et al., 2013). This study was undertaken over fifteen years, a period which highlighted a rapidly changing WE as hospitals made efforts to reduce costs, streamline services, and cope with nursing shortages. Similarly, a European study by Heinman et al. (2013) demonstrated that WE characteristics such as leadership, professional relationships, and career development opportunities were related to ITL. More recently, Hiler et al. (2018), identified that only 59% (n=192) of CCNs were satisfied with their job and 73% (n=238) had considered leaving within the last twelve months.

Imison (2016) highlighted an urgent need to review the nursing workforce, as more nurses appeared to be leaving the profession than those being trained, causing a 'hole in the bucket'(Twitter). The sub-specialism of CC is not immune to this effect; however, CCNs are a distinct Community of Practice (COP)[20]. CCNs have a distinct social role, form a professional enclave and demonstrate a high level of clinical competence due to the complexity and acuity of their patients.

Against this backdrop, it was important to explore the longevity of service amongst CCNs by seeking to identify the factors which contributed to this and any relationship to the themes emerging from the literature. Aims included to determine any relationship to the theoretical constructs of COP: professional development, ambition, education and experience, personal and professional resilience or social factors (including identity, elitism, mutual support) as highlighted in the literature review.

The focus of the FS was to explore why nurses remained in CC, demonstrating longevity[21] rather than adding to the plethora of narrative of why nurses leave the profession and speciality (Frijters, et al., 2007; Cortese, 2012) and the strategies designed to enable seasoned nurses to continue practising (Storey, et al., 2009). The findings were then used to guide the research design for the main study (Malmqvist, 2019).

[20] The Community of Practice (CoP) concept was originally defined by cognitive anthropologists Jean Lave and Etienne Wenger (Wenger, E. 1998). CoP are a group of people who have a sense of common purpose, share a common concern, set of problems, or an interest in a topic and come together to fulfil both individual and group goals, What is a community of practice? - Community of Practice. CoP share best practice, create new knowledge to advance a domain of practice, which includes interaction.
[21] Longevity is defined as relatively long duration of employment (Free Dictionary, 2017).

5.3 Methodology

Malmqvist (2019) highlights the limited guidance available for conducting a FS in standard qualitative texts and the evidence base. Pratt and Yezierski (2018) report using a FS for a larger main study; to add further credibility to the study, amongst other functions. Here, the FS objectives were twofold: to trial qualitative data analysis methods on a relatively unexplored subject area, assisting the development of the interview guide for the main study, and to develop researcher skills in conducting interviews and analysis (Table 13).

Table 13: Feasibility Study Outcomes

Feasibility Study Outcomes
Firstly, to explore CCNs motivation for remaining in CC, gaining preliminary data to inform the main study in-depth interview guide.
Secondly, exposing the researcher to the techniques required for the facilitation of focus groups and elicitation of responses.
Thirdly, to trial an analysis technique and uncovering potential problems in data collection and analysis, in preparation for the main study.

5.3.1 Sample

The FS was undertaken in a non-NHS situation; this removed the need for an application to the Health Research Authority (HRA), important due to time constraints. This practical solution targeted a non-probability[22] sample, with full knowledge that it was

[22] Non-probability is a sampling method which is not inclusive of all members of the population (King, et al., 2019); a non-random selection of a group. Typically used when there are financial or time restraints, based on accessibility (Creswell & Poth, 2018). Therefore, there is an element of subject judgement. Typically this should be a homogenous sample with a minimum size of 4-12 (Business Research Methodology, accessed 12.11.23 Non-Probability Sampling - Research-Methodology)

not representative of the CC nursing workforce. Although lacking diversity, this convenience sample was deliberate, available, less complicated, and acceptable, as the intention to generalise the findings did not go beyond providing a prelude for the next phase (Cohen, et al., 2018).

The prime criterion for qualitative research is whether the participant has experience of the phenomenon or the culture under study (Beck, 2021). The participants were a discreet homogeneous sample of ten post-graduate students, accessed whilst attending their QIS within HE. The homogeneity of their background was ensured by advertising participation to those on the HE CC pathway; they were professionally on the same educational journey, thus ensuring there was no status differential (Ayrton, 2018). The participants were comparable in terms of professional development and academic level but were heterogeneous in age, gender, length of service, geographical location, and WE (whether Tertiary Centre, District General Hospital and Cardiac CC (elective surgery)). The students were all registered CCNs, of professional band 5 or 6, and had worked within CC for at least eighteen months; thus, fulfilling the criteria of targeted experience (Table 14).

Having identified the sample, approval was sought from the University Ethics Committee (appendix 4), with additional permissions required from the School Access Committee, as they were students within the Health Faculty. This prevented overburden to the student population by regulating the research studies undertaken at any one time. The concepts of recruitment, data collection, and data protection were included within the applications and were addressed accordingly. All applicants were successful and attended the focus group interview.

Table 14: Feasibility Study Focus Group Demographics

Focus Group	Participant number	Gender	Type of CC	Length of Service in CC (years)
1	*1*	*F*	*Cardiothoracic*	*4*
1	*2*	*F*	*General ICU*	*21*
1	*3*	*F*	*General ICU*	*7*
1	*4*	*M*	*General ICU*	*4*
1	*5*	*F*	*General ICU*	*16*
1	*6*	*F*	*General ICU*	*3 ½*
2	*7*	*F*	*General ICU*	*7*
2	*8*	*M*	*General ICU*	*2 ½*
2	*9*	*F*	*General ICU*	*2*
2	*10*	*F*	*Cardiothoracic*	*5*

5.3.2 Focus Groups

Focus groups[23] provide a

> 'naturalistic situation bringing people together….which can encourage recall and stimulate opinion elaboration' (King, et al., 2019, p.94).

Focus groups are recognised as being economical on time, provide orientation to a field, allow development of themes for subsequent interviews, derivation of hypotheses, gathering of quick low-cost data, allow group opinions to be voiced, and empower individuals to speak out using their own words, providing greater coverage than possible from a survey (Cohen, et al., 2018). It was recognised that bringing together a distinct

[23] A focus group can be defined as a guided group discussion about a common topic (Stewart, 2018). Originating in 1956 (Merton et al., 1956), gaining in popularity in qualitative research, the technique lends itself between a structured meeting and discussion with liberty for participants to input on each person's narrative (Sim & Waterfield, 2019).

section of the CCN workforce forms a contrived setting, however, this met the needs on the influencing factors relating to ethical gatekeeping and time. The timescale influenced the number of focus groups. One group was insufficient to be able to interpret behaviour as unique to this group or to those at a similar level in their career and educational journey (Creswell & Poth, 2018). While two focus groups appeared appropriate to provide an

> 'opportunity to reveal the social and cultural context of their understanding and belief' (King, et al., 2019, p.95).

The guiding principle of data saturation is sampling until no new information is obtained, which was potentially unachievable in this case (King, et al., 2019), and is not required for a FS. The non-achievement of data saturation was deemed acceptable as the data generated was not the outcome for the FS, the 'testing' of skills and techniques held equal importance (Legard et al*.,* 2003).

An invitation email was forwarded by the HE administration team to students on the CC programme and included details of dates, time and venue, as well as the Participant Information Letter and Consent forms. Direct correspondence was avoided to reduce bias and acknowledge that some students may have felt coerced into participating due to the joint position of the researcher being the programme lead.

Ten students accepted the invitation: six participants attended group 1 and four attended group 2, aligning with Morgan's (1988) focus group recommendations, albeit Fowler (2009) highlights an opinion that six participants should be the smallest cohort size. There was no over recruitment as suggested by Morgan (1988), all participants who

expressed interest were invited and attended. Group size can provide a disproportionate pressure on the dynamics of the group (Cohen, et al., 2018), however as seen on the verbatim transcripts (appendix 5), the participants were mindful of each other's time when speaking and respectful of each other's opinions. It is a challenge to reduce the power dynamics in research, and it is unlikely that it can be eradicated completely (Maynard, 1994). The homogeneity of the group ensured that the participants felt comfortable to voice their opinion; recognising they were among peers, all working within CC, albeit from across a geographical region. This aligned to the phenomenological tradition, ensuring that the participants had the same targeted experience whilst allowing exploration of diversity of individual experiences. Essentially, uniformity was ensured in some areas only.

This participant sample meant that there was no generalisation to the wider CC workforce, the FS presents data from a distinct case profile; CCNs at a specific stage in their CC career. Transferability can be offered to those who resonate with the results and discussions when considering their workforce at a similar level e.g., those that are undertaking their CC QIS. Although this type of sample worked well, recruiting from a specific clinical group, one must acknowledge and reflect upon the impact that this may have on the data (Chapter 8).

5.3.3 Methods

The descriptive phenomenological approach required a declaration of prior experience, assumption, and presupposition. However, this existing knowledge was used to develop the focus group topic guide, to explore the CCNs motivation for remaining in CC. The

focus group also provided an opportunity to moderate a group and analyse data using descriptive data analysis.

Two semi-structured focus group interviews were audio taped, with consent, and conducted using a pre-prepared focus group guide. Following review of the study objectives and consent process, participants were encouraged to talk freely, outlining their experiences, (Cohen, et al., 2018). With group interaction, the participants viewpoints emerged providing a collective rather than an individual or researcher point of view. Each group lasted approximately an hour, at which point the group appeared to be offering no new information, reaching group saturation, and therefore leading to termination of the focus group. There were no signs of participant fatigue, meaning they had exhausted their commentary on the focus area rather than being exhausted from the experience (Hennink & Kaiser, 2021). The researcher's role was to moderate the group to ensure a balance between being too directive and ensuring responses to the open-ended discussion were focused, with equal participation (Cohen, et al., 2018). This moderator role is reflected upon in Section 5.5.

Due to the timings of the focus groups, there was no concurrent data analysis, transcribing and analysis were conducted following the completion of the second focus group. The negative effect of this was that important themes highlighted by group 1 were not developed upon with group 2. Verbatim transcribing was a timely process which included the addition of the participant number and time of response (appendix 5). There were no transcription difficulties, the audio quality was good, and the ability to discern what was being said was straightforward. This was also aided by using a voice recognition technique, by asking each participant to identify demographics, a period of

talking which enabled the allocation of a code to a voice (P1-P10). This ensured that each narrative could be aligned to a participant; although more useful in Carey & Smith's level of analysis (1994, as cited in Polit & Beck, 2021), it was useful to identify some contrasting salient narrative.

5.4. Analysis

Focus groups pose analytical challenges with little consensus on technique, despite their prevalent use (Polit & Beck, 2021). Consideration was given to analysing the group data as a unit of analysis as highlighted by Morrison-Beedy, et al. (2001, as cited in Polit & Beck, 2021) or by group and individual level as argued for by Kidd and Parshall (2000). Carey and Smith (1994), advocate a third level of analysis; the analysis of responses in relation to the group, identifying whether it supports or contrasts with that of the group as a whole; although this method can be difficult with the use of audio technology. Due to time restraints, a decision was made to analyse the data as a unit, the rationale for electing this method was that what individuals say in focus groups cannot be treated as personal disclosure, as it is influenced by group dynamics (Sim & Waterfield, 2018). However, during the bracketing process, salient points were documented when participants had contrasting narrative and are shared in the discussion.

To make sense of the focus groups dataset, Colaizzi's (1978) strategy of descriptive analysis was used to extract, organise and analyse the narrative material. This process involves the reading of the narrative to first identify significant statements, then meaning. Following which, meanings are sorted into categories, which are then clustered, and themes are derived (Table 15). This method ensures that the findings are

integrated into an exhaustive description of the phenomena being studied (Shosha, 2012).

During this process the transcripts were read three times, ensuring familiarity with the data; with initial thoughts and feelings added to the bracketing diary, aligning with Husserl's' theory (1981). The analysis identified 387 significant statements from focus group 1 and 220 in focus group 2 (appendix 7). Further analysis formulated statements into meanings; in total 607 meanings were found. These were extracted from the transcripts, transposed, and coded to include the focus group, participant number and time, (Table 15). This reduced the data into more manageable units, that could be retrieved and reviewed for presentation of the findings.

Table 15: Colaizzi's Strategy Step 3: Examples of Meanings Extracted

Significant Statement	Formulated Meaning
P5 (4:47) if you're sent to A&E confidence can be knocked we are not A&E nurses but it's ok for them to say I can't go to ICU if they are not busy because I'm not an ITU nurse, it's very much that an ICU nurse can go here there and everywhere, you can go to AMU, everywhere don't we	CCN complain that confidence is 'knocked' when being sent to emergency and assessment areas, Acknowledge that A&E nurses refuse to work in CC, in similar position, when dependency low
P5 (14:54) you know you choose when you go into CC, it's I think personally from my own, and I went there knowing I wanted to care for people you know at a very advanced level, and that patients are really sick that are in ITU so you are looking after the whole patient and getting really stuck in and being able to learn and being on a ward it's a little bit more kind of, I don't know kind of, and I think people go to and I think people stay in ITU for that reason, because you like the buzz of it if you like,	Realisation that when you choose CC as a WE that you will be caring for the acutest patients in a holistic way that will also develop your knowledge and understanding which is different to the ward environment. CCNs like the 'buzz' that you get from this type of care
P2 (16:17) a lot of our staff, well 50% of our staff have been there fifteen years plus and because they haven't got degrees, they are not willing to make the leap, and they won't change jobs because they can't, they haven't got degrees and not seeing that they can apply for other jobs and promotions	Half of the CC staff are seasoned practitioners without degrees, preventing them leaving as it is thought that a degree is required for promotion and jobs in other environments
P3 (23:05) but it wasn't for not wanting to, it was because of staffing levels and the more experienced being sent to go to the wards and sent to different units and things the new starters were being left, they weren't being looked after and all the experience had student's, mm, so they weren't able to have	The lack of support wasn't intentional, it was affected by the staffing levels, supporting the wards and experiences staff mentoring student nurses

P7 (4:29) I think the institutional challenges at the minute is the … (pause) the fact that we have to more with less, we have to look after more people, sicker people with less nurses, less resources. Everything has got to be perfect, but everything has got to be quick, and that's a big institutional challenge at the minute	The institutional challenge for the nurses is caring for more acute patients with less nurses and resources The pressure for perfection within the timescale is an organisational challenge
P9 (4.56) Nationally as well everyone is saying publicly how the NHS is failing, erm, each trust is known locally, erm, is said to, certain trusts owe millions and millions in the back of your mind. We have messages from our err directorate, they tell us how we are doing financially how we are doing and that has an implication and err cutbacks doesn't it throughout certain units	The global evidence of adversity relates to the public opinion of the 'failing NHS', the financial debt. The local institution informs the nurses of the crisis and its implications to each unit.

The next stage grouped meanings of similarity into categories (Table 16), presenting fourteen clusters (Table 17). These clusters related to content and context rather than numbers; Graneheim and Lundman (2004) state this allows for a clearer view of the emerging content. Each theme fell into one category ensuring internal convergence and external divergence (Mason, 2002).

From the emergent themes came the phenomena; typically, a secondary qualitative researcher would validate these for accuracy, checking how these were derived from the thematic map. However, this FS data was not intended for triangulation of data with the next phase which minimised the potential for idiosyncratic biases (Polit & Beck, 2021) and access to a supervisory team was beyond the remit of the FS.

Table 16: Feasibility Study Colaizzi's Strategy: Examples of Clustering and Emerging Themes

Theme Cluster Developed from Formulated Meanings	Emerging Themes
Organisation pressures, Lack of organisation support, Organisational challenges, Evidence of wider organisation adversity, Organisational structure and change, Influences of shift patterns – reducing teaching time, Loss of protected teaching time, Shift pattern – stress of long days, Dependency Tools- not adhered to, Effect of non-adherence to dependency tools, Loss of supernumerary lead, Additional workload, Agency Staff – recruitment, Agency staff – lack of experience, Agency staff – safety, Agency staff as part of the team, CC Admissions criteria, Admissions Gatekeeper, Change in type of admissions, Effects of type of admissions on funding,	Awareness of wider organisation affects
The 'buzz', Types of patients they care for, Provision of quality care, Increased Autonomy, Empowerment, Intrinsic reward, Personal insight, Positive reward, patients returning, Extrinsic reward, Positive shift patterns, Lack of qualification to work elsewhere, too qualified to work elsewhere, Lack of experience elsewhere, Lack of awareness of job opportunity, Fear of change, Fear of Working elsewhere, Protected Environment, Lack of personal drive, Continued Learning, Privileged role, Longevity in practice, Support from specialist roles	The Reasons Why CCN Stay in CC?
Cliques in CC, Intensity of patient flow, Lack of recognition, Nurses that contribute little to patient progression, New autonomous role, Lack of support, Tertiary centre versus smaller unit, Supporting junior staff, Nurse allocation, Consistent exposure to acute patients – no respite, Vulnerability in a senior role	Challenges for the CCN
Definition of belonging, Belonging and the family, not necessarily belong to the wider organisation, no sense of belonging	Sense of Belonging

Table 17: List of Emergent Themes

Emergent Themes
1) Awareness of Wider Organisation Affects
2) Reasons Why CCNs Stay in CC
3) New Starters in CC
4) CC Recruitment
5) Reasons for Nurse Attrition
6) Ward Reallocation and the Effects on CCNs
7) Characteristics of a CCN
8) The CC Family
9) CC Education
10) Challenges for the CCN
11) Sense of Belonging
12) Decision Makers in CC
13) Power Relationships
14) Environments – the Ward Versus CC

Stage 6, of the approach, was multifaceted, involving the reduction of the findings and searching for misused, overestimated or redundant findings (Shosha, 2012). It also ensured that statements were not removed if they misaligned with prior assumption. Redundant items in this instance related the following emergent themes: Decision Makers in CC, Power Relationships and Environment: Ward versus CC. For transparency, these have remained in the transcriptions, significant statements and formulated meanings but have been identified as redundant as they lacked any substance in their meanings or provided little comparison or contrasting discussion from other participants. In hindsight these should not have been identified as Significant

Statements at Stage 2, however, on reflection it was not until the meanings were formulated that it began to appear that they lacked substance.

5.5. Discussion

The aim of the FS was to recognise the worth in developing a main study. Three dominant themes emerged, with the remaining themes used to structure and guide the interviews in the next phase of the study. In addition, the dominant themes align more explicitly to the original question on how COP may inform an assessment of the decision to stay within CC? More specifically, why do some CCNs have longevity in practice, remaining highly motivated in an emotive and intensive area of work, whilst others leave early in their CC career.

5.5.1 Reasons Why CCNs Stay in CC

The narrative that lent itself to this emergent theme was sweeping and powerful, and clearly demonstrated a 'survivor's pride'. Wolin and Wolin (1994) define this as the feeling of accomplishment derived from persisting in the face of adversity. The nurses' pride was transparent across all groups, gender, length of service and was not limited to days in which they achieved dazzling success. Their examples of intrinsic and extrinsic reward, 'the buzz', 'appreciation of the quality-of-care delivery', and 'although identified as the overwhelming feeling of seeing patients return with their families cannot be underestimated'. Although identified as a privileged role, CCNs acknowledged adversity and recognised where shortcomings were evident, and how the 'family could help them fit in'. They reflected on 'their behaviour, and how this has informed future practice relating to the 'nurturing' of new starters within their first year;

a period they identified ‘as the most difficult, with fear of making clinical errors and much to learn’, and their ‘lack of support for the new starters wasn’t intentional’.

Nurses identified CC as their family; being so comfortable in that family that the nurse shared experiences and personal tragedy, noticing when something was not right, creating a safety net that they were unsure if this was available elsewhere. This theme integrated within the remaining emergent themes, including the narrative of adversity, attrition, characteristics, belonging and challenges.

5.5.2 Ward Reallocation and the Effects on CCNs

In contrast to the positive statement of why nurses remain in CC, the ITL and negative experiences of working in CC were also prominent. These negatives related to the ‘reallocation [of CCNs] to the wards in times of lower patient dependency’. This issue was later presented as a new phenomenon in 2018, with CC3N launching new guidance on the ‘‘Best Practice Principles to Apply When Considering Moving CC Nursing Staff to a Different Clinical Care Area and between Nurse Staffing Levels and Adverse Events’’ (CC3N, 2017). The negative effect of reducing numbers, and the lack of opportunities for junior staff to work with senior staff caring for more complex patients had been previously reported by Coomes & Lattimer (2007). Similarly, the Royal College of Nursing (RCN, 2017) provided advice for staff being moved from their normal working environment, stating:

> ‘Employers can….ask specialist nurses to work on wards, however if the specialist nurse has any doubt about their competence they must decline and give reasons why. E.g., they may state that they have not worked on a ward for over 10 years

> if ever, so are not up to date, or that they would be working outside their professional code' (RCN, 2017).

The participants were unaware of this guidance, instead, these confirmed that they 'felt vulnerable', 'lacked competence', and were used for ward leadership rather than a 'pair of hands; while new starters were identified as missing opportunities to be supervised in caring for the more acute patient, impeding development. Nurses raised these as causes of stress and anxiety and a significant factor for ITL.

Like the integrative review findings, areas of adversity within CC provided a lengthy narrative and were highlighted as some of the emergent themes of why some CCNs want to leave, however the FS foci were on the opposite, ITR, therefore they remain outside the scope of the findings to report.

5.5.3 Belonging

The concept of belonging was identified, albeit with less narrative, but remained relevant to the next phase of the study. Belongingness was explored as a possible reason for retention. As social creatures, the need to belong and be accepted is fundamental (Levett-Jones & Lathlean, 2008). CCNs describe a sense of belonging, recognising that there are 'negative aspects to working in CC, but they would not work in any other environment'. Their sense

> 'of closeness and support from the team makes the nurse feel that they belong, and therefore why they remain in CC'.

There are multiple references to a CC 'feeling' or the CC workforce 'being like your family', but there was a distinct reference that this was not related to the wider organisation, 'the higher structure' or 'management'. The sense of belonging was not immediate, with some recognising it took 'one or two years' to feel. Exposure and the personal satisfaction of the role increased the CCNs feeling of happiness and belonging.

There appeared to be a common trend of CCNs requiring several years to settle and after demonstrating resilience through the initial period of adversity, they may achieve longevity in practice with a family to which they feel they belong.

With reference to unit analysis, as suggested by Morrison-Beedy, et al. (2001, as cited in Polit & Beck, 2021) it is worth noting that both focus groups proceeded without any inter-group disagreement, they were mindful of each-others' speaking time and the group dynamics did not appear to intimidate participants from disclosing their opinion. Some participant narrative was neither agreed or refuted by the remaining participants and some exposed difficult experiences such as P8 and P9s when referring to personal experiences of bullying, and cliques within CC. This is another example where individual analysis may have provided deeper insight into the individuals experience, supporting the benefit of seeking individual narrative in the subsequent phases.

5.6. Discussion

The initial assumption was that the FS would provide narrative linked to the extrinsic reward relating to professional development. The rationale relates to the non-probability sample; with all participants studying for their QIS, supported by their

employer. The findings, however, provided insight into the phenomenon of ITR in CC, which was not located in the evidence base.

The FS achieved both outcomes. Objective one was achieved; good quality data which proved valuable when shaping the interview guide for the next phase of the study. The second objective, testing Colaizzi's (1978) analysis technique, generated real life narrative by focussing on concrete actions, feelings and events using a technique which was easy to follow. Such an approach appears reductionist in its initial data management moving to constructionist in the final analysis phase, with clustering into meanings and the presentation of conceptual patterns.

Reflecting on this process, the data analysis processes were robust, and the skills developed progressed into the next phase of this project. Facilitating focus groups and developing the skills of eliciting responses helped achieve objective three, researcher development.

Researcher bias, such as anchoring bias, band-waggon effect, memory distortion, self-serving and social desirability bias (Bourdieu, 1996) was minimised, by not misinterpreting the discussion, being aware of the focus group environment, in this case, the participants place of study and the power relationship, whether it was actual or perceived. The aim was to ensure passive sharing of information with a presentation of accurate narrative. The situation could have been prone to influence, by venue, body language and physical signals; this was monitored during both focus group sessions. However as stated, additional techniques to confirm the lack of bias, such as using member checking, were not incorporated due to time constraints.

5.7. Summary

The FS focused on three objectives: the exploration of CCNs motivation for remaining in CC to inform the next phase in-depth interviews guide, the assessment of a descriptive analysis tool and exposure to several research techniques including focus group interviews and the practice of elicitation of responses to gain in-depth narrative. It can be concluded that these aims were successfully met. Important learning points related to research skills, time management for approval applications and the consideration of the generational lens as a concept in the following phase (see Chapter 10).

This FS achieved its objectives and positively influenced the next phase, demonstrating its value as part of the research study. A recommendation would be to incorporate a FS in all future research processes to prevent taking unnecessary risks.

Chapter 6: Methods

6.1 Introduction

This chapter presents the motive behind adopting the data generation methodology, descriptive phenomenology. Marshall and Rossman's (Creswell, 2013, p.82) structured approach provides an illustrative framework for the methods utilised for this study design (Fig.8) and Colaizzi's (1978) strategy was used to analyse the interview data. This approach facilitated examination of the social science relating to the CCNs experience, including their professional journey and why they elected to remain in CC, demonstrating permanency against adversity.

6.2 Design and Methodology Procedure Approach

This study applied Husserl's transcendental phenomenological methodological approach to describe the intentionality of the study, the how and what of a phenomenon (King et al., 2019). The intention of the study's was to gain an understanding of the CCNs lived experience, to provide a depth of understanding relating to the knowledge gap in the prior research (Miles, 2017), and to answer the research question:

> *Why do some CCNs, exhibit longevity and remain highly motivated in an emotive and intense area of work, whilst others leave early in their career?*

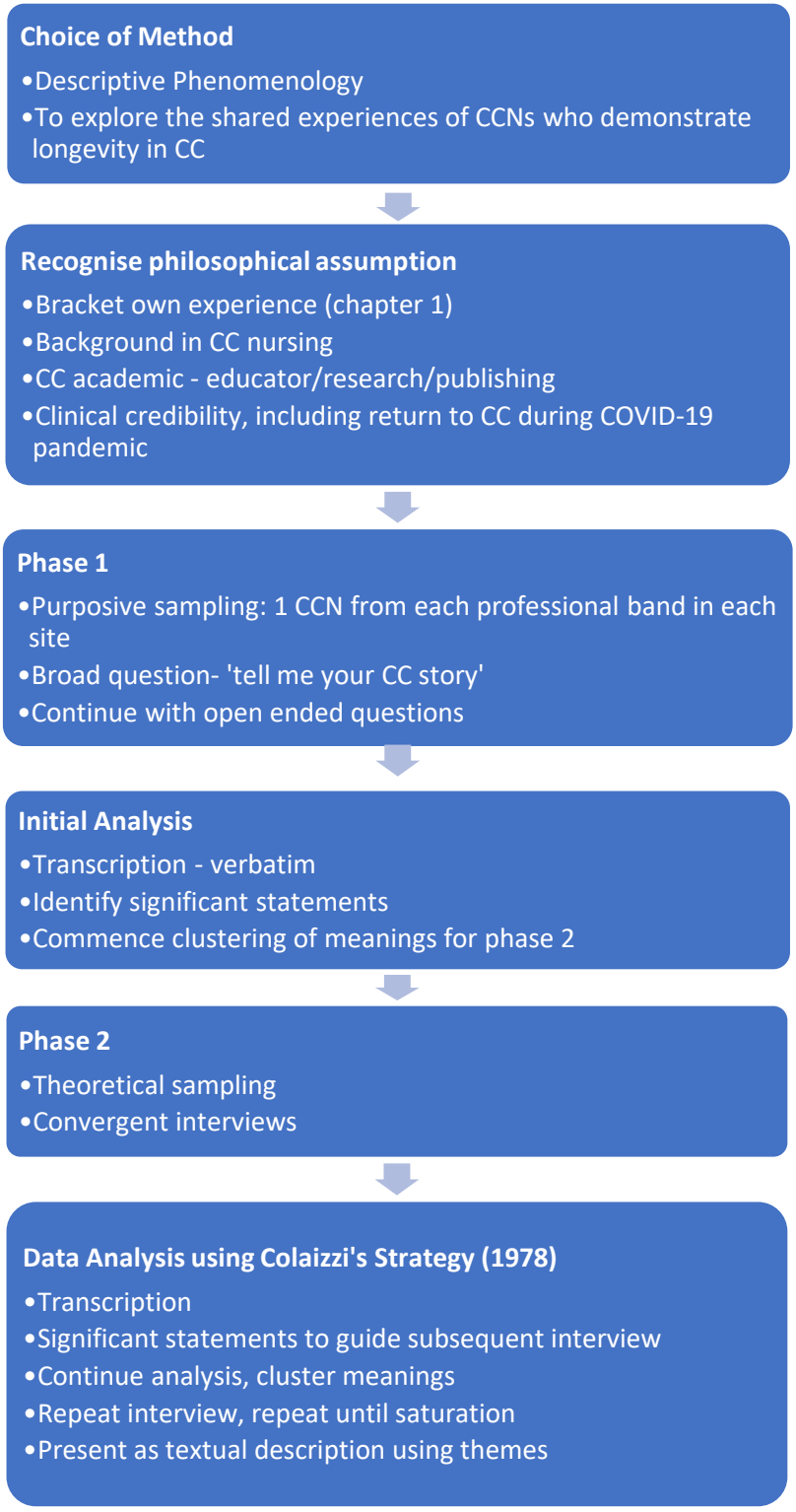


Fig.8: Adapted Method Framework for Conducting the Phenomenological Research Marshall & Rossman (Creswell, 2013, p.82)

6.3 Main Study Data Collection Method: Interviews

In qualitative research, interviews are a trusted method for meaningful data collection; they are an opportunity for participants to 'think aloud', detailing their account of the phenomena under investigation (King et al., 2019; Silverman, 2020). Interviews also enable participants to reflect on the past and link to the present and future (Conlon et al., 2015). Husserlian methodology ensures the researcher moves beyond the insignificant consciousness of the participants, revealing a more in-depth response (King, et al., 2019). This requires the researcher to be attuned to analytical issues, adding the 'when' and 'to what extent' (Silverman, 2020), to ensure depth of discourse is achieved and to enable clarification when the participants narrative appears vague or ill-defined. Adopted interviewing techniques should ensure uncensored discussion, so the narrative encompasses the wider picture, thus allowing the researcher to establish patterns to describe the nature of experiences. This aligned to one of the FS objectives, to expose and develop researcher skills, as well as aligning with Husserl's central tenet of the researcher ensuring participants articulation of their experience (Beck, 2021).

6.3.1 Phase 1: Initial Interviews for Emerging Themes

Many phenomenological studies collect data via semi-structured interviews, due to its versatility, specifically the flexible interview guide (King et al., 2019) (appendix 8). During phase 1, at the start of each interview, participants demographic details were recorded, with consent, including age, gender, length of service, both as a Registered Nurse and within CC, educational achievement and CC education certification. The interviews progressed through a simple core question to capture the CCN experience, designed to

encourage participants to 'instil a spill' (Imison, 2016; Twitter). This episodic interview question, invited the CCN to recount a specific situation relating to their professional nursing journey, focusing on their ITR in CC:

> *'Tell me about your CC journey, in relation to how long you have been a CCN and why have you chosen to stay in CC'*

Phase 1 interviews proceeded using semi-structured 'open-style exploratory questions' (Buys et al. 2022), focusing on the CCNs motivation to remain and their career journey. In addition to using a topic guide (Table 18), the use of probing questions focused on the 'when and what extent' (QUAL[*itative],* 2023), whilst encouraging the participant to speak in a relaxed manner, with little interruption. One of the strengths of interviews, is the interviewer accessing participant self-reflexivity which enables

> 'people to organise their personal biographies and understand them through the stories they create to explain and justify their life experiences' (Richardson, 1990, p.23).

Interviewing requires more than being a good listener; whilst this is required to develop rich accounts and rapport, social similarity may affect what is shared by the participant (Silverman, 2020). The researcher requires a skilled approach to encourage participant ease during the interview, a skill enhanced during the FS. Husserl's principle of epoché

and 'intentionality'[24] aligns with this concept of social similarity, with participants aware of the researcher's background, their current role as a CC academic and recent return to CC practice during the pandemic.

Table 18: Phase 1 Interview Schedule / Exploratory Questions

Phase 1 Interview Schedule / Exploratory Questions
When did this happen?
To what extent did this……? Awareness of wider organisation affects
Additional prompts included: • What matters to you in your work? • Has CC been a positive experience for you? • What has been rewarding? • What challenges you at work? • Why have you remained in CC? • Have you considered leaving? • Why do you think others leave? • What allows you to do your best • What impedes you to do your best?

The disclosure provided a clear insight for the participants of the researcher's intersection with the social location, providing participant assurance that they could speak using typical CC language and feel comfortable to provide a candid account of their experience (Chapter 10).

[24] Intentionality is 'Husserl's reference to the relationship between the individual and the object of the experience', intentionality is every act of consciousness, and every experience is intentional (Beck, 2021, p.13). The phenomenological notion of intentionality applies primarily to the theory of knowledge, not to the theory of human action (Sokolowski, 2012).

6.3.2 Phase 1 Sampling Framework

Reliable data collection is dependent on gathering a sample of a representative population; this meant ensuring the lens provided a meso[25] level view of multiple meanings into the CC nursing community. Absence of a micro-level review ensured the data collection shared a common understanding of the social practice of CCNs rather than an individual account; thus, aligning to the descriptive phenomenological approach.

Qualitative research does not attempt to represent samples statistically or align to the generalisability found in quantitative studies (King et al*.,* 2019). However, this study does aim to achieve some form of transferability, requiring the participants to correlate in a systematic manner to the social world of CC and the phenomena being investigated. A diverse sample, representing the variety of positions within CC, was sought, to share meaningful experiences; this type of sampling is referred to as *purposive* (King et al*.,* 2019). The effectiveness of purposive sampling depends on the researcher's knowledge of who would have 'some involvement' with the phenomena (King et al*.,* 2019); as such the researchers experience allows efficient identification of those participants that should be sampled.

For ease of access, participants were recruited from two medium to large CC units within the Midlands; in total this provided access to approximately four hundred and seventy-

[25] Meso level is defined as a population size that falls between the micro and macro levels. The middle level structures which can relate to institution or organisations in which people are confirmed adhering to social norms. The focus is of characteristics of specific networks, groups or collectives. Mesa level researchers might study 'norms of workplace behaviour', studying human behaviour, mezzo-level phenomena (Bronfenbrenner, 1974).

nine registered CCNs (Unpublished data). In Phase 1, purposive sampling aimed for one CCN from each professional band[26] (5-8) from each site, ensuring a diverse range of experiences were explored (Table 19).

Table 19: Phase 1 Participant Demographics

CCN	Professional Band	Site	Code	Gender	Age (yrs)	Registered Nurse Length of Service (yrs)	CC Length of Service (yrs)	Audio file
N1	5	1.	5:1:1	M	57	35	12	0811154
N2	7	1.	7:1:2	F	65	45	43	0811155
N3	6	2.	6:2:3	F	57	31	26	0811156
N4	6	2.	6:2:4	M	31	7	7	0811157
N5	8	1.	8:1:5	F	50	29	22	0811159
N6	5	2.	5:2:6	F	30	4	4	0811161
N7	6	1.	6:1:7	F	57	34	33	0811163

6.3.2.1 Inclusion and exclusion criteria

The philosophical position influences the sampling strategy, with phenomenology requiring a smaller sample size than quantitative study designs and no requirement for statistical power (Shosha, 2012). Indeed, the aim is to gather a homogenous sample of single figures to early teens, typically offering sufficient depth of analysis (King et al., 2019). However, the descriptive phenomenology approach contends for a greater range of diversity to assist crucial aspects of the phenomenon to be robustly identified (King et al., 2019). As such, specific control defined the sample group using inclusion and exclusion criteria (Tables 20 & 21). Whilst allowing variance in aspects such as age,

[26] Agenda for Change Professional Bands in nursing refers to Registered General Nurses on pay band 5-8. Band 8 is typically the ward manager.

gender, length of service in CC and as a registered nurse (Gerson & Horowitz, 2002), this phase 1 sample aimed for one CCN from each professional band from each site, supporting that robustness.

Table 20: Phase 1 Participant Sample Inclusion Criteria

Inclusion Criteria
Registered Nurse working in Adult CC (level 2 and/ or 3)
Minimum two years length of service working in CC
Professional band 5-8, in clinical roles, one from each research site
Age 23 upward
Male and female
Participants who agree to be interviewed in phase 1, may be considered for phase 2

Table 21: Phase 1 Participant Sample Exclusion Criteria

Exclusion Criteria
Registered Nursing Associate
Non- registered nurses
CCNs' during their induction period
CCNs' working in non-adult units
Allied healthcare professionals working within CC
Below two years CC experience

6.3.3 Phase 1 Study Procedure

Study packs were provided to each CC site manager which included recruitment posters (appendix 9), introductory letters, study and consent information (appendix 10). Participants were recruited via these materials with posters displayed in both sites and email invitations distributed. These emails were sent by the Unit Manager, who acted as a gatekeeper. The study also advertised at local and regional stakeholder meetings,

including the CC Practice Educator Forum, CC National Nurse Lead Education Forum and CC3N.

Methodologically, there was a balance of self-selection, where some participant subsets may not wish to apply; the purposively sampling frame was applied to prevent bias, however this essentially remained a volunteered sample. The sample of purposively selected participants required operational management to ensure the enlisting of equally stratified groups of nurses, across each site, to ensure maximum variation with a maximum number of eight participants. Where applications for participation exceeded the required number, such as band 5 CCN at Site 1, random sampling was used. In Site 2, no professional band 7 or 8 volunteered, one band 7 indicated keenness to be involved, however they were unavailable within the time frame. Instead, two CCNs at band 6 were interviewed; with one a bedside nurse and the other in a distinct role as a CC educator, ensuring variance in the cohort of interviewees. Participants for phase 1 were recruited in a timely manner and gained more responses than necessary. Those respondents not interviewed were acknowledged and provided with a brief explanation for the decision made. They were then invited to participate in phase 2, if the phase 2 inclusion criteria were satisfied. On completion of phase 1, instead of the recruitment target of eight, seven interviews had taken place. The band 8 from Site 2, however, was available for interview during phase 2.

The phase 1 participant sample was a homogeneous group of CCNs from two CC units within two separate organisations across two geographical regions (Table 22). Recruiting at the meso-level had the intention to affect the community of CC and the

wider level that is the organisation, and CC globally, the macro level (Salmon & Morehead, 2019).

Table 22: Phase 1 & 2 Site Comparison

	Site 1	Site 2
Geographical Location	Midlands	Midlands
Hospital Type	District General	Tertiary Centre
Bed Capacity	30	36
Band 8	7	10
Band 7	9	21
Band 6 (Including outreach, PDN, trainee ACCP)	49	74
Band 5	118	191
Cultural Diversity	99 overseas nurses (50% Filipino)	Data Unavailable
% Culturally Diverse of Nursing Workforce	54%	Data Unavailable
Total Registered Nurse Head count	183	296

6.3.4 Phase 1 Data Collection

The participant information letter (appendix 10) ensured that participants understood the research question, and an awareness of the data collection strategy and outcomes of the findings. This understanding was checked prior to commencing each interview as it was essential that the participant understood and deemed the topic under investigation relevant (Wendler & Grady, 2008).

Following consent, two of the seven phase 1 interviews, were conducted each lasting approximately sixty minutes. One additional Band 7 indicated keenness to be involved, however, they were unavailable within the timeframe. This initial data collection period commenced prior to the COVID-19 pandemic. Following a break in data collection

(Section 5.4: Ethical Considerations) the remaining participants were given a choice of remote or in-person data collection as per governance recommendation. The remaining five interviewees selected remote interviews, based on convenience. Aligning with Flannery, et al. (2023), consideration was given to gaining trust and rapport when video conferencing.

The early elicitation of the CCNs lived experience required little more than to listen, observe with sensitivity and to encourage for further reflection. Participants were focused, and with validation of their humanity, they provided a reconstruction of their reality. Participants were keen to share their view, without obvious signs of power dynamics.

6.3.5 Phase 2: Theoretical Sampling

Phase 2 used theoretical sampling to explore and probe the narrative and evolving assumptions expressed in phase 1. Participants were recruited using the same approach and in addition, those that had expressed interest for phase 1 but had been unsuccessful, were considered. Initial interviews proceeded with serial and contingent sampling depending on the emerging concepts (Polit & Beck, 2021). The conscious decision to use this method, typically used in grounded theory, allowed for a flexible, continuous sample; adapting participant recruitment throughout the research process, aiding emerging explanations. The researcher concentrated on one type of participant then another, relating to specific argument, providing an all-inclusiveness to the data (Charmaz, 2011). Although this process was time-consuming, the sample was refined as themes emerged which were especially interesting for the research question. This

underpinned the decision for the next data collection (King et al., 2019), creating a greater understanding of the CCNs lived experience. This process aimed to capture and reveal what was worth knowing and sits firmly in the inductive realm, following the central tenets of descriptive phenomenology (Beck, 2021).

Phase 2 used neutral questions for gathering in-depth data on phase 1's concepts. The focus was emic and rooted in the participant perspective using open ended questions (Table 23).

Table 23: Phase 2 Interview Schedule - Exploratory Questions

Phase 2: Open Ended Exploratory Questions
Why have you remained in CC?
What is it like to work in CC?
Are you thriving or striving?
Do you feel like you belong?

Phase 2 consisted of nine, serial contingency interviews, each lasting approximately sixty minutes. Nine was determined as reaching saturation; saturation has been defined as a

> 'judgement that there is no need to collect further data' (Wiener, 2007, p.306).

Saunders et al. (2018) clarified the concept of saturation; debating the position of saturation within varying methodologies and the relationship with data collection, analysis, and theorising. It appears that the perspective on data saturation, rather than theoretical saturation, is central to this study. This positions itself to completing several interviews until

> ‘nothing new becomes apparent’ (Saunders et al*.,* 2018, p.1895)

and what Sandelowski (2008) describes as *information redundancy.* As the researcher

> ‘hears the same comments…. data saturation is reached…. it is time to stop collecting information and to start analysing’ (Grady, 1998, p.26).

Dey (2007) argues for quality over quantity, similarly, Morse (2015) states that data saturation is the ‘gold standard’ for determining sample size (2015, p.587). Here, lies a potential difficulty for the ethical gatekeepers[27]. During the application for study approval, the researcher was unable to determine the sample size for phase 2 (this dialogue is further debated in Section 5.4). Saturation can also be determined at an individual interview level, when probing no longer discovers new information, and the researcher has a

> ‘full understanding of the participants perspective’ (Legard et al*.,* 2003, p.152*).*

The repetition of responses, with no new presentation of information, both across and within the interviews, led to the conclusion of the phase 2 interviewing process, with a participant sample of nine, totalling sixteen interviews in phase 1 and 2 (Fig.9).

[27] King, et al. (2019) define gatekeepers as someone who has the permission to accept or reject an approach to prospective applicants.

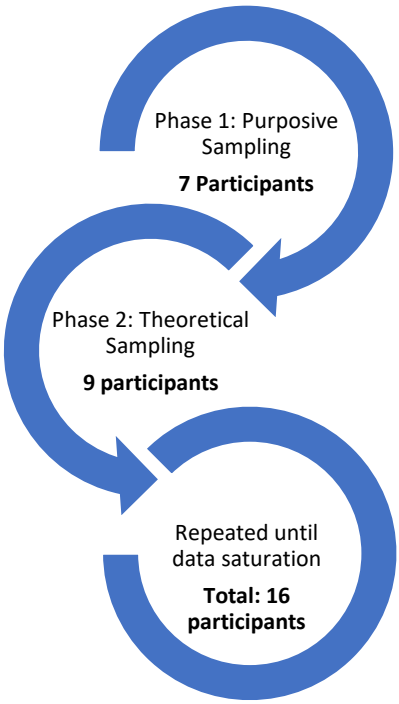


Fig.9: Research Phases and Data Saturation

Table 24: Phase 2 Participant Demographics

CCN	Professional Band	Site	Code	Gender	Age (yrs)	Registered Nurse Length of Service (yrs)	CC Length of Service (yrs)	Audio file
N8	6	1.	6:1:8	F	58	38 (40 at Trust)	32	8110015
N9	7	2.	7:2:9	F	60	42	38	8110016
N10	7	1.	7:1:10	F	50	30	30	8110017
N11	6	1.	6:1:11	F	46	24	14	8110019
N12	7	2.	7:2:12	F	38	16	16	8110020
N13	7	1.	7:1:13	F	55	20	20	81100 21/22
N14	8	2.	8:2:14	F	60	22	21	8110023
N15	5	1.	5:1:15	F	46	26	20/24	8110024
N16	8	1.	8:1:16	M	46	26	18	8110025

6.4 Phenomenology Data Analysis using Colaizzi's (1978) Strategy

Phenomenological methodology provides an insight into reality (Van Manen, 1990), resulting in an all-inclusive description of the phenomena. This commences with the researcher affirmation of bias, assumption, and presupposition (Shosha, 2012) prior to data collection; to openly detach what is already known from the participant narrative. This suspending or *'bracketing'* of understanding ensures validity in the data collection and analysis stages, preserving objectivity of the phenomenon (Speziale & Carpenter, 2007). This is the assurance that the researcher aimed to find, the true participant experience and not be blurred by assumption.

Colaizzi's (1978) multi-staged analytical procedure (Table 25) 'extracts, organises, and analyses the narrative data set' (Shosha, 2012, p.31), reducing the data, to develop a description of the experience that the individuals have in common, providing the essence of the experience (Creswell, 2013).

Table 25: Colaizzi Data Analysis Method (1978)

Phase of Interview	Description of Process
Phase 1	Stage 1- Familiarisation, reading through the written verbatim transcripts several times, gaining a sense check, of the whole (appendix 11). Context was added where necessary, ensuring simple verbatim transcripts included intonation, including sighs, laughing and crying. Transforming the basic transcription to one that was more helpful to the analyse. Each participant was awarded a unique reference, assuring anonymity whilst allowing cross checking to the original transcript (Table 26). Interpretation validity is assured by the descriptive validity provided in the transcriptions; these are verbatim (appendix 11). Stage 2- Statements were extracted, (e.g. two examples provided, Table 27). Stage 3- Statements were aggregated into meanings (appendix 12)
Phase 2 – theoretical sampling, convergent interview - analysis	Interview based on initial and emerging meanings from initial theoretical meanings. Stage 1- Repeated, read, and re-read new transcripts, gaining sense check, and adding context. Stage 2 and 3- Repeated, extracted statements were coded according to the transcript line number, then added to formulated meanings, developing new meanings until saturation achieved (appendix 13).
Analysis Stage	Stage 4- Grouping of the meanings into themes (appendix 13). Stage 5- Emergent themes provided distinctive constructs and exhaustive description of phenomenon (Fig. 11). Stage 6- Reduction of the findings, ensuring clarity between the themes (Fig.25)
Validating of exhaustive description	Stage 7- Validation check with supervisory team

Table 26: Key: Participant Coding

Unique Reference	Professional Band	Site	Interviewee Number	Associated Line on Transcript	Identifier used in Findings
5:1:1 (7)	5	1	1	7th	N1
8:2:14 (10)	8	2	14	10th	N14

Table 27: Examples of Creating Formulated Meanings from Significant Statements

Significant Statement	Formulated Meaning
8:1:5 (161) because I quite liked, all of a sudden, you get to know everything round here, and I quite like, people actually listen to what you have to say	Having a voice
6:1:7 (36) urm, and I loved the people and had such fun with them, urm and I could see that they gave such amazing care, [emphasised the amazing care] obviously we only had two patients, but everything was so like perfect	Love for CC, 'Perfect care', community

The Stage 4 process organised formulated meanings, into seven unique clusters of distinct concepts, capturing significant reoccurring meta-themes across the participant interviews (appendix 13). Each thematic group can be viewed as an info-graph (Fig. 11).

Stage 5 integrated the findings into an exhaustive description of the phenomenon, presented in Chapter 7. The final stage in Colaizzi's strategy, stage 6, identifies 'redundant, misused or overestimated descriptions' (Shosha, 2012, p.41) that may 'weaken the description, or are ambiguous' (Shosha, 2012, p.41). However, this should not be perceived as ignoring data or narrative that does not follow the developing

theory/assumption. These sub-themes, relevant to the research question, may be of less importance but were not ignored or dismissed from the analysis. The reduction of the central stories from each theme is discussed in chapter 7.

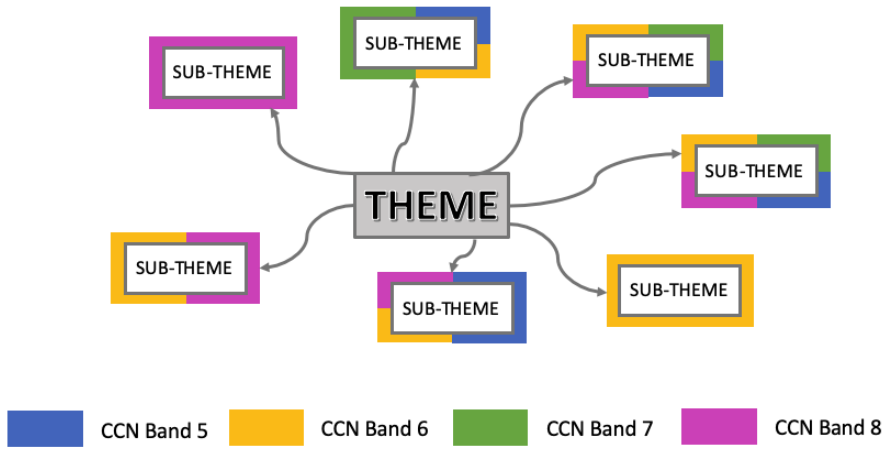


Fig.10: Example of Thematic Group Info-graph

Stage 7 relates to 'member checking' (Shosha, 2012, p.41), which required re-accessing the participants to discuss the results, validating the researcher's descriptions of their narrative. This study has not remained true to Colaizzi's (1978) and the Husserlian approach, positioning more towards Giorgi's (2009) descriptive phenomenology which does not support the return to the participants to consult them (Beck, 2021). The rationale for this method slurring related to the timing of the data collection and analysis period; this aligned with the second and third wave of COVID-19 and therefore re-accessing participants was perceived to be an added burden for the CCNs who had already participated during a period of unprecedented and challenging times. The ICS described this time for CC staff as a time when

> "Every ICU care worker was facing traumas of their own as well as coping with the extremes of a new, unknown virus, unprecedented numbers of patients, personal danger of infection, colleagues falling ill and the loss of scores of people in our care" (ICS, 2020).

From this, it was uncertain not only whether the effect of COVID-19 on CC and CCNs would subjectively influence participant responses in comparison to the data collected prior to the pandemic outbreak and whether recruitment would be viable. Therefore, to consider asking a CCN who had already sacrificed time, to forgo more time to read and discuss the transcriptions, seemed unreasonable. To set aside any bias and prejudice, the process did not align with *'member checking',* however, the researcher continued to bracket their researcher experiences. The narrative, transcripts and formulation of meanings were also discussed with the supervisory team in attempt to add rigor and ensure narrative was presented in a true form (Chapter 10).

6.5 Ethical Considerations

Ethical practice in social research is '*complex and demanding'* (King et al., 2019). Within this context, Murphy and Dingwall's (2001) framework for '*ethical theory*' was applied (Flick 2015). These principles of non-maleficence, beneficence, autonomy and justice were adhered to by ensuring informed consent, confidentiality, anonymity and data protection (Flick 2015, p.32).

Regulations that ensure ethical principles and the protection of the participants were respected by the following study approvals: the initial study protocol was approved by Keele University HumSS Faculty Research Ethics Committee (HU-180005), followed by

University Ethical approval (RG -0297-19 SNM, appendix 14). An additional layer of governance was required due to the participants working in healthcare. Application to the Health Research Authority (HRA)[28] (IRAS Project Number 263561, appendix 14) determined that the study was ethically and methodologically sound. HRA approval protects and promotes the interests of patients and the healthcare team in health and social care research (Health Research Authority, 2024). The HRA process was not a new experience for the researcher, however this was time consuming. An initial concern by the researcher, relating to the conscious and deliberate decision to use theoretical sampling (Glaser, 2005, Corbin & Strauss, 2007), and the inability to provide clear participant numbers was unfounded. Additional permissions were sought from each of the hosting Research and Development Teams within the NHS organisation ensuring the capability and capacity to support the research activity (appendix 15).

Additional ethical consideration arose in April 2020, due to COVID-19, which required the 'pausing of recruitment' as authorised by the sponsor and HRA. The pandemic substantially impacted CC services, with the need for increased capacity and redeployment of other healthcare professionals to work within CC. This caused data collection to be halted (ICS, 2020). Three months later, in June 2020, both the sponsor and HRA advised that if the validity of the study worthiness and with consideration of safety mechanisms relating to the COVID-19 situation could be assured, then data collection within the NHS could recommence. The validity of the study was then

[28] HRA approval protects and promotes the interests of patients and healthcare team in health and social care research (http://www.hra.nhs.uk), using a code of ethics. These standards define that all research studies must adhere to strict application guidance prior to approaching research sites.

heightened, with ex-CCNs returning to support the CCN workforce, with an increase in the exit of existing nurses from the CC environment witnessed.

Following initial contact, Site 2 agreed to site readiness, enabling application to the sponsor to reconvene, which was subsequently granted[29]. It was suggested that e-consent/proportionate consent was to be considered. Sponsor support was re-established with additional safety considerations for both the participants and the researcher. These safety precautions whilst positioning to the no substantial amendments framework included the modification from onsite data collection to remote source data collection. This aligned to social distancing regulations and addressed the limited access to healthcare venues now available. The preferred method of interviewing moved to an online platform, typically using Microsoft Teams. The sponsor also recommended proportionate consent which required no substantial amendment to either ethics or HRA (IRAS) approval. Guidance was followed for the adaptation of participant information and for confirming consent using remote data collection methods (HRA, 2020). The amended documentation for consent allowed for electronic signatures returned by email, demonstrating informed consent.

For the participant, methodology fluidity, honesty and integrity were assured with informed consent (Elliott and Lazenbatt, 2005). Following identification of the participants, an invitation email was forwarded that included the request for informed

[29] Guidance on no substantial amendment was adhered to and could be originally located on the HRA website.(https://www.hra.nhs.uk/covid-19-research/covid-19-guidance-sponsor-sites-and-researchers/.https://www.hra.nhs.uk/covid-19-research/covid-19-guidance-sponsors-sites-and-researchers/#reopening). This site can no longer be accessed.

consent. The interview commenced by discussing the participants understanding and awareness of the study information letter and consent documentation. Consent forms were signed and held by the researcher. The process of withdrawal was also made clear, with the participants able to withdraw from the study following the interview, up to the point of their narrative being included into the meaningful statements. If participants decided to withdraw, then their data would have been destroyed in accordance with Keele University guidance on destroying hard copies and electronic data. Participation was voluntary, no inducements were offered, and no participant made the decision to withdraw their narrative.

All responses were confidential, anonymity was assured by the assignment of codes. Face to face interviews took place in an environment selected by the participant, with online interviews available if preferred. The storage of data was explicitly explained to the participants. Data was stored on Keele University secure servers and stored separately from the audio storage area. The computers were password protected and stored in locked offices, with only the researcher having access to the passwords. All sensitive discussions were sent via password protected files. Hard copies of data and consent forms were kept in locked filing cabinets at Keele University, School of Nursing and Midwifery in locked offices and destroyed following Keele University guidance after successful completion of the final thesis.

Positionality addressed power relationships, between the researcher and the participants. Bettez (2015) 'communion' argues for meaningful connection between all parties but respects that these are influenced by culture, beliefs, and social position. Although mutual respect for shared equality and inclusion was the aim, reducing power

dynamics is not easy. Consideration for the participant's feelings, resulting from the implication of their responses and the dissemination of the findings warrants respect. In addition, participant wellbeing was considered, with signposting to support services detailed in the consent and study information.

6.6 Summary

This chapter presented the approach for data generation across a two-site, two-phased study using semi-structured interviews. The employment of Colaizzi's (1978) strategy for analysis demonstrates how the data from sixteen CCNs lived experience was gathered, extracted and analysed. The initial ethical considerations and the amended response required due to COVID-19 are conveyed, demonstrating a responsiveness to ensure the findings are trustworthy and authentic.

Chapter 7: Presentation of Findings

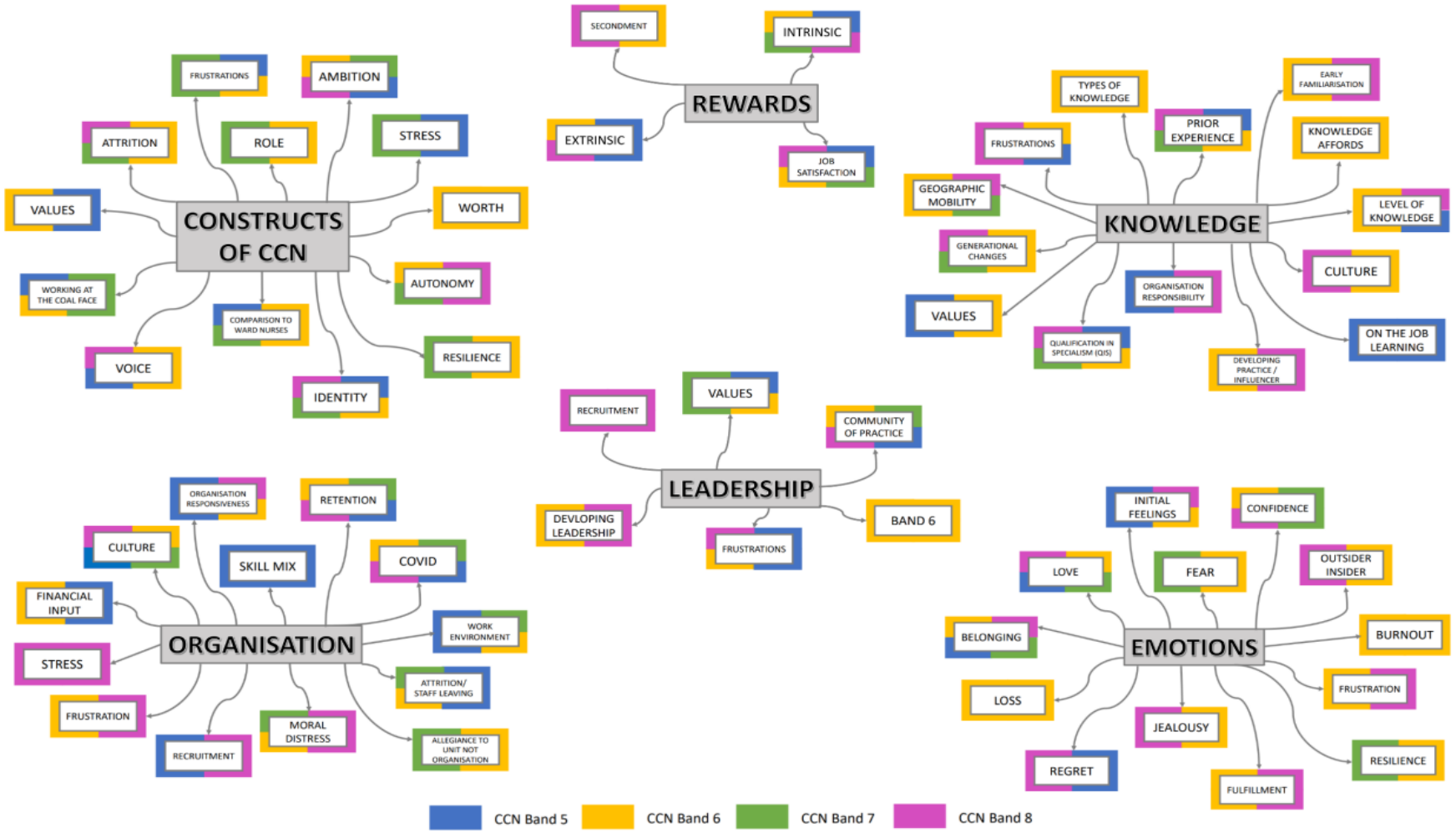
7.1 Introduction

This chapter presents the study findings, exposing the lived experience of seasoned CCNs, who remain in a workplace recognised as having unhealthy work conditions. The findings reveal if they are thriving and why they remain. The experiences of CCNs were explored using semi-structured interviews, and using Colaizzi's (1978) systematic approach, the formulated meanings were clustered into themes. Sixty-seven themes summarise the distinctive characteristics of CCNs experiences as textual patterns (King, et al., 2019). The textual patterns are the constituents that present the underpinning meaning, relating to the research question:

> *Why do some CCNs, exhibit longevity and remain highly motivated in an emotive and intense area of work, whilst others leave early in their career?*

7.2 Presentation of Findings

The sixty-seven themes have been organised into seven broad thematic groups (Fig.11, Table 25), the groups are not hierarchical, and their frequency was not measured but all were noted to have occurred typically more than once.



Seven themes emerged from the findings: constructs of CCN; rewards; knowledge; organisation; leadership; emotions and frustrations.

Fig.11: Findings Infograph

Table 28: Broad Thematic Groups

Group	Total Number of Associated Themes (discussed)
Constructs of CNN	13 (6)
Emotions	13 (2)
Organisation (including effects of COVID)	14 (6)
Leadership	6 (2)
Knowledge	16 (3)
Reward	5 (2)
Frustration (Culminated from all groups)	1 (1)

Fig.12 provides a visual presentation of one of the themes and includes the professional band of each CCN that expressed narrative of that theme, (Fig.13 demonstrates a theme in full). As an example, the intrinsic reward sub-theme is presented below. Intrinsic reward is part of the broader rewards theme and demonstrates that CCNs from four professional nursing bands spoke around this concept.

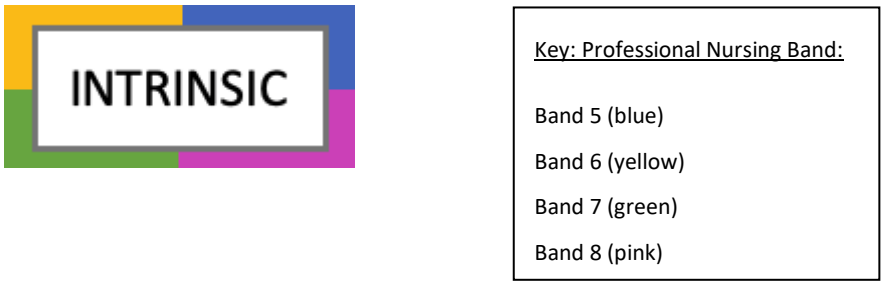


Fig.12: Sub-theme Representing Professional Band Narrative

7.3 Participant Profile

The participant profile (Table 29) aligns with the national picture of CCNs. Participant ages ranged from thirty to sixty-five years, with an average of twenty-two years' of CC experience (range four to forty-three years). Thirteen of the participants were female (81%), three were male (19%); higher than the 11% of male nurses recorded with the NMC (2022). Eighty-one percent were UK nationals, and 19% were born and educated overseas. There was an imbalance across sites; Site 1 provided 62% of the participants and Site 2, 38% of the participants. Representation of all professional bands, 5-8, was achieved at both sites. Table 30 presents the participants and their nursing experience.

Table 29: Participants Profiles

Characteristic	**No. (Percent)**					
Gender	Male: 3 (19%)			Female: 13 (81%)		
Nationality	UK: 13 (81%)			Non-UK: 3 (19%)		
Site comparison	Site 1: 10 (62%)			Site 2: 6 (38%)		
Professional Band	Band 5	Band 6		Band 7	Band 8	
	3 (19%)	5 (31%)		5 (31%)	3 (19%)	
Length of Service in CC (in years)	<5	6-10	11-20	21-30	31-40	40+
	1 (6%)	1 (6%)	5 (31%)	5 (31%)	3 (19%)	1 (6%)

Table 30: Summary of Participants Clinical Experience

Prior Experience	Phase 1: 7	Phase 2: 9
CC Experience (current unit only)	N6	
CC Experience (multiple units)	N1, N3, N5	N9, N10, N11, N12, N14, N15, N16
CC Experience and ward /alternative specialism experience (cardiac, palliative care etc.)	N1, N2, N3, N4, N5, N7,	N8, N11, N14, N13, N15, N16

The following sections describe and explore meaning of the participants experiences using vivid quotes.

7.4 Constructs of a CCN

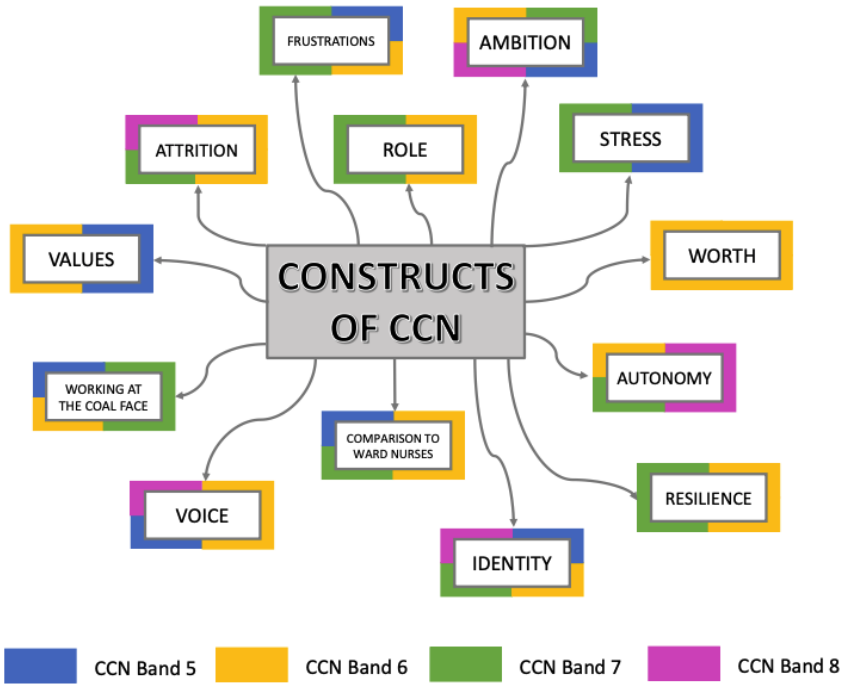


Fig.13: Theme and Identified Sub-themes: Constructs of a CCN

Constructs of a CCN (Fig.13) initially identified thirteen subthemes, these were further reduced to ensure that significant experiences relating to how a CCN maintained motivation and remained in CC were presented (Fig.14). This ensured the participant remained central to the narrative and that data specifically relating to the research question was presented. Redundant data will be shared in an alternative discourse.

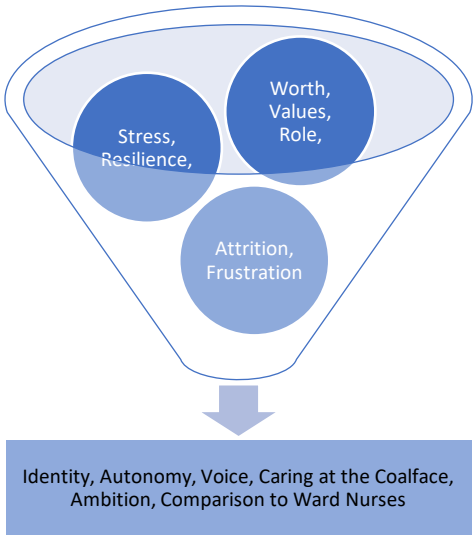


Fig.14: Reduction of Constructs of a CCN Theme

7.4.1 Identity

The role of a CCN was identified as complex and multilayered, frequently referred to as 'hard-work….clinically interesting' (N4), of being 'clinically capable' (N1) and 'stimulating and exciting' (N10). N5 highlighted that identity was more than a place of work or speciality,

> ‘you not only enjoy the work, you identify as a CCN….it’s in your blood, you are always a CCN; even when I left for those two-years I would call myself a CCN….it is your identity….as a ward Manager….it just wasn’t CC nursing. CCNs are special and since COVID they are now more recognised….we are proud to be a CCN…. stand out, and noticeable’ (N5)

There was a ‘sense of pride’ in being a CCN (N6), with CCNs describing a similar work ethic summarised by this senior CCN,

> ‘their work ethic, their level of care, they are fabulous, they don’t get bored and they love what they do’ (N5)

This sense of pride and work ethic was illustrative of a shared value, with expectations of holistic and high standards of patient centred care provision for those across the age ranges and acuity (N1,N2,N3,N4,N7,N13). The provision of focused, perfect care (N1) was seen as one of a CCNs highest values. There was no cutting corners and variety prevented boredom (N1)

> ‘ITU is as close to perfect as care can get, quick intense decision making, efficiency, it’s a physical demanding role’ (N1)

For most, this shared value related to their ‘skill set….and additional capability’ (N3), this was confirmed by the senior leaders,

> ‘I want someone to look after [patients] that is highly skilled, highly qualified but with all the human attributes as well as the nursing attributes, because that is what an CCN is’ (N13)

There is an expectation that a CCN has a broad knowledge base (N4) because CC is 'so varied and there is a need for 'competent practitioners to care for anything that comes through the door' (N4). 'There are only certain people qualified to look after' these patients (N12). There is an understanding, expectation, and commitment towards the development of a highly desirable skill set (N4,N14). However, CCNs are expected to constantly self-develop, be prepared to develop outside of work, meaning the role can be 'frustrating' for those that 'expect to be spoon fed' (N1,N10).

Nearly half of the CCNs identified that their role encompassed teaching and role modelling (N3,N4,N9,N10,N13,N14). N3 and N4 both had clinical education backgrounds and shared how they 'enjoyed the bedside teaching'. They identified their role was to instil compassion, love and passion for CC, and this is how they achieved self-actualisation. Both appeared altruistic, highlighting that there was more to being a CCN than the professional band, articulating they have a 'duty to share knowledge' (N4).

> 'strive to share….I have a great deal of freedom to work alongside the nurses and react to their needs and to their [pause] lack of skills….it is….left for me to assess where the nurses are at….predominately our job is very much trying to work with junior nurses in order to facilitate their learning….whether that's directly teaching them or….signposting them where to get the best value, or who best to teach them' (N3)

In addition, CCNs expend emotional energy, describing themselves as passionate whilst managing complexities whilst performing their responsibilities,

‘empathetic, compassionate, interested in learning, organised and patient centred is the identity of CCNs, having a passion….I’m going to blow my own trumpet here, I’m a bloody good CCN, I miss being in the bedspace, because it’s a puzzle, it’s a dedication….not everyone knows how to talk to someone when they are asleep or when they are waking up….or when they have delirium and that is a worry. CCNs are kind caring and compassionate....compassionate to families....look at the grief they are going through and the stress and the worry…. imagine yourself in that position with your loved ones in that bed….I would be beside myself’ (N12)

‘to be a good CCN you need to have passion and commitment and sadly we don’t see it in everybody. CCNs want to care….provide holistic care…make a difference….to the patients and the family….I don’t think it’s something you can teach…its part of that person’s personality….it’s like a commitment….it isn’t just a job it’s a vocation….it’s that wish to go the extra mile, some see machines….[CCNs need] tolerance….empathy to be able to provide that reassurance for those waking up, with delirium or traumatic brain injury’ (N14)

Participants reflected that organisational restructuring had challenged the identity and status of some of the CCNs. N3 described their previous status of a Junior Sister, and how this had been challenged during restructuring, with the loss of additional roles, such as appraisals and the loss of the associated status which left them feeling less valued

> ‘we were very much in charge….and we could lead….[now]….you had no input into off-duty, organising the next shift cover….into allocation, that’s done by the band 7….you were literally a supporter and organiser of breaks on your shift’ (N3)

To regain that sense of personal achievement and job satisfaction N3 focused on alternative roles without title or status, including education and staff development. Their reward, albeit now intrinsic, was reinstated with the sharing of knowledge and demonstrating that their skills were transferable across sites.

> ‘it was pleasing to make them feel less anxious….to show them that the skills they bought with them were very much transferable’ (N3)

N3 shared how physical identity with the use of titles and uniforms was important to some. During organisational change they experienced professional downgrading; this sense of being ‘devalued’ led to ‘challenging conversations’ to maintain a title in name rather than uniform. They spoke of the change in recognition of status through the wearing of uniform rather than the recognition of experience and knowledge,

> ‘Previously we wore scrubs and therefore the only demarcation of our band was what was written on the scrubs, not actually the colour of the scrubs….there was a change there for us as well….because we were….trying very hard to make it so that the patients and relatives didn’t realise they had a junior nurse looking after them because of the colour of your uniform’ (N3)

Visual representation of identity was not always seen as helpful,

> ‘we found it very helpful that it didn’t matter [to relatives] which grade was looking after them….they could see that if somebody was very junior, a more senior nurse came and helped and supervised and supported but actually they only knew that because of our actions, not because of what our uniform said’ (N3)

Band 7s were identified as the clinical experts (N2,N7). Although some recognised that their role was becoming increasingly focused on ‘managerial responsibilities’ such as ‘leadership’, ‘problem solving’, ‘managing staff and beds’ (N2,N7,N9,N10). N2 and N9, with a total of eighty-one years’ experience between them, articulated how much ‘busier’ CC has become, and the role was becoming less clinical.

> ‘In the 90s, the senior team were very dynamic, they were on the shop floor and being in charge then meant they were party to the patient care being given, this active involvement set the scene for a supportive culture’ (N3)

There was reference to CCNs being seen as elitist, keeping themselves socially distanced from other healthcare workers,

> ‘elitist, well perhaps they have earned that right….it may be because a lot of the time they do not leave the unit for break. Because if there was an emergency they’d be called back, and they wouldn’t like anything to happen to their patient while they are gone’ (N9)

The construct of a CCN was identified as being physically and mentally gruelling, not always adrenaline fuelled (N4) and very different to the view held by society.

> ‘societal impression of CC is different to reality, its physically and emotionally hard-work….it’s not like Grey’s Anatomy or Holby City, or that people are acutely unwell constantly….there is rehab….managing delirious patients…a lot of physically and mentally draining work that isn’t exciting or adrenaline fuelled…. it’s the in-between bits, between getting them better, between acutely unwell and going to the ward and sometimes that can be a really physical mental hard slog….team leading, taking a patient, it’s exhausting’ (N4).

7.4.2 Autonomy

Autonomy was a shared value for six CCNs (N3,N4,N5,N11,N13,N16). Professional autonomy means having the authority to make decisions and having the freedom to act in accordance with one’s professional knowledge base (Rouhi-Balasi et al*.,* 2020). Autonomy was recognised as important to CCNs and something that differed between CC and wards:

> ‘I realised that we would be more involved with decision making and….having to be more autonomous and that would grow as I became more experienced just because of the nature of the illness of the patient’ (N3)

> ‘the ward is task orientated….I don’t see that there is time to reflect, this is the best for the patient or this is what needs to be done. It is all about do this….this needs to be finished and in CC you have that luxury of….thinking or processing

things and suggesting things, I don't think that luxury exists on the ward. I'm speaking for myself when I was on the ward' (N16)

Knowledge was identified as an enabler for autonomy, it allowed information to be drawn together to have an understanding on how to 'correct something' (N8). Autonomous practice required 'quick intense decision-making' skills (N1,N7). CCNs were required to develop the professional and practical skills ensuring capability and courage to manage situations where they are responsible. The level of clinical decision making can be a shock to the newer generation of nurses (N3); unlike themselves when they describe not being daunted by having to manage the shift

'As the band 6 junior sister, I would be on shift on my own with band 5s…. with the senior sister in charge on the main unit….we were very alone…. the consultant did a ward round and then no medical staff stayed on the unit at all' (N3)

'because of the intensity….when someone is admitted it's like quick, quick, quick, there is lots of work to do in a short space of time, you can't faff about, you have to be on the ball, you have to know what you are doing, you can't dilly dally about, you have to be efficient' (N7)

Experience and length of service was seen as key in developing such clinical decision-making abilities,

> ‘I was very challenged….but also a little bit able, because I was able to make those decisions because of my length of experience and having had quite a long time in ITU and been a ward sister. I was very comfortable with making uncomfortable decisions…. I backed myself to be able to choose when I needed to seek medical help’ (N3)

A CCNs autonomy was seen to be affected by the size of the unit; those working in smaller units, even if they were sections of a larger unit, were able to demonstrate more autonomous practice (N3). They voiced how the CC band 6 nurses, frequently ‘lead’ the unit without consistent medical cover.

Not only the size of a unit but the specialism was seen as affecting autonomy and decision-making, especially when comparing cardiac to general CC (N5,N15). General CCNs were identified as working in a less prescriptive manner requiring increased knowledge base (N5,N11). It was also suggested that the relationship with the multidisciplinary team in general CC was more supportive towards autonomous practice (N5).

The level of autonomy influenced decisions relating to which CC unit to work in, when relocating (N3). The capacity to work with the multidisciplinary team, gathering and sharing information to inform treatment plans was of great importance to them.

> ‘as an ITU [it] was busy, interesting people….you had an awful lot of autonomy, so therefore I could use the skills I had learnt up to that point and I could continue to make decisions for my patients’ (N3)

Those CCNs with additional roles such as clinical educators recognised their increased autonomy. They were able to engage with 'free ranging activities' which they associated with intrinsic reward (N3,N4).

> 'there are days when you know there is particular training that we have got to achieve and get done but even so during that time….we are only working in small groups. And therefore, you can still individually identify where people get stuck or when they look confused, it's not big group teaching' (N3)

Autonomy was valued as more important than ambition (N3,N5), due to the increased feeling of self-worth that resulted. It was more important to enjoy work, choosing satisfaction over promotion and financial reward (N5,N7). CCNs were able to work independently from their professional band. This was so important to some, that they chose to relocate to another CC, accepting demotion rather than working in an environment with a negative, more prescriptive culture (N3,N5).

The 'value' of autonomy was linked to having 'control in the bedspace' (N13). N11 recognised that CCNs working in the UK were more autonomous, which increased their job satisfaction and 'fulfilment in nursing'.

7.4.3 Having a Voice

Similar to autonomy the concept of having a voice and being heard was important and frequently articulated (N3,N5,N8,N11). There was consensus that CCNs have a voice, and they are

> 'upfront about things' and 'people are sincere' (N11)

Being an autonomous practitioner and having a voice, enables a CCN to be the patient's advocate

> 'on the wards there is no time for complaining, it is just do what you've been told to do….that was my experience. In CC….the staff members can say I'm not happy with that or this is an issue, you can raise your concern, or….if you've got something on your mind. You are free to say….well in my personal experience….it is not generalising, on the ward you feel restricted, you feel like you can't say something' (N16)

Having a 'voice' was seen to develop with experience, where they learnt to question decisions especially relating to clinical care (N8). Whilst laughing, N3 reflected that they were 'very vocal' and although this 'wasn't always well received' it related to

> 'self-preservation, [to reduce] moral distress….I am a very vocal nurse….and I still get growled at because I can't not say when I think something could be changed for the better….there is room to do that' (N3)

N4 articulated how in CC their voice was valued and listened to by the senior team, reflecting on a time where they had recognised and reported on the missed learning opportunities for new starters during the COVID period. Managers had seemingly reacted positively, and the identified knowledge gaps were being addressed. This participation in decision-making provided positive intrinsic reward for this CCN (N4).

Contrary to the consensus, one CCN spoke of not being heard, until they moved out of CC following securement of a secondment,

> 'all of a sudden, I thought, you get to know everything round here, and I quite like that, people actually listen to what you have got to say' (N5)

This CCN articulated how they felt when they returned to CC and the feeling of frustration of 'handing back their voice' and not being heard within a larger band 7 team (N5). Increasing autonomy and decision making led them to seek out further opportunities once again outside of CC within the same organisation, where once again they were

> 'listened to and I quite liked who I was becoming' (N5)

When a permanent position was offered, there was a realisation that 'self-actualisation' was not being met due to the nature of the work, it was not the specialism that they 'loved'.

> 'It wasn't CC, and CC is in my blood, and I love ITU' (N5)

This CCN realised that opportunities which enabled her to 'have a voice' whilst working in a CC environment needed to be met; following securing a managerial position, they once again had a voice, was a 'decision-maker', and they felt 'self-satisfied… trusting my own instincts' (N5).

N8, raised tentatively how 'being heard' within the unit, was reducing, and how this was personally 'frustrating' (N8)

> 'I am 58-year-old women, and I don't need this' (N8)

The newer generation of nurses were considered more vocal, with a confident and clear voice,

> 'they have a great deal more discussion in schools now which is really great, and makes them very clear, they can have conversations with their teachers….they can have a view….they have an opinion that is valued' (N3)

However, whilst recognising this is a positive characteristic, there was recognition that there must be a greater understanding of when to speak out, highlighting an occasional lack of understanding of when to interject and use that voice (N3). There was no expectation for those new to CC to undertake tasks which they were uncomfortable with or did not agree with but N3 suggested that part of the education process to having a voice is to have the knowledge base of when to use it.

> 'they just need to get on with the job' (N3)

7.4.4 Caring at the Coalface

The concept of caring at the coalface was related to job satisfaction and joy at work. It was evident that these CCNs cared deeply for critically-ill patients and, despite the continued effects on their emotional intelligence and exposure to end of life care, they did not want to work elsewhere.

Fourteen of the CCNs interviewed, had regular patient contact as bedside nurses, with two occupying managerial roles. Six of the these identified themselves as clinical leaders, and passionately disclosed that their reason to remain in CC related to the nature of patient care and the ability to remain at the bedside at their level professional level. Four, spoke of the one-to-one care, and 'the challenge of caring' for the critically-ill and the importance of providing quality care,

> 'really sick patients, that's what made me start here and made me stay….the one-to-one care and helping the families….I can't imagine being able to give the same level of care….I can't imagine working on a ward and….know that you've been able to skim the bare surface of providing essentials to the patient and not being able to provide everything they need' (N2)

> 'I am a nurse that loves patient care….at the coalface, I'm working with my patient's, their families and that's very much where I will always see myself as a clinical nurse (N4)

CCNs highlighted their 'need' to provide the 'best care', skilled, and one-to-one care enabled them to do this (N4,N7,N8,N9).

> 'I feel that CC allows me to do a job well rather than lots of jobs badly….I can't see myself as going into management or corporate….I will remain clinical as that is what I enjoy….and where I can make the most difference in my professional career' (N4)

> ‘if I wasn’t in CC I would be bored, I know it sounds big headed, but we do know how to look after our patients….you can give your all, there was no cutting corners….it was complete focused care….I can do it to perfection, but I don’t think I could do that on a ward….and that is scary….I have got used to giving the right care to the right people at the right time….I am not saying we are perfect but CC is as close as you can get to giving perfect care to people’ (N7)

N14 also spoke of making a difference, instead referring to what they considered as important in nursing, even if the patients do not remember,

> ‘make a difference….the holistic care….sad as it may be….If I have got time to wash somebody’s hair, clean their teeth….that is why I came into nursing….to make a difference (N14)

> ‘cardiac is like a treadmill….conveyer belt nursing….[however] these patients are so grateful, they remember you, they remember everything…. general patients don’t remember how you loved for them….you cared for them….stroked and washed their hair, done the things that saved their lives….their families do’ (N13)

Working at the bedside, remaining clinical was more important to some participants than seeking progression (N2,N3,N8); financial renumeration was not mentioned by any of the participants. However, the importance of remaining patient centred, had caused role versus career conflict. N3 had found a compromise for this role conflict, by moving into in clinical education; here she enhanced other skills without the reduction in patient contact. The senior nurse recognised that their clinical remit was lessening over time (N2, N12).

The nature of care delivery in CC was identified as changing, it used to be

> ‘muck and bullets and the high adrenaline pressure situation….now changed gear….more the rehab side….change in the nature of work, the long conversations….[I am] heavily involved in supporting the families and we do complex rehab….a little distancing….from the stuff that used to keep me up at night….the issues are different….still challenging and upsetting’ (N12).

7.4.5 Ambition

The personal conflict between career advancement and remaining at the bedside was shared by nine of the sixteen CCNs (N1,N2,N3,N4,N5,N7,N8,N9,N15). The ‘passion’ to remain at the bedside combined with autonomous practice and leadership activities, including supervision, teaching and supporting (N3) were seen as more important than promotion (N7,N8) and entering management (N16).

> ‘there’s lots of my colleagues….stay as a band 5, or stay as a band 6 for their entire careers….it is more important to enjoy the work that you are doing and to feel comfortable in the work that you are doing’ (N4)

> ‘I didn’t become one of the band 7s, I was still of the oh no I don’t need to step up into that role….very much bedside nurse, very much involved in doing many things….I was part of the teaching….we set up an education package….the inhouse course….I did a whole range of sort of, management type roles, but very much at the bedside rather than stepping into true management’ (N3)

> ‘fulfilment in CC, whether there is no promotion, you just like to work in the unit, general was and still is my love’ (N13)

There was recognition of the lack of appetite for the senior band 7 role, seen as a lesser attractive role due to its association with the management of bed capacity and staffing issues (N5) with limited patient focus (N2,N8) and higher pressure (N7). One of the senior CCNs reflected on the teams feelings of the senior roles,

> ‘why would we want your job….fighting fires about staffing, and beds….managing sickness and stuff like that, they do not see it as an attractive role’ (N2)

> ‘I became a nurse to nurse….to look after patients, to have hands on responsibility….not sit in an office writing reports….pen pushing….that’s not me’ (N8)

N1 did not associate with the progression conflict. With thirty-six years nursing experience and having already been a senior nurse, they had moved to CC late in their career, at a time when progression was no longer their focus, or seeking the added pressure related to ambition, being ‘happy at work’ was their priority, rather than

> ‘career driven, happy to take a back seat….not blossoming because at my age and with my experience….I think I am now in that retirement phase. I think there is a different perception about going into the job’ (N1)

Although they appeared to lack ambition, at a stage of 'stepping back' in preparation for retirement, they were fulfilled in their work role, and frequently stated how they 'loved' CC and continued to 'thrive'(N1). They acknowledged that they did not have the external pressures that influenced their ability to thrive such as childcare and finances.

> 'see those struggling with childcare, they are stressed, they are tired really tired, I haven't got that responsibility….I have a different perception of the job, being in a retirement phase as opposed to somebody who works full-time with a lot of commitments….I've got that financial background….someone might have a different financial setup, they have to do their bank work, they work many hours' (N1)

Promotion was identified as a slow process (N8,N4,N16) with the workforce likened to a hierarchical 'pyramid', with more nurses required at band 5 and, reducing numbers at senior levels (N4,N5,N7,N11). For those that identified themselves as ambitious, CC was seen as having limited opportunities (N5,N7)

> 'when you look at ACCP jobs, and….junior sisters, senior sister and matron jobs, they are dead man's shoes….people when they get there, they tend to stay there….opportunities are less' (N4)

One CCN described how it took six years to progress to band 6 and a further seven years to a CC speciality role, even with substantial ward and emergency care experience (N16).

> 'I'm always ambitious, I always want some development, I remember even though I was new….I still applied three years later for my CC course….and I

> remember a colleague saying oh he's quite new, why he is applying for CC course' (N16)

N7s emotive yet candid response, related their slow career progression to their lack of confidence. They had remained in a band 5 position for nineteen years, seeking promotion during a period of organisational expansion when there were multiple vacancy opportunities.

> 'I was quite happy but you come to a point where you don't want everybody else to be jumping over you….I know I say I am happy where I am….I was scared to go for it, but I did alright, I passed, and I felt quite confident….I have never had the confidence to go and do anything else….I have put it off, then I think it's a bit too late really' (N7)

Whilst recognising they were 'happy' in a sister's role; they identified the conflicting factors of age and confidence which influenced their progression. The realisation now was that the extreme physical demands of the job may have been reduced had they been in a leadership/ management role.

> 'getting too old for this game, and you can be less physically active in a more senior position….you will think I am crazy, because my reasons for not doing it…. probably four or five years ago I thought I have to do it because I am getting older, I could do with more admin type things [laughing] you have to do the ALS….I know [it] is mad as I'm actually fine during arrest situations, in fact I'm as cool as a cucumber, I don't panic and my heart rate barely rises' (N7)

During a moment of reflection, this CCN became emotional,

> ‘born to older parents….they needed help and support from the family for quite a while before they died. It would have been impossible for me….the stress of the ALS is not the only reason [for not progressing]’ (N7)

Speaking of their frustration regarding their barriers to professional mobility, their reduced confidence had meant they are unable to voice their fears to the senior team,

> ‘they will say you have got to do it, don’t be daft and it’s really easy and it’s not that big of a deal’ (N7)

A ‘fear’ of failure stemmed from their A-levels, ‘early exit from a nursing degree’, ‘family circumstances’ and ‘not handling being away from home’, all effecting their confidence for nearly forty years and stifling their career opportunities. Now with thirty-three years of CC experience they regretted never applying for a band 7 role. This CCN interjects that they were confident in the clinical role, although known for being ‘quiet and reserved’. They confirm their ‘love of CC’, whilst recognising that they may have stayed because

> ‘lack of self-belief has always been my downfall, lack in confidence….once I had got a sisters post, I think I was about 40....I was quite old’ (N7)

Initial ‘naivety’ regarding promotional opportunity in CC compared to a ward environment led to N4’s emotional account, sharing how this led them to leave CC for promotion to Advanced Practitioner in a ward. However, this became a negative experience and included a period of ‘bullying’, and loss of self-worth before realising CC

was their 'home'. The 'love for CC' enticed them from a senior position back to CC but at a cost of once again waiting for a promotion.

> 'me being young, a bit naïve and not really knowing the process….but now seeing it from a different angle had made me definitely think there's nothing wrong with you….promotion is a waiting game….I had always thought it was a race, get that promotion, do it as quick as you can when really there is no race….it's all kind of nonsense in my head that I have imagined that nobody does think any better of you for it….[promotions] are rare and they are lucrative, and when they do come up there is a very strong pool of developed staff, the competition is high' (N4)

Similarly, other examples were shared of leaving CC to gain promotion. N13, launched their CCN career in the early 2000s reflected on gaining CC experience in education, follow-up, general and cardiac, over a ten-year period before leaving to seek promotion.

> 'it was a case of move up or move out....I was at the point of what more could I do' (N13)

N12, following eight years of experience in multiple CC units and having the QIS, found it necessary to relocate to Site 2 to gain promotion. Even then, they initially accepted a junior position. However, following several successful promotions, three years later they achieved a band 7 role. They reflected how 'committing to CC' may have limited their career options, during a sixteen-year CC career,

> ‘having committed to the QIS, been at cross-roads twice….it isn’t easy to transfer your skills….pigeon-holing myself’ (N12)

This waiting-game for promotion was in stark contrast to N9, who back in the 1980s secured a secondment to undertake the QIS and gained a promotion to a sisters post within three years of registration and working in CC.

However, not all CCNs had career plans, N10 reflected on being happy in their role,

> ‘every position I’ve had I’ve really enjoyed and almost fallen into by accident’ (N10)

However, when a senior position became vacant, and following peer endorsement,

> ‘it was only because everybody kept asking me to go for it, it was probably flattery. When enough people say it to you….you would be good at it….you sort of think, that is what tipped me into thinking go on. And once I had made up my mind, then I wanted it more than anything else….I had no intention of becoming a band 7, never interested me….never wanted to go up....gosh it makes me sound boring and dull....but I never wanted to go up the ranks’ (N10)

N2 highlighted the inconsistency of those who seek ambition, noting that many, who have been in CC for over twenty years choose to remain at a band 5 position following completion of their QIS. The rationale related to being ‘happy in the position they are in, not wanting to progress’ (N8), a preference to remain at the bedside, family and financial issues, with some seeking financial gain in and out of the local unit rather than promotion (N1,N2).

N15 aligns to this assumption, as a band 5, with twenty-four years of CC experience and the QIS, they shared why they have remained as a band 5,

> ‘adjusting to life outside your homeland, new culture….career comes later….I know I am settled and I’m doing what I do best is something that is important to me and I am happy with that….career wise….I am still band 5….but thinking about going up the ladder….but it’s not really something that I am focused on because I am also just as happy with what I’m doing….I still have that intimidating feeling….it is still a scary thought….I am so comfortable with it. It is a comfort zone, isn’t it? I want to keep my options open’ (N15)

The most senior of the international CCNs, stated,

> ‘It’s a cultural thing….most of the Filipino are contented to stay where they are, people ahead of me are still band fives, because it’s a cultural thing we tend to shy away from responsibility and management….we don’t want that responsibility, content with what we are as a culture….the main trigger as to why people stay as they are and doesn’t want to move because if you compare the earnings here a band five to a charge nurse or a manager in the Philippines, it is still way high above the salary….the Filipino culture, would be contented staying where they are, so you can see that there are only a few of us who have moved on or up the ladder. I think for those who are not scared of moving up like me….or ambitious….those are the ones moving up the ladder, others they have just stayed….as they are….it is up to the individual to want to aspire to move forward’ (N16)

The international CCNs demonstrated an awareness of the promotion process within the UK and compare this to their experience overseas, where promotion is typically based on experience and competence rather than interviews. N11 reflected on their initial lack of awareness, whilst in the ward environment. The lack of organisational understanding led to the loss of permanency following a secondment position, not realising there was a process for application. The impact of this led to their application to CC, albeit a junior position, but returning their area of expertise.

> 'quite ambitious, and knowing [my] craft….I have learned all the tricks….I have learned in the UK that promotion is different that you actually have to apply for it and have to get interviewed, luckily I did manage to pass' (N11)

N16 relates the lack of progression for most of the international CCNs due to intrinsic behaviour, however, adds that there has been a lack of specific education by the organisation following their initial registration.

The international nurses shared that they located to the UK for financial reasons, moving from a third world country to provide financial support to their families. They shared how it was instilled that they had been 'trained' as an 'export commodity' (N16), originally for the US workforce market until the 'disaster of 9/11' (N16). The UK had not been the initial choice for two of the three international CCNs (N11,N16), having been educated in a system of American style of assessment. Two of the three international nurses had significant CC experience prior to embarking on their UK nursing career (N15).

N11 shared how, even with prior CC experience, promotion had been protracted, waiting eight years before seeking promotion. They reflect on feeling 'heartbroken' when initially unsuccessful at interview and taking alternative routes to 'thrive' including post-registration study, whilst waiting for another progression opportunity, finding 'tears of joy in the end' (N11) when finally, sucessful.

N11 shared a difficult conversation regarding cultural differences and her unsuccessful attempt at interview, with peers stating

> 'it was because [she] was up against a white person' (N11)

When asked to clarify their position on that point, they were clear that this was incorrect, and although she was

> 'unable to express herself….[she] wasn't treated unfairly' (N11)

N16 was asked to share their experiences on promotion activity, and they confirmed that they had always felt like progression was

> 'equal opportunity….[but] there is a doubt in my mind sometimes because I am trained overseas….but that didn't deter me from going forward, it's just in your mind all of the time. But now that I have reached this stage I think that I would still say….it's still not 100% gone….it's always like a little voice in your head saying that you may have been here for a long time but you are not British, you are a man of colour. I don't know, that's just personal [laughs]' (N16)

Childcare commitments and the need for flexible shift patterns was a potential concern for N11, suggesting that they may have to consider alternative positions if this could not be accommodated.

The most senior participants, N14 and N5 shared two very different experiences relating to their ambition. N14 spoke of having no career plan to become a senior CCN, initially moving to CC on a rotation and never returning to the ward. When the band 8 opportunity became available

> 'I didn't want someone else to come in who wanted the [matron post] rather than they were passionate about CC….I've always felt that if you look after your staff, you invest in your staff….your patient safety….patient quality works, you get the staff retention….so I came in to make a difference probably a little bit naively, but then I suppose none of us knew that the pandemic was around the corner and I would say the last two years or so, it's been literally firefighting' (N14)

This was in stark contrast to N5, who had manoeuvred across CC and ward environments to gain experience and promotion. Now in a position of seniority, finding themselves

> 'being professionally unhappy but having nowhere to go….I am confident enough to leave for the right role' (N5)

N5 articulated a love for CC whilst but describing the frustration of working hard to achieve a senior position and being channelled into a role, which was not as advertised. This was in addition to having to work with a multi-disciplinary team that she described

as like the creatures within Harry Potter, that consume happiness, creating an ambience of coldness, misery and despair.

> '[they are] soul suckers….dementors, who are emotionally draining' (N5)

N14 articulates how they had witnessed premature promotions,

> 'it used to be that you got a band 6 for how long you had worked here….[having] the QIS and two years' experience, you are not ready to be a band 6 in a [Site 2] ….that's naive....people….thought that….they were fulfilling that job role and to me they were dangerous' (N14)

This was in contrast, to their rationale for applying for a senior position, their 'passion' for CC, 'drove' them to apply, when realising that

> 'no-one else was going for it [and rather having an outsider who didn't] know the team….or the challenges….[I] didn't want a boss who didn't have that drive [for CC]' (N14)

Those in the most senior clinical role, band 7 (N2,N9,N10) recognised that they had made a conscious decision not to progress into management. Two had experienced management positions during secondment opportunities (N2,N10) and shared a personal difficulty focusing on 'meetings' rather than being clinical, finding 'it hard not been clinically involved' (N2).

Reference was made to the more recent opportunities since COVID-19, due to unit and service expansion, in areas such as rehabilitation and outreach (N7,N14).

7.4.6 Comparison to Ward Nurses

All participants shared a respect for nurses working in a ward environment. Working as a nurse was described as hard-work (N2), with ward nurses 'run off their feet' (N8,N14). Both, ward and CC nursing were identified as very different work (N1), both busy (N2,N4,N7,N8), with nurses demonstrating tolerance and empathy (N12) and wards experiencing,

> 'non-stop pressure, not having breaks, not enough time to complete the work, this contrasts with CC where it is a different type of stress, CC is psychologically hard work' (N1)

N1 who had extensive ward experience, shared their frustration on others perception of a CCNs busyness,

> 'the night shift, they spend the first hour gassing….it gets to 10 o'clock and they think….we really are busy, we need to start this….I think that is ridiculous, my perception of busyness is different….ward nurses caring for eight to ten patients, you might not even get a break….in CC if you have a death or a patient come through its all singing and dancing….you're on your roller skates and you are literally non-stop….the patient hits the bed, they've got no lines in….they are clinically unwell, you have to go on your norad….filter….artic sun….its absolutely crazy, so it can be hard-work. But it's a bit of a balance between the unit being hard-work, and….some shifts that counterbalances it' (N1)

> ‘when you hear some of the things we complain about….we think we are busy, got a hard life, we haven’t got it anywhere near as hard as the ward…. getting off on time….it is very rare that we don’t….its very rare that people miss their break, they might be a little late off but it is not commonplace’ (N2)

> ‘[CC is] busy, but….on the ward you will have two bays to give drugs….ward rounds, that’s a busy area, CC can be….very busy….but there is always some time that you can sit together….if you have a problem you can debrief each other, there is always that support’ (N16)

CC was recognised as a challenging busy environment but one where you have time to understand what is going on and support the relatives. N14 reflected there is ‘no time for this on the wards’ while N7 compared the wards to an ‘absolute storm’, being ‘run ragged’, and ‘understaffing’ (N8)

> ‘[wards] in-terms of their fast pace….and so many patients, there isn’t enough staff so all you have to do is your work and then go home’ (N11)

The level of care delivered in CC was constantly referred to; and frequently related to staffing levels (N2). The care provision was referred to as holistic rather than episodic care (N4,N14) and empathetic, ‘they wanted someone to hold their hand and give them a hug’ (N8); with a sense that this could not be achieved on a ward (N12), where

> ‘nurses are more task orientated, functional, I’ve got to do this….I’ve got to finish my drug rounds or….the ward rounds….talk to the families….but it is all broken into to do lists or tasks….I think ITU is holistic in a sense, it is not just a task….there is something else in the background that you need to do….there are only one or two patients that you are looking after compared to so many’ (N16)

When describing the difference between ward and CC patient-staff-ratios,

> ‘it is not like a ward where you have responsibility for all the patients, you have responsibility for one sick patient and that is no different….[in terms of effort] and I feel I can say that because I have staffed on a ward’ (N9)

Many who originally came to CC during a secondment, stated they would never return to the ward area following working in CC (N7,N8,N14). CCNs identified themselves as having different characteristics to a ward nurse, such as a deeper knowledge base, increased intuition, assertiveness and increased patient’s advocacy (N9). Assertiveness was suggested to be part of a CCNs toolkit, which was ‘quickly learnt….even the quiet ones are quietly assertive’ (N9)

> ‘it’s a personality thing….all sorts of personalities….work on CC, they are of a personality that once taught….by….their role model....it has a knock-on effect…. no doctor would ever be able to walk into CC and do wrong by them patients because none of them would let them….it’s the one-to-one nursing, it’s my patient, this is my domain’ (N9)

Prioritisation was also highlighted as part of the CCN skill set, with CCNs being able to 'prioritise the sick patients' (N9). Ward nurses were seen to work in isolation or sometimes with a care support worker (N9). The reduced staffing numbers means that

> 'ward-work is heavy work….[CC] it's a good environment to work, the support is there if you need it unlike on the ward you would be on your own….there is less support….whereas CC large team provided support from a higher band or from your manager or from a doctor....I've worked on a ward and that is the difference in terms of support from your peers….managers….or higher ups, it's always there. There is a closeness in terms of relationships with your peers, there is teamwork I would say most of the time' (N16)

CC provides a wealth of knowledge, with the team 'working like bees around you' (N13)

> 'a wealth of knowledge [providing] safety bubble….it's a protective work environment' (N9)

There was a feeling of closeness, within the CC team, albeit a large team (N9). This also related to accountability with N7, expressing that being 'accountable for your actions would be very scary on a ward'.

> 'personal stuff that makes the difference….this doesn't exist on the ward, it is very busy, the relationship, the personal relationship is not a priority' (N16)

The wards were also identified as less challenging (N11),

> 'I don't want to undermine their intelligence….they are experts in their field [but] the changes in staffing affects quality of nursing….there is less understanding about when a patient deteriorates, or what they can offer the patient to make them better' (N11).

7.5 Emotions

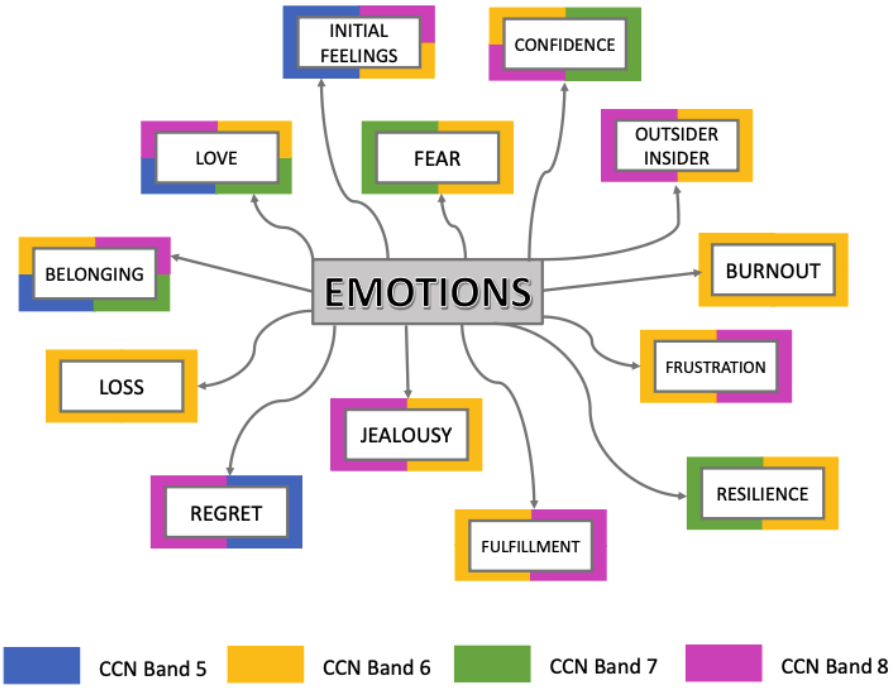


Fig.15: Theme and Identified Sub-themes: Emotions

The thirteen sub-themes, within the broader theme of emotions (Fig.15), were reduced ensuring the most applicable experiences were presented (Fig.16).

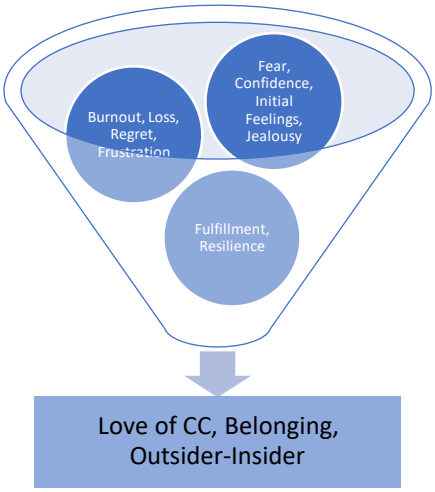


Fig.16: Reduction of Emotions Sub-themes

7.5.1 Labour of Love

Labour of Love was the most poignant of all subthemes, with all participants highlighting their 'love of CC'. With reference to Maslow's (1943) Love and Belonging, love is exemplified as friendship, intimacy, trust and acceptance, receiving, and giving affection. Here, not only was there a sense of connection with their CC nursing peers, but there was also an overwhelming love for the nature of care which span throughout all interviews.

Many participants became emotional whilst defining their meaning of the love for CC. CCNs 'love' for CC' was evident very early in each interview, with participants frequently describing how they 'fell in love with CC'. N5 described their twenty–two-year career history, undertaking strategic moves to return to her preferred place of work, necessitating brief periods of working with people and areas she did not like. This rekindled her love of work,

> ‘loved the autonomy, decision making….loved the types of patients’ and the banter’ (N5)

This love of being a CCN (N8) and the job, related to a sense of fulfilment of working at the bedside, caring for acutely-ill patients, and the family (N1, N7, N11). They recognised themselves as the patient advocate, describing CC as ‘their bedspace, my area, my responsibility’ (N13)

> ‘their domain and they love the patient dependency’ (N9)

> ‘CC patients are special….they’re as poorly as can be, I don’t mind what stage of life they are at….recovering or at the end of life….there’s a huge amount of value caring for somebody at any stage in their critical illness’ (N12)

The ‘love of CC’ and care provision included understanding the ‘disease processes’ (N9), enjoying the technical aspects whilst applying the sciences (N3) and the ‘requirements to understand detailed information of how the body works (N3,N11).

> ‘capture[ing] imagination, attention, and interest….I love the fact that I’m going into work and I’m not going to know what patient I am going to have….they are like puzzles, looking at the systems, looking how they integrate with each other, looking how everything fits’ (N13)

The variety of the CC work was recognised as bringing joy; patients

> ‘are not all at deaths door….post-operative and cardiac patients….that’s lovely as well….the job satisfaction that you are making a difference, even those that don’t get better, the families….there is so much to it, there is so much joy’ (N10)

> ‘loved to teach as it was in the bedspace, I love how you get to learn the changes in your patient and be responsive’ (N13)

CC was not always referred to as highly technical; the holistic care provision was also fondly referred to, in particular, N13 shared an experience encountered during their first week in CC, when caring for an obstetric woman,

> ‘[assisting her to] express her milk for the baby….and never have done things like that before, it was such a nursey thing to do….and literally the next day I was on level 3, sick septic, multiple inotropes, multiple infusions….and to me that is it, its CC….you don’t know what you’re going to get from one day to the next, everything is different, and I love the long-term weaners….I love to get to know them as a person....I could go on forever...Iove everything about it’ (N13)

This nurse linked her love for holistic care to her professional social care background,

> ‘fell in love with CC as a student nurse….I live to shave a patient, make sure the human part is looked after, the personal care, brush their teeth, respecting them as human being….reluctant to call it the sexy bits, because it is the interesting bits, makes my brain tick….it keeps me interested, the science the biology’ (N13)

Others spoke of a different introduction to CC through a rotation or secondment opportunity; highlighting initial trepidation before realising that they wanted to remain and had done so for thirty-three years (N7). Their justification for doing so related to the joy of the work and job satisfaction. Further probing identified that focusing on one patient and the ability to provide appropriate care was important (N7,N11), as was the 'love for the people', and the 'friendship and camaraderie' (N7,N11).

> 'loved the work….and that it is done properly….such amazing care….everything was so perfect' (N7)

The support from the team when caring for these acutely-ill patients was recognised, there 'always somebody there to help you' (N8). N9 shared how they were financially stable enough to retire, yet chose to return in a part-time role, to a job she 'loved', never tiring of it, embracing her joy of work. Similarly, others commented on retirement suggesting 'the reality is I think I would find it hard [to go]' (N10). They can distinguish between those that are ready to retire, and those who are not,

> 'they are tiring of it [CC] others are still working hard when they leave, they still love it….and they can't imagine not coming to work, I know that I am not done yet' (N10)

Reference is made to never losing the motivation to come to work, although some recognised, they are a bit slower physically (N2,N7,N9, N10). Others jokingly describe themselves 'as crazy', for being able to sustain working in CC, recognising that is all they have known,

> ‘all my career has been in in this type of environment and there is comfort in that’ (N10)

N7 relates their fulfilment to the leadership role, and the need to support others

> ‘joy of band sixing….leading a team….you get involved in everyone’s care, its more interesting….you are supporting others’ (N7)

Nurturing is a common thread throughout the themes, with N9 highlighting how fifty percent of their time is spent ‘looking after staff’; it’s about ‘people skills’. Whilst others shared

> ‘if you are not teaching them, you are nurturing them….they are the nurses of the future….they are going to be the people looking after us’ (N9)

> ‘your challenges in terms of intelligence is being fulfilled….you work quite well with the people around you. They respect you, the doctors treat you well, you can express yourself and when the unit merged [Site 1] the cardiac way of looking after their staff become much better….the seniors have introduced a kinder way to treat their band 5s’ (N11)

Others spoke of love, in a manner of making a difference; ‘the satisfaction of getting someone better’, ‘succeeding’, and ‘teamwork can make the difference’, this was frequently referred to as the joy of work (N8, N9, N10). Bernard (2019) similarly defines, joy at work as making meaningful connections, generating impact and working in a healthy environment.

‘it can be joyful at times….the achievement you get from seeing people....you know they are really sick, the working as a team….you pull these people through’ (N10)

‘years ago my mom used to tell me I was never going to be as good as my brothers because I didn’t work as hard as them, [visibly upset]….she hit you with the hard stuff….but looking round….I haven’t done so bad, have I? No…. whether I was out to prove something….I don’t know, but I just loved it. Loved being with the people, making a difference, being part of something’ (N8)

‘it’s a hell of an achievement when you see somebody, for example we had one lady, looked after by many nurses, her husband sitting by her through COVID, we think we may as well give up, what are we doing, she’s been on 100% oxygen for days, been prone….in CC for forty days and she walked out with her baby…. wow what an achievement’ (N9)

Those CCNs rotating onto outreach, spoke lovingly of the continuing relationship with ‘their’ patients on the wards (N8). Others related the love of work to the

‘buzz….you think Christ I’ve earnt my money, but look at what we’ve managed’ (N10)

‘You thrive on the adrenaline with a really sick patient, there is always something to keep you focused….it’s the intensity’ (N8)

Comparisons are made to ward experiences, and the 'need' to return to CC following a period of working in a ward environment to gain management experience. N3 reflected on how during that time, they were

> 'a little burnt-out….and a little out of love with the NHS, so I returned to my first love, CC' (N3)

This CCN recognised that social needs, in terms of finances, needed to be met and job security was important. However, there was recognition of the need to feel loved and be loved, which could only be met by returning to the CC WE. Similar comparisons were made,

> 'love CC, [having experienced] ED and the wards….I wouldn't appreciate the other types of nursing….if I go to psychiatric, I'd be one of loopy patients, if I went to orthopaedic, I'll just be in pain, if I'll be in paediatrics I'll just be crying with the family so I think I find the balance in CC' (N11)

Other comparable experiences of CCNs leaving then returning to CC, related to those who only recognised their love for CC when they had left the specialism,

> 'what I loved was the skills, the independence….just working your best. I think when you say love, you never really realise how good you are in your job until you actually do something different and then you realise….I missed that part of myself where I can contribute more, with the skill set I've got, I know that I am a good nurse, good trained CCN, a good team player, and that is what I realised in the theatre, just doing the job….passing instruments….but in CC you work as

a team….you get that patient contact….you get to see them recover and….it's a good feeling when you get to chat with them, and they thank you…you know you are contributing to their health and recovery…. those feelings came to me and I missed it, at the same time missing my independence….making decisions' (N15)

CC was suggested to become part of their being,

'I keep saying love, because I wouldn't stay in a unit as long….if I didn't like the work. Whether there are challenges in the unit at the end of the day I would still choose the unit….I like the patient journey, I like how autonomous nurses are….I will get promotion whether it takes a year, and I find I get treated equally' (N11)

Reference was made to CC as a family, 'the seniors that I look up to, I would consider them as family in the unit. They are like your work wives' (N11).A 'work-wife' was described as,

'when you treat somebody like you already know them inside and out….you come to work….you know how they work.…the quality of care they give or….having a bad day.…you know who they are….so you know their capability when you give them work, and….that's why I said work-wife' (N11)

All CCNs were proud to work within CC, having a

'sense of pride, not everyone wants to work there, or can work there, its somewhere special….I don't want to get….cheesy about it, but it's a privilege, to look after these patients….it's very busy, really stressful.…but you have a lot

> more opportunity to give people the very best care….you're caring for patients and their families in the most desperate of circumstances, with no promises of a good outcome.…you love working in that environment because it can be extremely fulfilling….it's a way of demonstrating love as well….those conversations that you're having with people is a way of demonstrating that you care….they are as sick as can possibly be….it's about empathy….being able to put yourself in somebody else shoes and that's what I mean by….showing love….you're all on the same team to help the person recover….and if you can put yourself in their position and hope that somebody would demonstrate the same back to you, that's….very powerful' (N12)

These CCNs frequently associated patients and family care delivery in relation to how you would want your family cared for

> 'a philosophy of look after them as you would like to be looked after yourself' (N7)

The CCNs who demonstrated greatest longevity (N2,N9) summarised their rationale for remaining for so long due to their love of CC, in particular the nature of care, and being able to deliver holistic care to patients and their families. N2 identified CC as a challenge, and they 'thrive' and 'love' that challenge. Also stating, that the most challenging times have also been the most motivating and rewarding, referring to periods of high intensity, such as during the 'flu pandemic'; N2 was interviewed immediately prior to the pandemic outbreak. N2 and N9 articulated how these challenging periods

demonstrated ‘good’ teamwork and a sense of community at its ‘best’. N2, brightly articulated, that they

> ‘love working in CC….you wouldn’t stay somewhere if you were miserable….you couldn’t sustain that for 41 years; you couldn’t go to work everyday like that….There could be only a small percentage of time that you could be miserable, for the rest of it has got to be positive….even me feeling [leaving] is fearful and if I am being complacent about [staying], you get stuck in your comfort zone, you couldn’t be miserable for that length of time and carry on….I love what I do, even though it has changed over the years’ (N2)

There was evidence of self-reflection, sharing that they may ‘moan a bit’, and this typically related to staffing levels and bed management issues, however,

> ‘I do feel, 90% of the time I do enjoy what I am doing’ (N2)

N9, also recognised how her joy in the workplace has changed over time; suggesting COVID has made a difference,

> ‘years ago I used to have a patient and be in charge of the unit, there were political arguments over the beds and people were always saying….I don’t know how you do it....I would say you can only do what you can do….and now I feel that things have changed dramatically and [pause....sighs] how can I say happy now is a lot harder’ (N9)

This CCN was interviewed post-COVID, and shared she was

> ‘happy is working with people....working differently, getting by….getting through the shift….to be honest with you at the moment it is horrendous, staff have left us and the staff need support more than ever’ (N9)

N9 had recently experienced their first long period of sickness in their career, due to a family bereavement; they shared how a short respite on nights ‘just being clinical’ away from the political dilemmas such as bed management was the respite needed before returning to normal duties.

Love was also connected to those that returned during COVID; CCNs spoke fondly of the many that returned to support the workforce during this time

> ‘so many people returned….at the worst time possible’ (N7)

Ten of the sixteen CCNs had previous CC experience, specifically general and cardiac. Those that made a comparison stated

> ‘[not meaning to] sound derogatory….[in general CC] you have to be on the ball….you are a proper team’ (N13)

N11, initially a cardiac CCN, who following a rotation to general CC remained because of a ‘love for the general side’ (N11). Similarly, N13 did not want to be a specialist nurse concentrating on one thing.

During a relocation, N3 was afforded the opportunity to trial CC units before selecting where to work, her selection was based on the 'love' of the unit rather than the grade offered.

7.5.2 Belonging Outsider-Insider

A sense of belonging was reflected within the findings of the FS, with the lesser experienced CCNs commenting that the feeling of belonging in CC was not immediate. For some, belonging and acceptance took one or two years to feel, but with longevity, there was increasingly a feeling of happiness and belonging within the workplace.

Viewed through the lens of Maslow's Hierarchy of Needs, Fulfilment Theory (1943), the concept of belongingness, the third level of human need, relates to the social need for productive and fulfilling interpersonal relationships which motivates behaviour. As social creatures, either as individuals or as a defined group (CCNs), the need to belong and be accepted is fundamental (Levett-Jones & Lathlean, 2008). The study findings clearly illustrated the need to belong as an overarching theme in the FS and referred to by every participant in phases 1 and 2.

CCNs shared how they felt like they belonged, with CC being a safe, supportive, and happy place to work. This alongside working at the coalface, love of CC was frequently cited as the rationale for remaining in CC for such a long time, considering it important to

> 'be part of something….I feel like a part, I belong, I belong to something really important you are working together for that patient' (N13)

> ‘you don’t want to work in an environment where you don’t belong, or where you don’t know anyone else, or you can’t tell anyone else something, it’s some personal stuff, it means something’ (N16)

This sense of belonging was associated with a sense of ‘camaraderie’ and with friendship, highlighted as the main rationale for N7 and N13 remaining in CC for fifty-three years collectively.

> ‘friendships was a reason to remain for so long….I’ve been happy here, it’s suited my personal needs throughout the different time frames in my life’ (N7)

CCNs described how they moved from various CC WEs to ensure this sense of belonging was fulfilled (N3,N5), suggesting that belonging was not always met because it was a CC WE. There was a recognition of dissatisfaction in their work-life when these psychological needs were not being met.

> ‘units are pretty often about personality and if yours fits and I don’t think mine was right for [Site 2]. I was an outsider in a well-established ITU, outside opinions and what you could bring, were not valued’ (N5)

This CCN identified that their needs relating to esteem, prestige and a feeling of accomplishment, could not be met as a senior nurse within that environment. Viewed through the lens of Maslow’s (1943) fulfilment, the need to belong could not be met as the precursors to fulfilling interpersonal relationships had not been met. In addition to the feeling of being an outsider, respect was not afforded from their peers, their experience was not valued in this well-established unit,

> ‘being unsupported by my peer group….being told that won’t work here’ (N5)

This unfulfilling peer-group relationship, a feeling of being an outsider and being undervalued led to a lateral career move and returning to their previous CC workplace, where they felt closeness, support and belonging. This career move provided a feeling of accomplishment where they flourished for several years. The sense of belonging did not appear a static state for this participant; rather it was one that fluctuated bi-directionally depending upon their seniority within the CCN team. Thirteen years since their return, they were now in a senior managerial role. They described how they once again, no longer belonged, felt isolated from the clinical nurses and from the organisational team. Attempts to fit in by joining the social workspaces, perpetuated the feeling of being an outsider and loneliness

> ‘you are so far removed from the 7s….the clinical leaders….and I don’t fit with the Matron network....I feel like an outsider….that’s what I miss the most, being part of the team….[entering the coffee room] just means talking shop, when I am in there, it's like an audience with….it’s difficult to be part of the team and manage the team, it’s a lack of identity, fit....it’s lonely’ (N5)

Others shared experiences of working in hostile WEs, outside of CC, following a move for advanced roles. They described the feeling of being an outsider, and receiving emotional abuse, conflict and awkward work situations, typically relating to how things are done. The lack of value for frank discussions, was not just from nurses,

> ‘it wasn’t nice, I had come from an area where the medical team respected….nurses, they valued their opinion, they would listen….and I went to an area where I was a senior nurse and I was shouted at…in the middle of a ward, and I was like, hang on here what am I doing, I wouldn’t have tolerated this within CC, why am I here, the way it was organised, the culture, was very different and it transpired that I was the fourth person to leave that post’ (N4)

The lack of respect, alongside a culture of exclusion, humiliation and bullying became intolerable, leading to a feeling of isolation for N4

> ‘these people really didn’t like me, didn’t like where I had come from, didn’t value my input….you are working with them day in and day out, and after a while when you hear that you are not good enough for long enough you begin….to believe it….I couldn’t see myself thriving, so I came back from….a little damaged compared to how I had left’ (N4)

N4 had reflected on their self-worth, having previously being afforded respect and being valued as an enabler of change. This resulted in them leaving their post, feeling ‘damaged’, without financial security and returning to a junior position in an environment which they ‘loved’

> ‘for self-preservation….I asked for a job, any job….I couldn’t see a way out….[returning to] the sense of community, belonging, working in a place where people know me and I know them’ (N4)

N15 found the move outside of CC to be positive in terms of learning new skills, but challenging in terms of stress and bullying

> ‘stress....dealing with people that I work with....and that I couldn’t deal with anymore….I would say….bullying from senior staff, non-nursing teams….it was too stressful for me….a feeling that you are being intimidated....there are times that you are told you are not good enough verbally….it doesn’t give you the confidence that you need….I was scared working with one surgeon….I said I cannot work that way….and I wanted to be professional….I thought it would not be fair of me to choose, work shouldn’t be that way….should be comfortable with everyone….I can do something better….that made me realise that I really enjoyed, really loved was doing CC….I consoled myself by leaving’ (N15)

Those with similar experiences of a short period of time away from CC, referred to the emotional pull back to their ‘family’. The term family was frequently used by both the bedside nurses and clinical leaders when reporting positive feelings of belonging and work-relationships, with peers representing that family unit. CC was defined as ‘like my work-family’ and you trust in your work-family (N13). The family is

> ‘not the organisation, as a CC we are very much a bubble….it was all grades….although there have been lots of changes, the relationships you build with people, it’s probably not individuals it’s the collective, a collective of individuals, we socialise together, we do shifts together, you know each other….there’s definitely a bond’ (N10)

> ‘family is a common term used in CC, I feel like the CC is a family to you especially if you have been there a long time’ (N16)

N10 was particularly surprised by their own response, and became emotional when referring to their peers as family

> ‘I felt like I had grown up in CC, with these people….I’ve got a family, that’s the daft thing, I’ve got a lovely family’ (N10)

International CCNs supported the importance of the work-family. This was in addition to their ‘Filipino community’, who were identified as the wider community of nurses working outside of CC and recognised as ‘our support group’ (N16).

> ‘Maybe it is because I have been there….a long time….you develop this interpersonal relationship, closeness with people, you know the name of their dogs….their cats, children and you know it becomes a family….even though you are not related because we don’t have other family here, people became our family, people become adopted to our family….you share your personal experiences, you share your personal thoughts not just work….even your personal stuff and that’s something that is nice….their children and how they are getting married and all this….I’ve known a lot of people already and I’ve stayed long enough I think to know people, know them well enough….they become your family, because we don’t have anybody else here’ (N16)

N16, with twenty years' experience in a UK CC, felt like they belonged. However, they also recognised the feeling of being an outsider, lack of trust and how this related to heritage and professional band.

> 'I don't think I could work somewhere else; CC is my life now….I have this feeling that….I have been here for a long time….there is always doubt in my mind that I'm not 100% fit….I am still a man of colour….there is always that sense that….black is black and white is white and brown is brown…. I am not a British born or a British trained nurse….it takes a long time to gain trust….when I was a band 5….even though you know what you are doing you can sense people don't trust you, like if they ask you something, you've given the answer, and they will still ask someone else. Its only like when I have got to this position that I have gained the trust of the people….they ask something….they will listen but if you are on a lower band then there is less trust….I think this is cultural, and it's not everyone, its only certain people….but you could sense that….people....don't trust you' (N16)

Being an outsider appeared to be a common experience, irrespective of nationality. A sense of belonging was described as more important than promotion (N3,N7). With one CCN reflecting that they had taken time to experience several CC WEs to identify which they felt more in 'love' with before applying for a position (N3). They described a sense of 'frostiness' and lack of recognition for prior experience within some units, subsequently agreeing to a junior position in a unit which 'ticked all the boxes' (N3)

> ‘I got a fairly frosty reception from [Site 2] because I’d stepped out of ITU for five years while I had been a ward sister, I was put off by the reception I had received initially, I’d quite like to come for a job in ITU, it was a very brisk, oh no you can only come as an E Grade, and I thought oh thanks’ (N3)

N7 compared their experience of not being made to feel ‘welcomed as a student’, which contrasted with their experience as a qualified nurse on rotation to CC. They recall CC being a ‘scary’ and ‘overwhelming’ environment and had since ensured part of their role included nurturing the young, which they feel new starters positively respond to (N7).

> ‘I got to CC, I absolutely loved it, everybody was fabulous….it is very much like a big family….nurturing….you tend to claim someone like your work daughter or son….you are protective of them….you take them under your wing….they know you are looking out for them’ (N7)

Organisation mergers were also cited as a cause for contributing to this feeling of being an outsider. Many had experienced organisational mergers, with N3 Identifying themselves as the ‘baggage of a merger’. This CCN with twenty-six years’ experience felt tarnished and treated like an outsider by their organisation and peers. Judged on their capability, due to working in a smaller and less specialised unit, there was no recognition of their skill set. Peers disregarded their experience and expertise, which provided N3 with a sense of being degraded and judged as second-class. Regarding this loss of self-worth, they spoke of challenging conversations to maintain their professional status. The negative experience was compounded by the organisations lack of recognition of prior experience and attempts of downgrading. Furthermore, disparities in ways of

working, led to ‘reprimand’ without cause or rationale, causing them to arrive ‘home in tears’ (N3). N3 described transcending from a role with ‘self-actualisation’ to one where their security and status was threatened. This CCN adapted to their new culture protecting their self, for fair and equal treatment, by working in an educational role.

Similar experiences were articulated, leading to a feeling of ‘being tolerated’ (N14),

> ‘we weren’t supported and that wasn’t just at my level, we were very much outsiders, and it was a very difficult time….became apparent quite quickly that….between us we had a significant amount of experience….in terms of development, rehab, follow-up clinic and other things that we've done, we were….quite a way ahead’ (N14)

Reflecting on the experience, N7, now sought to ensure

> ‘every single person that was employed was made to feel welcomed, supported and that I never wanted to hear of anyone feeling the way that I was made to feel’ (N14)

Those with experience of working in smaller units, and those who had witnessed significant organisational growth, identified that the smaller units had an increased sense of belonging. This has been recognised in the unit, and they are now sensing ‘real positive changes’, due to restructuring the unit into smaller divisions

‘I remained in the smaller unit for so long because I felt I belonged…. I felt I was liked and loved in that team….we were supporting each other….but when I moved to a bigger unit….I lost a lot of that….it felt disjointed and it knocked my confidence….I've had to rebuild that sense for myself, and in the team that I now helped to support and run because I felt that was lacking. Now the there's been a huge amount of change at [Site 2]….we had lost our way a bit, and that was now changing’ (N12).

7.6 Organisation

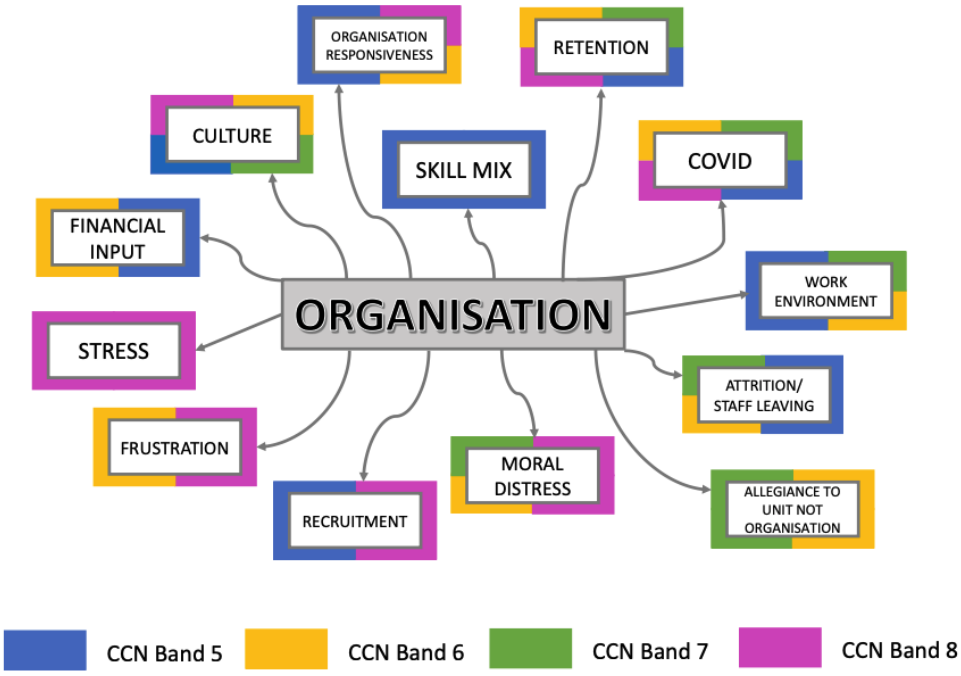


Fig.17: Theme and Identified of Sub-themes: Organisation

From the thirteen sub-themes (Fig.17), those common to participants in at least three of the professional bands are presented (Fig.18).

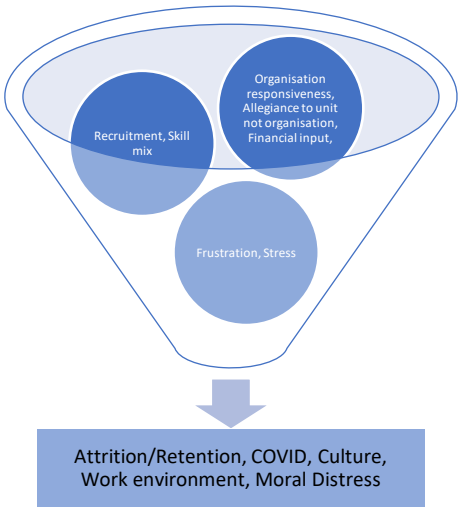


Fig.18: Reduction of Organisation Sub-themes

7.6.1 Retention –Why CCNs Remain

CCNs recognised their longevity in the CC environment, however, remaining in CC had not always been a conscious decision. They had not considered spending their whole career in one place and frequently began their professional journey with no career plan. Instead, many had never experienced a reason to leave, and they recognised that if you had experienced longevity in one area of work then leaving requires a 'leap of faith' (N5). CC was referred to as working in a 'protected environment', with participants stating how they felt 'cared for', 'safe', and 'fulfilled' (N4).

> 'they enjoy what they do….they remain passionate….they don't get bored, they absolutely live and breathe what they do, and this is fine, its fabulous, because that is what CC is about' (N5)

> 'I would think to myself I am not going to be one of those that just stays somewhere and stagnate, not learn….not necessarily going up the ranks, I don't

> think that was my plan. But I think just learning and refreshing, being fresh….was what I wanted.…but I never wanted to move….after quite early on having been here I really liked it and I've consciously wanted to stay definitely' (N10)

> 'as hard as it is in CC.…its quite comforting to know there's a group of people that you know you have to help, people have got your back, someone is there if you need them.…I like it here, it's a better place than elsewhere' (N7)

One CCN spoke of how they strategically manoeuvred themselves through varying job roles until they returned to a unit where their 'personality fit' (N5). They were aware that this appeared 'shallow', but it was the 'friendship circles' within CC that encouraged them to return (N5).

> 'great camaraderie and family feeling, great place to learn with lots to learn…. and variety' (N7)

Similarly, N13 shared the need not only to 'work together' but on a personal level, it was a 'need to be part of something' (N13). This sense of wellbeing was linked to retention, recognising that 'goes hand in hand' (N14). The ability to make a difference, providing holistic care was cited as a common reason to remain, alongside the inability to picture themselves anywhere else, even after thirty-two years (N3,N8,N9).

> 'making a difference, and we do….I don't want to go anywhere else….it's the love of the job that keeps me here (N8)

Participants spoke of techniques for sustaining working in CC, this focused on distraction activities, using diversions such as 'out for lunch or having a haircut' (N8), so they returned 'refreshed'. N8, with over three decades of CC experience managed their difficult personal life with an intense working life, by

> 'I have a home head, and a work head….if I let the two heads be one then I could make a mistake because there is sometimes a lot going on at home' (N8)

N2 reflected on their forty-five-year career, and suggested they 'hadn't done much', and referred to themselves as

> 'too comfortable….too lazy or complacent to leave….it all sounds so boring' (N2)

They referred to a 'fear of going somewhere else', 'fear' of the unknown and 'fear' of not being able to provide the same level of care, 'of not being able to do another job…. not being up to it….not being able to change', suggesting this would leave them feeling 'vulnerable' outside of CC' (N2).

> 'I can't imagine working on a ward….knowing that you've been only able to skim the bare surface of providing essentials to the patient and not being able to provide everything they need' (N2)

Whilst expressing this concept of 'fear', N2 spoke positively about working in CC, remaining clinical in a senior role, knowing the staff, and reasoning that they had never had cause to leave. N9 also referred to the fear of leaving, however, unlike N2, they had been exposed to a wide range of clinical experience outside of CC in their thirty-eight

years of CC experience. Acknowledging they had never actively wanted to leave, linking this to the financial burden of being 'the only bread winner',

> 'I used to think, I only know how to do CC, it's the only thing I know….it would be very hard to move when you are the only one working, my husband was a house husband.…I do additional nursing….agency, nursing homes, I've done everything' (N9)

Similarly, others 'having never looked seriously' (N7) for other positions, suggested they could attain a similar position outside of CC due to their

> 'knowledge and experience….but you would need to learn the ways of a ward.…I can't imagine that it would be difficult….but why would I want to….working on a ward would be an absolute nightmare' (N7)

Those that spoke of an awareness of an ITR, suggested that this impacted on their decision to not progress academically,

> 'I enjoy what I do….the team that you work with make a massive difference….I think that is why I didn't academically improve, I didn't want to, I didn't need to, I didn't want to move, didn't feel it was going to benefit me unless I wanted to move' (N10)

However, one experienced senior nurse considered leaving CC after COVID,

> ‘I was frustrated by the politics….I have to put up with it or do something else or make it better. That is when I realised I can [make it better]. I did the masters module….my practical….and management ability did not match my academic level….I haven’t got anything at all….certificate level and my diploma’ (N10)

N10 suggested that this lack of further study, left them feeling vulnerable if there were to be another organisation change. Following completion of a leadership module they spoke of feeling empowered, equally across their clinical, managerial and academic abilities.

> ‘I didn’t care because I didn’t need it….if there was another skill mix review, but I can hold my head above the water’ (N10)

The international CCNs recognised they came to the UK for financial security. They now saw CC as their ‘home’ and choose to remain in CC because of the ‘camaraderie’ (N11).

> ‘Retention in the unit is excellent, nobody leaves….because they love CC’ (N11)

Remaining in CC was not related to financial renumeration, there was recognition that there ‘there are easier ways’ to earn a living (N10). Likewise, N14 referred to financial security when sharing their post-COVID experience, traversing between ‘being re-energised’ and remaining only for financial reasons. They reflected on their own and others’ ‘fragility’ since the outbreak, whilst claiming they ‘still has more to give’ (N14), and the WE was returning to its pre-pandemic status. Likewise, the most senior internationally trained CCN stated,

> ‘I would say that most of the time….the reason why people stay….is they are happy with their job, not just the pay relationship….we have good support with the Filipino community, a big community….in CC, so that alone is a big factor….I had the choice to go to America, most Filipinos had the choice to go….but for me personally it is not all about the money….but in the back of my mind I have a good relationship here, I have a good family, a good community, money isn’t everything. I would have earned loads, triple what I am earning….but it is about personal relationships….and for me the main thing is that you are happy in the job….and….environment that you are working in’ (N16)

However, N16 highlighted that if they had not progressed at this hospital, if job opportunities were not available, they would ‘have gone, but not left CC’ (N16). This CCN rationalised this to their ‘life experience’, and personal financial circumstances, for them, with a background of educational opportunity through ‘scholarship’, this had developed a personal ‘drive’ to achieve

> ‘[I] struggled through university [financially]….education in the Philippines is very expensive….scholarship….you had to receive high rankings 1st, 2nd or 3rd in secondary education, this has to then be maintained, achieving 85% and above.…I had to work for it, and that was embedded….in my mind, don’t be contented.…there are people more privileged than me, but they don’t work-hard, and they don’t move on, but me because I struggled from the beginning that was my motivation….the difference is I had the life experience that was difficult, and the only way forward is to work-hard.…I wanted to develop’ (N16)

N4 revealed that after seven years in CC, due to a lack of challenge and fulfilment, they secured an ACP role outside of CC. However, finding themself in a work situation of bullying and harassment, the emotional abuse, loss of identity and a culture of negativity was the reason to return to CC, a place they 'loved'. The 'love' for CC nursing, justified returning in a junior position, and financial deficit. Returning to a supportive culture, with the management team touching base frequently, personal value was reinstated,

> 'feeling looked after, especially after all that unpleasantness….made me feel like I've done the right thing' (N4)

N1 spoke of regret, assuming CC nursing 'would be too hard', 'high pressure' and out of their reach. Now acknowledging that those initial assumptions were ill founded, and CC had been a positive WE for eleven years. The regret was not moving to CC sooner as they were in the twilight of their career.

Two CCNs provided unique responses to why they remained in CC,

> 'if everyone else is leaving then who is going to stay….that could be my relative….and I don't want my relative to be looked after by a very junior staff….someone has to stay. I feel useful in CC….I know, my skills are needed in CC more than anywhere else. Every-time I see a patient leave I always think this could be my relative….that was my motivation….this could be my dad….my wife….my child, it's always the case….it keeps me grounded, all the safety issues, all the best that I can give to these patients….this could be me….and I want to be cared for like the best…now it's a bit scary….because there are a lot of junior

staff….you think bloody hell I don't want my relative or me to be looked after by this nurse. It's that bad that you doubt your safety and you feel sorry for the patients, because you know for a fact that this shouldn't happen, an inexperienced nurse should not be looking after this patient. It's a sad reality….but it's the truth, there are a lot of inexperienced people being left on their own and part of the numbers when they shouldn't be' (N16)

'no point in retiring….your pension is not massive compared to your salary….do you want to sit at home on less than half of your salary, doing nothing….I'm not ready for that….if my family needed me I would go….I would consider going early' (N7).

7.6.2 Attrition

Attrition was recognised in two themes, constructs of a CCN and Organisation; the narrative from both groups have been merged here.

There was recognition that CC has a large staff turnover, nationally and regionally:

'it is difficult to say why….maybe because of the nature of ITU, and it's not for them' (N4)

The emotional labour of CC, associated with the acuity of the patients, the intensity of the workload with increased end-of-life and withdrawal of care were also alluded to as reasons why the newer generation of CCNs left. CC was not always what a newcomer had 'anticipated' (N2), typically due to the lack of role clarity, having to care for the

patient and the family and a presumption that the nurse patient care ratio of 1:1 would be easier option (N2).

> '[CC] more stressful, which they weren't expecting and that is why they don't stay' (N2)

> 'it's like marmite….some people will thrive….some think it's all adrenaline fuelled, some people don't like that and they actually experience a period of looking after an acutely unwell patient, and they panic….and say it isn't for me and I don't like it, they are too unwell, and I don't know what to do….physically and mentally gruelling….on a shift rota pattern days and nights, it does take its toll on home life….on mental health….and physical energy levels' (N4)

N15 recognised the physical and mental effects of working in CC, admitting 'loving CC', and returned when the new environment wasn't as fulfilling.

> 'going to [other speciality] made me realise just how stressful the work in CC is, so stressful that I can feel it in my body….not doing nights….going home early or on time on the day, not so much tired when you go home, I felt the difference,' (N15)

> 'she said she couldn't hack it [coming] from a ward….couldn't deal with the alarms….it was making her nervous' (N9)

However, the relationship between working in CC and slow career progression was highlighted as the most common reason for leaving. It was suggested that ward nurses are 'less skilled but get promoted sooner' (N7). Participants recalled students 'who have

progressed on wards very quickly' (N7), questioning 'have they got enough experience', and suggesting this was a 'gutsy move' (N7).

Although there was recognition of the service expansion post-COVID, CC was seen to be used as a stepping-stone for career advancement for the array of opportunities outside of CC. This related to the 'newer generation [of nurses]', typically band 5s who were identified as having 'career plans' and aspire to 'career mobility' (N5,N14) recognising 'there is no upward movement' in CC (N2). Professional mobility for those with CC experience and skill set, was seen to provide a good background knowledge making 'it's so easy to move' (N2,N4,N8). Using CC as a stepping stone, enabled those no longer seeking career sustainment, and the timely wait for the QIS to gain promotion elsewhere. The lack of opportunity, promoted a sense of there was little point in trying to pursue a career in CC, 'you can easily get a band 6 on the ward' (N7), there are 'more opportunities….and the youngsters want to develop….they want to move on quickly' (N2).

> 'they use it as a stop-gap, it looks good on your CV's' (N9)

N5 recognised the difference between themselves and the newer generation who presented with 'career plans and high aspirations', having an end goal of becoming ACPs. This was in comparison to those who chose to remain are

> 'quite happy to come and do their job and go home again and never go any further….[not meant] in a derogatory way, we all need those [nurses]' (N5)

The new concept of using CC as a stepping-stone to maximise career goals was identified during the interviews for new staff,

> ‘what courses can they have….when can they have a masters….what they can get out of it….[rather than] wanting to work in CC and look after those patients’ (N5,N14)

There was, however, acceptance that those using CC for career advancement continued to offer value to the service, albeit short-term

> ‘you have to look at the face value, you know they will fit in and I will get at least twelve months before they go….they will make good CCNs’ (N5)

> ‘CC isn’t for everybody, you see some come, they stay….12 months and they decide I don’t like it because it’s so different to ward life. Some stay for a matter of months. They come, you train them, they go and you’re thinking, okay let’s start again. And some people are there, like us, for years and you just can’t get rid of us’ (N8)

There was recognition that leaving is the right choice for some; their ‘candle had burnt out’ (N4). COVID was also linked to increased signs of ‘burnout’, which affected CCNs decision to leave (N10).

> ‘the moaner- groaners have gone….it was the best thing for them they have been there a long-time and they need a change….those that moan, never happy, perhaps need to re-evaluate where they want to be, I think people sometimes stay because it's all they've known, and therefore they're fearful of doing

> something else….there are those that remain, have been here for years, who remain as passionate and committed as ever….I think you've got a range of people and it was interesting that the moaners pre-COVID was enough to break them, enough to say….you need to go….I'm always very supportive….if somebody feels that it's not right for them they need to….explore something else….it is about having that conversation that I'm hearing that you're not happy, what is it that you're unhappy about? I think you've got those that have outgrown it and perhaps don't want to move up the ladder, it's having the confidence….Interestingly we've seen quite a few people that have gone off in different pathways….to outreach, to rehab….ACCP's, nurse specialists….not bored but ready for a new challenge….a new level of responsibility….You've got those that perhaps have got comfortable….a little complacent, that you need to encourage to explore other things but then….I've still got band 5s that have been here years, never wanted to progress….they're passionate and committed as they've always been' (N14)

COVID had also generated service expansion such as Outreach services and 'attractive new positions' which had previously been rare. This provided band 5s with promotion opportunities and seen as easy way to get a band 6 (N7,N13) whilst expanding on the previous limited options of 'management, teaching or ward work' (N10).

These roles were seen as ideal for a nurse with

> 'desirable CC skills and pandemic experience especially relating to the care of a deteriorating patient….they don't leave because they no longer love CC' (N13)

However, N1 suggested that there had been a 'lot of movement over the last couple of years'; this participant was interviewed prior to the pandemic, suggesting this was not a new phenomenon. N1 suggested that some CCNs were looking for a change, as they had done during a period of personal difficulty and indecisiveness. Suggesting 'the grass being greener' with ward versus CC. They revealed that the stress and effort of preparing for and attending an interview, after such a long period of time; was one reason which impacted on their decision to remain. In addition, being financially secure, semi-retired and a responsive decision (reflecting their belonging) by the senior team agreeing to a reduction in hours, improved their work-life balance and aided their decision to remain.

However, staff movement and increased vacancy rates, resulted in a noticeable reduction in skill mix, 'putting a drain on CC' (N13); typically, those leaving were,

> 'the top tier of band 5s….typical of the NHS, sacrifice has been made from one area to another' (N7)

> 'increased shadow opportunities outside of CC, [no longer] dead man's shoes….if someone is achieving their goal, that's successful….what makes me sad is when somebody leaves because they are dissatisfied because they haven't had opportunities' (N14)

In contrast N3 and N4 shared their 'uncomfortableness' with the 'regular churn' of staff and the effect of this on the band 6s, which was already highlighted as a difficult role. When 'ITU isn't for them', some nurses have discovered alternative roles such as

'cosmetic work' (N1). However, this CCN suggested this motive for leaving was less valuable and held less status than the CCN role (N1).

The skills set of an experienced CCN was frequently expressed as a positive attribute to enable geographic mobility. N5 detailed how easy it was to move from one CC to another, transitioning initially for educational development and then for promotion. However, not all relocations had been positive. The lack of belonging reemerged when reinvesting in a new role with new people, faced negative reactions, and 'continually jumping through hoops' (N4). Against the backdrop of negative 'reception' from their new senior peer group, these CCNs returned to CC where they felt like they belonged (N4,N5).

For those that had considered leaving and actively partook in examining other care sectors, they expressed shock at the lack of induction and structure to learning, suggesting it 'looked even worse' than CC (N12). N12 recognised CCs current challenges, realising that having no structure in a new service development was different to moving to an existing service with no structure, supporting their decision to remain; one which they continued to reflect as being the right decision.

> 'too much of a risk from a pin number point of view…they see patients literally from the moment of arriving in post….no period of supernumerary, no competences….I knew I was good at my job and I knew what I was doing….could make the best of that and the risk was less' (N12)

> 'some think the grass is greener, it isn't always….everybody is working constantly to get more work done in the same amount of time' (N2)

Other participants admitted to having looked at alternatives, with less pressure or for a change of leadership during times of frustration; however, they realised 'there is nothing else I would rather do' (N13) and 'other roles would have to relate to CC' (N5).

Working conditions, such as long shift patterns were also noted as a reason they leave CC, with N13 sharing an experience which they had witnessed,

> 'she would walk in the changing room….and her heart would sink and think oh my god I've got 12 ½ hours of this, I can't be here. I don't think necessarily short shifts would have made her much better but….the long shifts can be absolutely exhausting, you are concentrating for that long on that person. But I think the days off more than make up for it, even though one of the days is usually spent recovering. The turnarounds from shift days and nights can be hard….a lot of thought needs to go into off duty and….I think we are pretty good, we try anyway' (N13)

N5 who had experience of working in multiple CC environments, expressed that they were reviewing alternative places to work:

> '[remaining] today, because I have nowhere else to go….I would be actively looking for it, but I don't know what it is….I'm not afraid to go….I think pre COVID, I would have been frightened to go as I would have seen it as a failure' (N5)

They reflected on their continued love for CC, stating it was in their blood. Recalling previous strategic career moves to return to CC, achieving a position of seniority. However, current role frustrations and anxiety related to the organisation, and

'politics….red tape….and lack of support' (N5). A recent secondment, 'had been appealing', perfectly timed, suiting personal and organisation needs. During the secondment 'self-actualisation' needs were met enabling their 'inquisitive nature' to 'unpick service needs' (N5). Following the secondment, the rationale to return to CC was based on the lack of a suitable alternative, citing the alternatives as 'poison challises'. The offer to return to senior management afforded application of newly learnt management skills whilst reinvigorating their 'love of CC' (N5). However, the return was met with a mismatch between the original proposal and organisation expectations. The lack of support and role clarity caused extreme conflict for this senior nurse, who expressed professional unhappiness. The feeling of isolation and frequent confidence challenges led them to believe they would always be a CCN, but 'regretted' their current position. The extreme anxiety caused by their organisational responsibilities led them to believe they were working corporately with

> 'non-compassionate leaders….who are cold….I don't think you ever really leave; I will always be an ITU nurse….if I did [it would] have some element of CC within it….[CC] it's in your blood when you have got as far as we have….am I talking like a buffoon….[I have] extreme anxiety, when called to divisional meetings….never quite sure, despite doing a lot of asking, what's expected of me' (N5)

The unclear role expectations, feeling of isolation and lack of belonging, as a CCN or manager, left N5 feeling like they were occupying some form of hinterland positioned between two roles in which they did not fit:

> ‘they are good at making me look like a buffoon, its horrid….it’s a difficult place to be….CC is in my blood, I love CC, if I am going to do anything clinical it will have to have some element of CC in it, [pause] I don’t know, I don’t think you feel like you ever left ITU really….nowhere else to go….I don’t think I can say biggest regret is taking this job because actually it isn’t the job I applied for’ (N5)

Comparable only in terms of leaving, N8 made the decision to retire post-COVID. The issues relating to working through COVID were not the sole decision for leaving, a family bereavement and a friend admitted to CC forced a realisation of premature deaths. This expediated a decision for early retirement following thirty-two years as a CCN.

> ‘[nursing] has had forty years of my life, it’s time for me now, there has to be more to life than retiring and then dying a few months later’ (N8)

N8, however noted that those with an ITL can be ‘spotted’. The features of this were that such staff no longer appear interested as ‘it’s just a job’, markedly different to those that

> ‘want to watch, want to know….you know straight away they will go far’ (N8).

7.6.3 Culture

Culture is defined as the ideas, customs and social behaviour of a particular society, including the way of life, attitudes, behaviours and opinions (Cambridge Dictionary, 2024). The participants described the culture within CC positively, relating this to teamwork, bonding, nurturing and being valued. Reference was made to socialising together and the importance of this for the team (N9). These work cultures make it a

> ‘pleasant place to work….people are pleasant….you know your consultants; they….sit and have coffee with you….if you have a sick patient they will come in and speak to the nurse first at the bedside….and value your opinion, and you feel the team….ethos is much better in CC’ (N4)

The concept of nurturing was commonly referred to by participants, reflecting on the culture of ‘a mothering role….mothering new starters’ (N7)

> ‘[CC has a] protective culture….looking after someone and someone would do that for your own children’ (N7)

> ‘they call me Mother because I look after them, and they are there for me when I need something because as millennials, they can help me with the computer….it’s like love….I am there for them if something goes wrong….or if they are not coping….they are there for me in another respect’ (N9)

The need to nurture others had heightened since the COVID pandemic (N12), with the senior CCN identifying this as an opportunity to

> ‘do things differently….get it right now in terms of culture….band 6s recognising their responsibility to be role models….and if they can’t, what do we need to do to get them there….is it that they have underlying problems they need support with....is it that they need time out….do something different…that is something we are working on’ (N14)

There was also recognition that the expanding service provision and associated increasing workforce came with challenges. These challenges linked to the diminished awareness of some CCNs competence and experience.

> ‘newer ones, they might be a bit slower or you find them doing odd little things and when you question them you find they haven’t come across this before and they don’t feel like they can ask….[it was] easier to recognise when someone was quieter in the bedspace….finding out things about them, offer them help, and now it is harder to pick up on those changes’ (N2)

CCNs acknowledged that those ‘struggling’ and requiring additional support were frequently discovered ‘late’ being identified only when ‘someone was having a crying episode’ (N2,N3). The primary source for these challenges were frequently ‘on a personal level’, which required the exchange of shifts and ‘support with childcare’ (N2). In addition, CCNs recognised the organisation’s developing commitment to mental health wellbeing and psychological safety post-COVID, whilst recognising that previously

> ‘we would have done this amongst ourselves….it was very rare that outside help was needed, we helped each other out’ (N2)

CC was identified as having a workplace culture based on being valued and not related specifically to seniority

> ‘I feel that I am more valued….even despite I am band 5, they recognise me as senior in a way because I have been there for such a long time. I have more valuable skills than some other band 6s….I have had all those years, almost 20 years’ (N15)

The international media coverage of the COVID pandemic highlighted the unrelenting work of the CC workforce. The sense of being valued by the wider public was recognised as a ‘sense of achievement’ (N13) making CCNs feel ‘like I am doing something important with my life’ (N13).

However, some CCNs experienced a transitory yet significant culture of negativity during an organisation merger. Referring to ‘them and us’ and the personal cost of working in the clinical environment at this time (N3), causing some CCNs to consider leaving CC, but they were not yet prepared to retire or change speciality or were bound by the geographical location of the workplace.

For one CCN, the ‘upheaval of going elsewhere’ wasn’t always an option, so at personal cost they changed their role identity, ‘to try and make it work’ for ‘self-preservation’ (N3). Moving out of the bedspace and team leader role, they became a Clinical Educator. Now recognising themselves as an active agent in supporting nurses, ‘enabler of change’, and reducing ‘custom and practice’ they found this a more positive place to work. Their fulfilment in the workplace was enhanced by supporting international nurses to adapt in a new environment and ensuring their ‘worth’ and ‘skills were recognised’. N3 was ‘very conscious’ that their personal worth had not been recognised and they

> ‘could actively see how uncomfortable they were because….certainly for the Filipino and Portuguese nurses, they were medically driven’ (N3)

N11 further noted this, considering how in UK CC units there was ‘increased learning’, ‘teaching was in more depth’, very different to the medical model they were familiar with, for example, ventilator weaning was undertaken by the Doctor. N11 goal was to increase their understanding of the ventilator, as they understood ‘nothing is done independently’.

Two of the internationally trained nurses spoke of witnessing ‘discrimination of culture’, as previously cited, with ‘rudeness’ from some leaders. Their cultural expectation was to gain employment abroad for financial security, and working in the UK was considered a ‘professional upgrade’ (N11). Culturally sensitive issues related mainly to language, with those considered to be white British speaking more openly, which can be ‘culturally insensitive’ (N11)

> ‘white British people would be just so open to what they can say, not insensitive because I find that your race can also be very sensitive to how other people feel but just being open….and even our culture as well, now I realise, because now we have been here for such a long-time and we are comfortable with how we are so it becomes like we can say whatever we want to say without actually thinking oh this is hurting someone’s feeling or something like that’ (N11)

> ‘we Filipinos in CC….we feel very comfortable where we are, we just speak just what we want to say but that’s our culture sometimes we would jokingly say something and we would take it lightly, not insulting, but if you say that to other

> cultures that's very insulting….but there are situations where it's totally different, where it is totally bullying, you are being shouted at and insulted by seniors or doctors because they realise you are new and they aren't happy with how you're doing the job, you know' (N15)

In addition, international nurses spoke of culture in terms of the community, and having two communities,

> 'there is the whole community of ITU and there is also the intimacy of the Filipino community because we share the same culture and speak the same language, we feel the same culturally, and I think that's the big thing so if there is an issue for example, even before we go to the higher-ups we talk to each other, we become peers, we become mentors to each other. There is always….support in terms of my own race, my people, my own culture' (N16)

N16 implied that culturally insensitive issues, such as 'people being nasty', would lead to initial discussions within that community, 'trusting' that it wouldn't be shared. This CCN, was resolute that these issues related to individuals rather than the 'CC culture' as a whole,

> 'feeling guarded and not wanting to say something that might go out or you know it might cause trouble….I know for a fact that if I say this to a person that I can trust….it won't spread' (N16)

The shared decisions from the wider cultural community, dictated whether further action was taken at unit or organisational level.

> ‘discuss….support, and how that could be dealt with outside of the community….there would be suggestions from the community and then it will be, okay we tell the band 7….tell the manager, it is always a discussion within the community first, or within a closed group and then people will be sharing ideas of what to do then, shall it be elevated or shall we not, we leave it’ (N16).

7.6.4 Work Environment (WE)

The participants experiences aligned to the RNAO (2013) definition, focusing on the workplace and the maximisation of health and well-being; and did not include patient outcomes or review of organisational performance, which were outside of the remit of this study.

The CCNs in a clinical role referred to being happy in the WE, highlighting how they worked in a well-staffed protected learning environment with investment in career and professional development. They recognised that they had time to provide holistic care, unlike in the wards, and the long-day work patterns allowed more days for respite between shifts.

> ‘it’s like working in a bubble, it is totally different compared to anything else in the hospital’ (N1)

> ‘you thrive on challenge….everyone pulls together….when you are really struggling and something kicks off….those are the times that afterwards you think it was horrendous at the time but actually it all worked out well, you feel

like you have achieved something that day, you have done a good job….it was better than a mundane day where you were plodding along' (N2)

Whilst referring to CC as a safe place to work, it was recognised that CC was exhausting especially in the post-COVID era. Staff wellbeing was recognised as a current focus for the senior leaders,

'staff experience, and how to make the environment positive to retain people….I would rather be on the team exploring how we can make things better….than being a naysayer….I genuinely think it's about making people feel respected and wanted and safe' (N12)

Aside from COVID, 'staffing deficit', defined as staff in post but not in the clinical numbers, was emphasised as an emotional drain on the workforce (N14). The senior leaders highlighted the difficulty in gaining organisation comprehension of 'what this means as a safety issue' (N14) and how this contradicts GPICS standards (ICS, 2024).

'we lost a lot of experienced staff after the pandemic....[during] COVID we saw sickest people I've ever seen from a respiratory point of view, they were single organ failure. What we're seeing now….is a high level of trauma, with multiple, things going on that requires…..probably 2 nurses, let alone somebody that's required to have two patients….I know the pressure on the band 7s. I know the pressures on the staff and I think you take every opportunity to escalate and I know that people are listening but nothing changes….so I can't offer that reassurance to the staff' (N14)

Those in a leadership role declared how stressful it was to break the cycle of recruiting whilst others leave. They identified WE challenges which related to skill mix and patient dependency; the medical teams increased expectations; capacity; and wider organisational staffing issues. There was recognition that there was room for improvement

> 'making [work] more flexible, but fair to everybody….listening to the staff voice….managing the here and now….whilst recruitment and education is taking place….having to fight their corner….try and protect them because I know how fragile they are….if we don't…we won't keep them….everywhere is on the bare bones….as a manager I know it is detrimental effect on their well-being to move CCNs, but I cannot justify not moving somebody when you are aware that the wards are working at that level….this gives me palpitations' (N14)

CC was described as becoming a less positive WE to work, with CC evolving in terms of increasing invasive management and complexity of patients. These additional work pressures negatively impact on the CCN as nurse-patient ratios have remained the same.

> 'it's more invasive and….not always in the patients' best interests….patients have become more complex, and treatments have improved, but they now need more than one nurse….as CC has evolved that hasn't been taken into consideration….working with haemofiltration, triple inotropes and ventilator trials….we've never been a place where we could have runners like they do in other CC's, a spare pair of hands, never' (N9)

CC was identified as having a poor physical environment and a lack of 'proper rest environments and changing facilities' which N14 associated with 'wellbeing and retention, [which] go hand in hand'. The senior team recognised that they 'still haven't got all these things right' (N14).

Throughout the interviews there was minimal reference made to the wider organisation. The organisation impact related to the potential to be reinterviewed for ones 'own job' and how this devalued the staff, restricting them from being '[their] best' (N5). Following self-reflection on their emotional intelligence, identity and self-awareness; they were now 'bored' of the politics

> 'the same HR crap….the red tape, things that are discussed cyclically for years' (N5)

The same CCN referred to personal integrity and wanting to achieve the 'best patient outcomes and care, without harm' (N5). However, as a senior leader they did not feel valued by the organisation, suggesting they worked within a reactive organisation; a culture which did not allow them to do their best and not providing sufficient time to do this. Their aspiration of career advancement came at a personal cost of anxiety and isolation from their CC peers and organisation seniors. It was noted that since COVID, there was a distinct lack of trust with the organisation team and having '[their] eyes opened', which they associated with role maturity.

> 'organisation meetings make me look like a buffoon' (N5).

7.6.5 COVID

Fourteen participants shared emotional encounters relating to the pandemic; the remaining participants were interviewed prior to March 2020. The diverse experiences ranged from initial fear to a sense of gratitude for those returning to support the existing workforce, during this 'traumatic time' (N8).

> 'over seven years I have never experienced anything like….and we have not had it as bad as other centres, yet I've never known anything as physically and mentally abusive as what COVID has been' (N4)

> 'it was hard, I was high risk….breaking down, couldn't sleep….it was tough….we are used to seeing death on the unit but you don't see death like one after the other, we have never seen in CC that everyone is just so poorly, that everyone is being ventilated' (N15)

A senior CCN shared their initial apprehension regarding the 'position they were put in' relating to nurse-patient ratios and the redeployment of ward nurses (N10)

> 'I remember clear as day like taking a breath in thinking they don't realise what they are expecting.…I thought I'll tell them I'll explain. You know that we won't be able to do that….that is not something that's realistic or safe or possible….thinking they'd go all right, she's right, you can't. And it was a case of there is no choice….lots of people….high people, talking about how this was going to happen….making sure we were safe as possible. And I was like bursting inside and I just had to say I'm really sorry but you're talking about safety. I have

been an CCN for near 30 years and if I was expected to look after three or four of these really sick critically-ill patients with novices I can't do it and you're expecting people that have been in CC for a year to do that….I've got all this experience, how the hell are we goanna expect somebody like that to do it and be safe…it won't be safe….obviously hearing what I was saying….we're just goanna have to be as safe as we possibly can….I remember coming back to the unit and going into the consultant's office….saying….do you know what the hell they are expecting here? This is what they think is goanna happen….he said….that is what's goanna happen….because….this is what the prediction is, and I am not going down to ED....watching people die when….we can bring them to CC and give them a chance' (N10)

N15 recognised they were the first nurse to care for a patient with COVID, and how ill-prepared they were

'I was just nervous….I thought that the hospital was not really prepared, it was so lenient, there was no proper rules as to how protection could go and what kind of protection we can have….we were only told to wear the mask when you were close to the beds and when you were doing something at the bedside but that patient was placed in the middle of other patients, that was crazy….I was in shock, I was shaking, I was so nervous….I said come….compose yourself, you have been in CC for a long time you can deal with this….so….I carried on. At the end I felt just compassion for the patient' (N15)

During the interviews, discussing the pandemic was when most CCNs were visibly upset, expressing their fear 'during this horrific time', relating to the psychological effects experienced, the intense physical demand, extreme pressure and wearing of PPE

> 'I don't know how much I can talk about it truthfully without wanting to start to cry, to be honest, the patients and things, it was very traumatic for everybody' (N13)

> 'it was like a war-zone….the stress was unbelievable….and the PPE, wearing a respirator mask for eleven hours, when you are supposed to wear them for forty-five minutes' (N8)

And during this time, reference was made to survival

> 'during the pandemic we were definitely striving, striving to survive' (N14)

N16 spoke repeatedly of

> 'realisation of COVID is that I was scared....I thought one day….it would be me in that bed. Literally that was my fear….I will be….the patient. That gave me an insight into life, that everybody is equal, rich, poor, PhD, no education, we are all equal we are all going to die. We were all going to be a patient in CC and that would be the end of us. It's even….more rewarding now experiencing COVID than before because….we've seen the worst, we have seen so many deaths, seen so many families suffer. I still have a few patients in my mind, giving me nightmares, if I remember how they died, that they shouldn't die….if only we would've done this….they should have survived….with COVID I think that will

keep me staying in CC, there is no other job as rewarding for me, being able to look after these patients' (N16)

N11 shared how they managed to get through a shift,

'I used to chant to myself, make sure at least the patient does survive, that we can offer what we can at the time of need….and as long as we can keep the members of staff....that came to help us somehow safe, that will do' (N11)

Whilst others spoke of what their families noticed, 'when we come home crying' (N8),

'I can't believe it happened….it was horrendous….it was a nightmare, and [husband] noticed it was taking me longer to recover from shifts….we had so much pressure on us, because you had people working with you who weren't used to working in the area….and whatever happens now, it won't be as bad as that, we will be alright' (N8)

The staff that were redeployed to CC to support the workforce were admired, 'they came back at the worst time', and this was related to being a 'family' (N8)

'we had anybody who had any kind of CC experience come back….people that had left ten plus years, other people that had left a year or so, we had people….from different divisions, and there was a spectrum of I do not want to work here anymore, I can't wait for this to be over, and I can go back to my old job and others that were like, do you know what, I love this, I have missed this, this is great, perhaps I don't want it long term but it is nice to come back and do a bit' (N4)

N4 and N7 spoke of the pandemic providing an artificial construct of normality to those who were re-deployed to CC. This was in terms of the increased intensity and reduced long-term management of the critically-ill patient.

> ‘they must have found it interesting, because it is hard-work….we explained that this isn’t what it is normally like’ (N7)

> ‘patients were so acutely unwell….it was like bells and whistles….by the time our cohort that had survived COVID had….got through the weaning phase….those staff had been pulled back to the areas that they needed to work in….and the difficult work of dealing with long-term respiratory weans and delirium was left to the core staff….it was a bit artificial’ (N4)

Some of the redeployed workforce were non CCNs and recognised their limitations

> ‘they were trying to be jack of all trades supporting everybody, firefighting with every problem that arose and at the end they were broken’ (N14)

However, through this tragedy, there was a sense of romanticism and high-profile media, with an outcome of a surge in recruitment in Site 1; applications also drawn from a wider geography that potentially would not have applied before (N5). Transfer requests increased and applications were identified as increasing by approximately ‘sixty per post’, and included some that had not been deployed to CC (N5)

> ‘we are saturated with applicants….they are not seeing what we saw….whatever they saw out there was romantic and fabulous’ (N5)

N8 reflects on this:

> ‘speechless….we were inundated….the redeployed came….you were grateful to anyone coming at one point….[out] of their comfort zones….some handling better than others….so many people that you didn’t know….but everyone pulled together and worked together, it was a good atmosphere….sad at times’ (N8)

During the first wave there was a feeling of camaraderie and being in it together, working in teams during what felt like a ‘war-zone’ period (N8). N8 reflected on the positive recognition awarded to CCNs from the deployed teams, with a redeployed Matron

> ‘appreciated being treated the same as the other redeployed nurses….treat me like any other nurse, [all nurses should] come and spend some time on CC to see exactly how you guys’ work, because you are amazing’ (N8)

N8 also spoke of the varying models of leadership to ensure the redeployed nurses could work in the most effective way, however, ‘it was hard supporting the team and taking your own patient’ (N8).

As COVID continued, the CCNs identified a change in the ‘team bonding’.

> ‘working with reverse [patient-nurse] ratios and no support….Cat-B’s….were pulled back…and COVID hasn’t gone away….I can’t make light of a surge we had all that camaraderie, but you have never seen so many people die’ (N9)

Difficult decisions were made by families, leaving them to make risk-benefit decisions about visiting which frequently led to the CCNs being constantly alone with patients when they died (N8). CCNs recognised the 'trauma' for families not being able to visit, and the emotional burden of face timing and telephone conversations and how families were bereft, they

> 'would be beside themselves if they couldn't visit' (N13)

The effect of continuing work pressures and lack of immediate changes to CCN staffing ratios were identified as the aftermath of COVID and associated with some CCNs leaving in 'droves' (N9), others taking 'a break' due to burnout, leaving those that remained to struggle with the associated stress (N4,N10). N15 spoke of the

> 'unkindness….we are short staffed again….quite an angry, sort of hostile workforce towards the senior staff….and I think the Band 6s when they were the….leaders they had their own patient, they got new staff, non-CC staff that they couldn't support and I think they were worried for their pin, but they were….mentally and physically exhausted….during the pandemic people did a lot more hours….they were going home and again the mum guilts….the kids were at home….having to be home schooled, there was no normality at work there was no normality at home, and they were very broken' (N15)

Participants spoke of those that have since retired realising that they 'can't do it anymore….having nothing left to give' (N13).One of the CCNs, a retiree, reflected that they may have stayed longer if it hadn't been for the pandemic, others however spoke of the personal trauma of COVID

> ‘COVID rewrote the rule book….it was horrific....coming out of a very dark period….falling off my perch after the first wave….completely overwhelmed’ (N13)

> ‘50% have just left, the stress….the PPE, the emotional baggage with all the deaths that happened and the quality of nursing at that time’ (N11)

These nurses recognised the feeling of being ‘out of control’:

> ‘unnecessary deaths….the unvaccinated patients….this was really traumatic….it got to the stage where I was so angry….you shouldn’t be here….you shouldn’t have died….I’m getting upset now as it is still quite fresh and raw’ (N13)

Others recognised personal resilience:

> ‘[COVID] didn’t last very long and so therefore I was able to regroup really fast in comparison to some other people and it made me think why I was able to do that and other people are even now still struggling….it stretched me at times….I was working with people I didn’t know and there were times when my shift was not well skilled….there were challenging times (N3)

All participants spoke of the significant number of deaths, with families not being present, or the separation of the senior team who were frequently outside of the closed unit dealing with the families. N9, spoke of the greater lengths that they went to, meeting with funeral directors to gain information about isolation and timings for funerals.

The repeated waves of COVID prevented a period of personal recovery:

> ‘re-energising….and re-motivate, incredibly long hours….and remaining on the backfoot….surviving [COVID] another wave and smack down, it’s all firefighting….even I have thought recently about leaving….being at 218% capacity, multiple beds in a bedspace….and they are still trying to come in and you have no staff….you’re in every nook and cranny….and I thought I just can’t keep doing this….I recognise now I am still fragile….it doesn’t take much for me to think I can’t do this….and then I get my mojo back’ (N11)

N14, a senior nurse, admitted to working long hours, but felt separated from the clinical nurses at the forefront of clinical care:

> ‘working under extreme pressure making difficult decisions but away from the nursing staff….felt responsible not only for the patients….[CCNs] were broken….they would be in tears….I couldn’t make a difference; I couldn’t promise that it was going to get better….I couldn’t give them more staff and that was hard….there was criticism that I was in an office….I wasn’t doing shifts’ (N14)

The effect of this criticism made them feel emotionally wounded,

> ‘emotionally fragile….whereas before I would think, that is your perception and naivety, and you would to a certain extent shrug it off….but shrugging it off has become quite hard’ (N14)

This senior CCN shared their commitment to nurse wellbeing by managing the staff rotation, relieving the CCN from caring for patients with COVID for a while. Doing so, they were trying 'to give them a break' (N14). The psychological support was recognised by some:

> 'the unit has become more aware on our own emotional side since pandemic came' (N11)

> 'staff are well-supported, [by] debriefing and defusing activities….post significant events….[Band 6s] facilitate these sessions….no staff are taking undue burden home' (N4)

However, this provided a mixed response, which was not site specific. N14 alluded to good engagement with the well-being activities, while N10 suggested the

> 'uptake for support has not been as good as it could have been….they cried….they are exhausted….the burden and the impact remains' (N14)

> 'staff are knackered, the staff need something, I don't know what it is, no one knows….they are not feeling recognised' (N5)

One of the few responses which related to the wider organisation and the management of COVID from N9, who shared their disdain at the lack of recognition for CCNs, whom they felt were being let down and forgotten

> ‘caring day in day out, it was hard, and I don’t think a lot of them got past it….the rest of the trust….when COVID finished, they [management] said right we have got no patients at the time….everybody had two weeks rest, CC didn’t get that, it was still mad and busy’ (N9)

The participants spoke of the lessons learned. Those band 5s and 6s working in Site 2, witnessed an increased emphasis on developing leadership skills, with shadowing opportunities with the nurse-in-charge. This was in comparison to N8 from Site 1 who reflected on the loss of

> ‘autonomy and decision making, COVID happened and it was all taken off you, you don’t get the same feeling and the band 7s are doing everything’ (N8)

The senior team spoke of it being a time to ‘repair bridges’, acknowledging there are many new staff, and ‘that it will take time’ to ‘return to providing quality care….basic nursing’ and teaching people (N14). There was recognition that the quality of care, ‘was gone during the surge’ (N11).

> ‘we have so many new starters that’s a worry….because how do we keep up our quality when you’ve got constant new staff all the time’ (N13)

There was also recognition that those nurses who joined CC just prior to COVID had deficits in their knowledge base from the lack of exposure to the typical diverse range of conditions and management during the COVID period (N3), suggesting this group were

> 'brilliant at respiratory....they know non-invasive ventilation….how to wean, and the process of COVID, however, they are allocated to a neuro, trauma and you forget they don't have it, it's not their fault….they have just not had the exposure that perhaps a year ago you would have more variety because all we had was COVID, for twelve weeks, and they were out of their supernumerary….we need to go back to the drawing board' (N4)

Some participants conveyed how post-COVID peers are 'kinder' to one another, and there is an increased sense of attachment (N11).

> 'more appreciative in a way that there's no time to actually moan….there is a greater problem that's beyond our means. We all came to work during a pandemic, despite of the hardship, our own hardships….we still have to provide care for our patients….we did our work despite being scared for ourselves being exposed to Corona. We all still came, we gave each other a hug, we cried together….I find that for the people who have been working there together for a long time became more attached' (N11)

N12 suggested that recognising one's vulnerability had improved working relationships due to

> 'being honest about how we feel….let your guard down….it had been more superficial before….engaging in staff support and wellbeing sessions….an acknowledgement between us that we were psychological struggling or an appropriate response to a really challenging situation….we looked out for each other….we would have a cry….we were human and its fine and we need to support each other….we are more united (N12)

Although not referred to by many CCNs, some reflected on the societal portrayal of nurses as angels and heroes, aligning to Stokes-Parish et al. (2023). Although, they recognised this was not intended as derogatory by the public and media.

> 'I haven't had a positive experience, I'm not a happy clapper' (N7)

> 'During COVID they were saying about nurses being heroes and angels…no we're not heroes or angels we're very well qualified people doing the job which we're paid and qualified to do and that is why it is a vocation and that is why we're doing it' (N12)

Although N14, spoke of concern on how this recognition changed,

> 'public change of shift, no visiting….we've gone from a very supportive public to a hostile public who actually were really being quite nasty to people' (N14)

Overall, the CCN perspective was one of pride of their role during COVID,

> ‘doing well as [a] unit and I think that is really important, we are brilliant, CC is brilliant’ (N13)

In summary, overwhelmingly, these CCNs, shared the experience of COVID as

> ‘something we went through and I pray to God that it is over….it was much longer than we dreamt it would be….before it happened I would never ever in my entire dream world believe what we had to do and were expected to do and did’ (N10)

7.6.6 Moral Distress (MD)

The role expectation afforded to the new band 6s has been seen to change, with increased responsibility for a lesser experienced nurse, with some senior CCNs worried about their vulnerability.

> ‘the band 6 role….are being asked to fulfil….an onerous role at a junior stage. There is very limited ability for them to have a band 6 role working on the shop floor without having to take charge and oversee all these junior nurses….it is quite challenging when they are on shift because it’s not just about organising breaks, its they are expected to know all the decisions….that junior nurses are taking but there may only be one of them on the shift with seven others nurses that are six-months qualified….it can be really challenging, and I know that because of the reception I get when I come on [shift]. Oh, thank God you’re here (N3)

Similarly, N4 spoke of the need for support mechanisms to prevent 'undue moral injury' (N4). The lack of support witnessed by these nurses, aligns to Henrich et al. (2016), causative factors of MD, and Dodek et al. (2016), causative factors for premature departure from the clinical environment. N3 expressed frustration and was 'saddened' by the unit's culture of support; for self-preservation they reflected on solutions to change this unhealthy WE. Rather than leave the unit, and potentially the organisation, evidence showed CCNs changing their role to cope. Both N3 and N4 identified that a change of focus, sharing their 'knowledge and experience' in the WE not only provided an intrinsic reward, increasing their self-esteem, but reduced the negative impact of MD.

> 'having decided that I wasn't keen on the environment [Site 2]….way of encouraging nurses and setting an atmosphere, I….decided that I have to do something about it or else I leave….you can't just keep moaning about it….I decided as a Practice Development Nurse that I'd have an essence of a bedside teacher….I have found it, less morally distressing because as a PDN I am very aware of the limitations of my responsibilities' (N3)

The reduction in MD eliminated this CCN ITL and recognised others experience and knowledge increased job fulfilment, regaining their motivating factors within the hierarchy of needs.

> ‘I can change, it’s about knowing what I can change and how much I feel responsible for the overall management of the unit, because I am still uncomfortable with the way its very task orientated but because I’m only there for a limited period of time….I can only do so much….I [can]....remove myself enough so that I’m not affected quite so much by the systems….I understand about moral distress is the stuff that I see and can do nothing about or am asked to do because of other systems or other people’s expectations or other people’s decisions that don’t sit comfortably with me, as a nurse or as a person. There are two elements….aren’t there? There is what you can justify in your head as a nurse and what you….feel because of your own personal beliefs….because I’m an older nurse, I’ve nursed in the health service when it was slightly less pressurised and that’s when I learnt my nursing, I am uncomfortable with the shortcuts that we have to take because of….nursing staff are forever being squeezed in terms of numbers (N3)

The senior clinical nurses (band 7s), speak of the increased emotional labour; caring for families increases the stress and potential for MD. However, it was recognised that families ‘de-sensitise’ after a time, which was not afforded during COVID due to visitation restrictions. They reflected on the resilience of the older staff, and solidarity of the team for the supporting mechanisms. N13 spoke of getting ‘burnout really quickly if you don’t remain that clinical and professional distance’, whilst adding, they

> ‘get upset when patients are described as bed numbers….they have a name….family, they have a life’ (N13)

N13 became visibly upset when discussing the causes of burnout:

> 'burnout happens a lot more than we think….the hours….the shifts can be good and bad.…some leave because of the long hours….burnout due to deaths, young deaths, tragic deaths, grief….the overwhelming feeling of being out of control….suicides, hangings, its traumatic for staff….the end-of-life stuff you shouldn't die in hospital if you can help it….we have some good deaths, that sounds awful….you take patients outside, you let their dogs in….we do some really lovely things on the unit, but it takes its toll on staff' (N13)

N10 recognises that their stressors have changed over the years, shifting from the technical skills, such as 'inotropes running out…to the emergencies', then realising 'have been there done that', to now, recognising their new stressors:

> 'I have found as I get older, it's not the management, but I get stressed more easily….I used to hide it better….now I get irritable really much quicker….people wanting you when you are in the middle of something' (N10).

7.7 Leadership

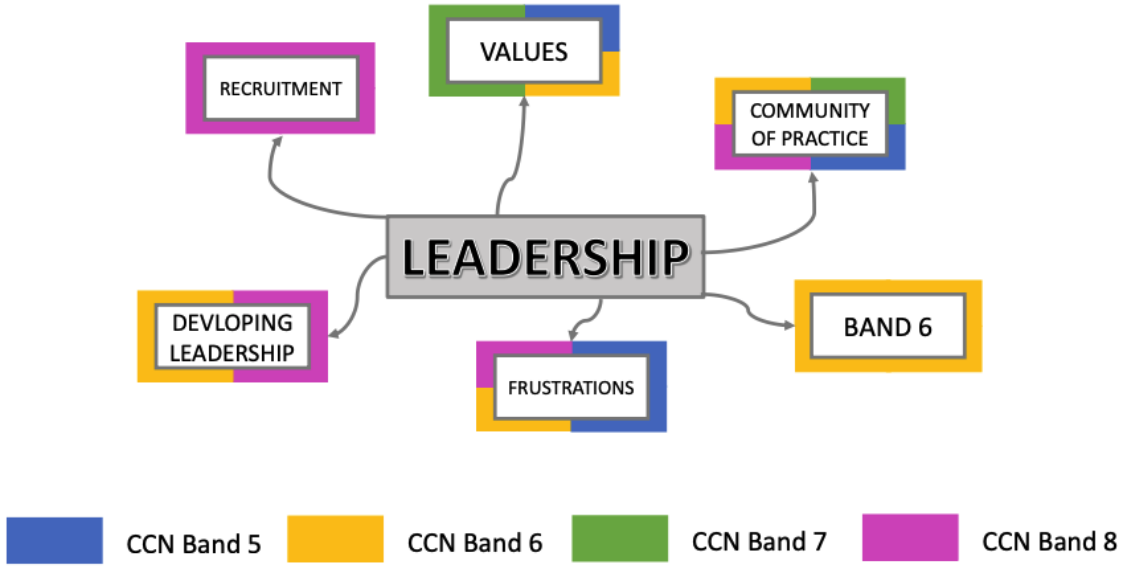


Fig.19: Theme and Identified Sub-themes: Leadership

The focus here relates to leadership in CC and the sub-theme of Community of Practice (Fig.20). The three other foci pertinent to participants, frustration, values and recruitment, have been merged and presented within other sub-themes.

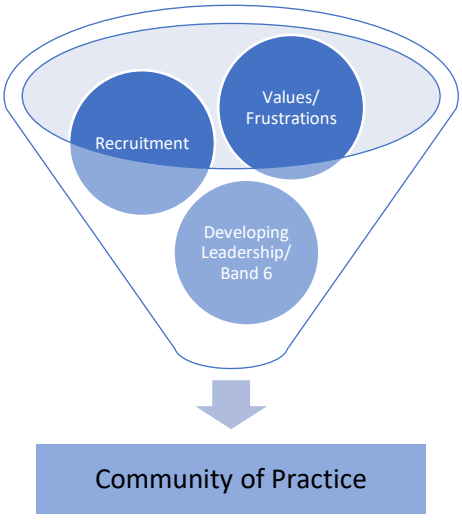


Fig.20: Reduction of Leadership Sub-theme

7.7.1 Leadership

Throughout the interviews the commentary associated to leadership focused on unit level; the few comments relating to organisational level have been included in section 7.6.5-COVID.

The band 7s are the clinical leaders, and their visibility within CC has been frequently commented on. Senior leaders are perceived to have become less visible over time within the WE (N9). The leadership role was alluded to as shifting from clinical expert to a manager (N8) specifically bed managers (N3). The changing role of the band 7, 'taking on the decision making' now affords the band 6s to undertake roles previously afforded to the band 7s (N9). This is seen as a less attractive promotion opportunity for some (N2, N3).

N10, describes the clinical leader as having a 'fire-fighting and coordinating role….I am less hands' (N10). The clinical leaders frequently articulated how they had made a conscious decision to remain as a band 7, rather than move into a managerial role, (N2,N9) preferring being 'on the shop floor….party to the patient care being given….actively being involved' (N3). Also recognising that management were 'far removed from the workshop' (N9).

However, N2 recognised how part of their role continued to ensure quality in care provision, whilst not 'forgetting how hard it is in the bedspace'; it was therefore important to be fair to the staff, demonstrating positivity, and being 'more encouraging',

> ‘we always seem to be telling them to do things, telling them about what they haven’t done….I try to be fair and encourage them, because I think they work really hard….they want to work-hard and want to do a good job….the youngsters are the future, we need to invest in them and make them feel like they want to come to work, making them happy and not want to leave’ (N2)

N8 also reflects on her leadership style, noting how CCNs are responsive,

> ‘I didn’t bark my orders, I could approach people, I’d got a rapport’ (N8)

N13, a clinical leader, highlighted the frustration on having to complete the Trusts ‘tick box exercises, finding more joy elsewhere,

> ‘it’s nice to dip in and out of the bedspace….you get looked at suspiciously when you are in a bedspace, it’s nice to be a leader though….you are striving for that quality….the best care for the patients….we look after the staff so they can give their best’ (N13)

This contrasted with the band 8 opinion who suggested that the seniors got ‘bogged down with the detail’ rather than empowering the team leaders to address the details of ‘breaks and turns’ (N14).

The band 6s, recognised themselves as team leaders, with a role which incorporated ‘pastoral care to junior nurses’, ensuring quality care provision. For example, N4, as a team leader, recognised the ‘knowledge deficit of junior nurses’ post-COVID, and how they shared this knowledge

> ‘up the chain….up the pyramid….these group of nurses that perhaps are being seen as competent, they need more time….and that’s part of our job’ (N4)

N4 shared how ‘having stepped out of the unit’, observed how on return ‘others had stepped up’ that were previously his junior; observing a hierarchy of experience within the same professional band.

> ‘they are….still finding their feet, whereas I didn’t need to, I went very much back to my 6 and hit the ground running, it was like I had never left…I had come in new but not new and was kind of bish bash bosh working quickly, making decisions, because it’s comfortable and I am familiar with it’ (N4)

Numerous participants spoke of secondment opportunities and how these had been used to explore leadership and management expertise (N3,N5,N14). However, N4 and N5 shared that their exposure into other WEs presented them with a culture of ‘bullying’, and how they now recognise the importance of compassionate leadership. However, N5 suggested this style does not fit with the ‘corporate’ style within their organisation.

> ‘I don’t think large organisations relish [compassionate leadership style], I’ve not got the corporate stance on things and this job needs more of that, than they have got with me….you can see it as a failure, but it’s not, I just lead differently….and I don’t think there is a place for me….I am a people person….probably at the detriment of doing the more corporate stuff and that matters even more since COVID’ (N5)

Although reference to unit managers was low, they were held in 'high esteem' (N9). N9 commended a manager's decision to support their 'retire and return', recognising their experience and length of service; 'she fought for us', safeguarding professional banding which avoided 'losing' CCNs with years of clinical experience. This same manager recognised the required need for change in workload strategies post-COVID. This 'different organisation feel' was recognised by N12 who spoke of the changes in support: one-on-one's, mentoring, role modelling and service development sessions. This leadership motivational initiative demonstrated commitment and value to the team.

> 'can't go in all guns blazing….I take pride….we are at a stage now that we're almost at the position where we were pre-pandemic where we were making it, looking at lots of different sort of changes, we're about to look at workforce structures, how we work, education and career pathways and stuff like that' (N14)

N14 speaks of 'chipping away', working with the senior team, making improvements, ensuring 'everyone knows your plans', and demonstrating how communication is important. N14 was keen to demonstrate that they have listened to raised concerns,

> '[share] what is being done about it….understand that we have heard them….and that their concerns are shared….huddles at the beginning of the shift….reflect at the end….introduced diffuse training [and] celebrate when there hasn't been an incident….people need to feel appreciated and valued as part of the team' (N14)

7.7.2 Community of Practice (CoP)

A CoP is defined as a group of people who share a common concern, interest or passion for something they do and learn how to do it better as they interact regularly (Lave & Wenger, 1998). A CoP has a sense of competence and commitment that distinguishes them from other groups (Wenger & Wenger, 2015). All participants shared this passion for CC, articulating how

> 'the enjoyment of work….was more than the workload' (N5)

> 'as a CC we are very much a bubble….although there have been lots of changes, the relationships you build with people, it's probably not individuals it's the collective, a collective of individuals, we socialise together, we do shifts together, you know each other….there is definitely a bond' (N10)

Teamwork and inclusivity were common threads amongst many of the participants (N1,N2,N3,N4,N7,N8,N9,N10,N13,N14,N16). The joy of work related to 'having a good team around you' (N1,N4), and for many working in the smaller clinical environments (N1,N2,N9). Teamwork was highlighted as the difference between working in CC and the wards (N9), with 'everyone working to the same standards', with team leaders knowing the staff and 'intervene to assist you' (N1,N4). This culture of support was identified as enabling CCNs to 'doing a job well' (N4)

> 'teamworking is very important for the patient to progress….if my senior nurse were to say to me, I need you to discharge this patient because one is coming in….everyone….help[s] each other….to achieve that goal….and when there are

> emergencies you see people helping out....you don't just get on with the day by yourself, you realise that your team is important around you to be able to achieve your goal for that day' (N15)

> 'Its not often I feel out of my depth but when I do I know that I have a supportive network' (N4)

The community spirit of working together, was most valued by the clinical band 5s (N1). For them, support related to being able to take time for breaks and appropriate allocation of patients, 'one that you can cope with', and 'there is always someone in the next bedspace for assistance' (N1).

> 'unlike on the wards….nine times out of ten someone will cover you for your break' (N1)

> 'no two days are the same….there is a sense of a community, it's the people that you work with' (N4)

Loyalty and knowing the team and understanding each other (N8), including who to ask 'if they needed a hand' (N9), was positively recognised with everyone 'getting involved….however busy it is' (N9). By understanding others, the group became more cohesive and supportive, 'you gel' (N8).

COVID had negatively affected the community, the 'lack of team meetings' due to social distancing, caused 'disjoint' with the higher levels (N4). Other causes of the team disconnect related to the not working with familiar people and the amended skill-mix.

> ‘Bridges are now being repaired with a recovery plan in place in attempt to focus on repairing our community’(N14)

CC nursing has been associated with ‘love’ and described as ‘more than the speciality’ (N5); it has been linked to support, with ‘collaborative working with the medical team’, ‘friendship circles’ and professional relationships (N5,N7). N8 and N9 concur linking making a difference to teamwork,

> ‘we worked well as a team….[looking at] the people retiring now, that is a big level of knowledge gone….we built that unit, we built it to what it is….that may sound wrong because a lot of people have played their part….not just the nurses….we have had so many laughs over the years’ (N8)

The characteristics of a CoP linked to how these CCNs defined their ‘joy of work’. N10 shared how CC was less personable compared to when they first started, suggesting this was due to increased bed capacity and the associated increased CCN numbers,

> ‘it is unrecognisable….that experience starting as a new starter would be really different….there would have been eight [on a shift] with a staffing compliment of over two hundred now, in comparison to seventy….you got to know everybody, quite intimately, you knew about their lives, about their families at home, you’d tell your tales about your nights out and that sort of thing….they were probably closer relationships than you have now’ (N10)

N10 identified the CoP as multiple teams within CC, making ‘you realise that you are not on your own….this is our new happy’ (N10). This is in addition to the team that you work

with each day. Similarly, the international nurses speak of a sense of belonging to more than one community.

> 'I mean we are one big team and every shift is a different bunch of people, it's not always the same people….and this has an impact on your shift' (N10)

N1 spoke of feeling exasperated with those nurses that work in solo, and 'don't feel the need to offer to help'. Similarly, N10 speaks of

> 'brilliant team mates and not so good team mates….and it's not just the experience, it might be….work ethic….in an emergency everybody on your side knows you're in the middle of an eye in a storm….I can honestly say 99% of people come good in those situations, and it's not always in emergencies when you need your team.… you might have a confused patient, and you are on hour 10 of saying put your hands down, get back into bed, you know you just need somebody to [say] go and have a brew, I'll sort this for the next half an hour' (N10)

N11, having over twenty years of experience, spoke of joining the large CC community, following the hearsay of cultural discrimination. However, she implied she had never

> 'felt the discrimination….maybe because, what I am telling them is, if you are not goanna speak up and your just gonna let people step on you obviously that is going to happen….they can't express themselves….they couldn't answer back….they nod and say yes, and they carry on even though they are not happy….because that is who they are' (N11)

Throughout the interviews the sense of community did not relate to the organisation, the commitment related to CC. N2 specifically referred to a 'fear' of the unknown, and how CC's working relationship may not exist elsewhere and how it was this sense of community that had been a primary factor for remaining in CC for over forty years.

7.8 Knowledge

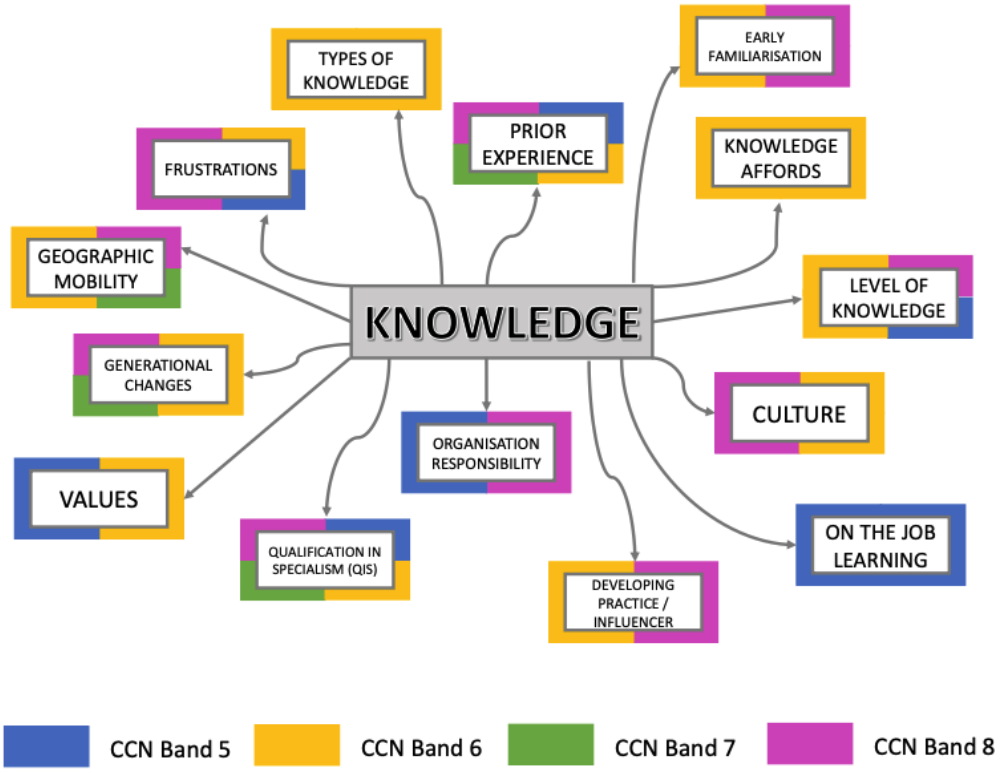


Fig.21: Theme and Identified Sub-themes: Knowledge

From the fourteen sub-themes (Fig.21), six were consistent across all participants. The sub-theme of culture, values and frustration are presented in 7.6.3, 7.4.1 and 7.10, respectively. The focus here aligns to the following knowledge sub-themes: QIS; geographic mobility; and generational changes (Fig.22).

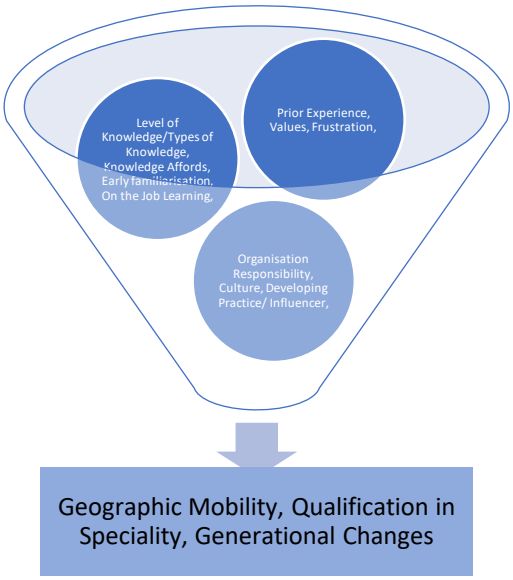


Fig.22: Reduction of Knowledge Sub-themes

The participants recognised that knowledge is 'empowering', and the wealth of speciality knowledge develops professional expertise (N5). It enabled them to work in any environment and provide the 'best possible care' (N3). They recognised themselves as 'experts' in their field, having a greater understanding of pathophysiology (N3) whilst accepting there 'is always something else to learn' (N5).

> 'I don't think we realise how clever we have got….you can always cram a bit more in' (N5)

As experts, they acknowledged they were sought after and lucrative to other specialities, suggesting

> 'all these years I should know something….acquired stuff that if I was to move to another area it would take too long to be an expert in that area' (N9)

Knowledge development was linked to 'thriving', having a good understanding of the technical knowledge, clinical conditions, and how to work within the acute environment. Developing this CC knowledge was important because

> 'the ventilator is only as safe as the person looking after it…don't be fooled by the technology….remember there is a patient there….and I just find that I am one of those people that keeps them grounded' (N9)

CCNs initial perception of CC was that it was 'high powered', requiring a 'high knowledge base', in comparison to that required by ward nurses (N1).

> '[CNN's] must be really clever, they are telling Doctors what to say' (N1)

It was also recognised that there was greater access to professional development in CC than in the wards, however, COVID bought new challenges for the junior staff

> '[education] went on hold, we weren't doing the Step 1 books….they weren't mentored properly, so now for the next six months, it's very much getting hold of that group of nurses….bringing them up to speed due to a number of clinical incidents….clinical mistakes have been made, not through negligence, but through a lack of education' (N4)

N3 focused on the concept of knowledge more than any other participant; they were one of the few CCNs who had no prior experience of CC before accepting CC for her first position as a Registered Nurse. They spoke of being 'proud' to be working in CC, and fondly of her time on the QIS programme and how this afforded time to be seconded to other CC units, broadening their knowledge, enhancing their clinical skills, and providing

early socialisation into leadership. Such opportunities were recognised as an intrinsic reward which is no longer offered to CCNs remaining in their own WE whilst undertaking their QIS. Now in an education role, N3 spoke warmly about anticipating the needs of less experienced CCNs, and sharing knowledge, which provided a sense of accomplishment and personal satisfaction.

N3 reflected on their CC journey and working in an environment deep in 'custom and practice', working alongside many CCNs whom had limited exposure to other CC units.

> 'It became more uncomfortable….I found it difficult when I was reprimanded….for not following protocol….I was expected to know and to find the information without being told, because I was working with nobody else on shift, and very few people that were actually trained in any way' (N3)

Initially finding this difficult to explain, custom and practice was defined as,

> 'they are very keen to do three hourly turns….rather than following an individualised patient plan….they have very strict protocols about some of the drugs….[previously] we were able to give 20mmols of potassium over a ½ hour, here is a very different protocol, it has to be given over two hours, regardless of whether your patients potassium level is low or not….I found it quite difficult, because I wasn't necessarily given a rationale that I felt was evidence-based, or even had any bearing other than well this is what we do….it was very difficult to find where the information was and to realise….that I wasn't following protocol or that I didn't even know that there was even a protocol' (N3)

Whilst sharing these examples, N3 shared how many CCNs had a limited understanding of practice variables, leading to frequent reprimands for not being aware of the local custom. Each incident was described as 'small' but collectively they unbalanced her 'concrete knowledge' which had been formed over many years working in multiple CC units (N3). Junior nurses practice 'task allocation….for protection of the patients' (N3). This was in stark contrast to their prior experience where she felt 'they were pushing the boundaries' (N3). However, in her educator role she was able to draw on her 'expert knowledge' and 'experiential learning' sharing this with the less experienced nurses recognising that this gave her an 'air of calmness', allowing her to respond in a stress-free manner,

> 'you can transpose that into something else that is happening because you have previous knowledge to draw on as well as actual concrete knowledge….we have theoretical knowledge, because you've seen a number of things….and you think to yourself, why am I still calm?….you look around at everyone else getting very excitable and….think let's calm down, you won't be able to think….why can I do that and it's just because you've seen so many other things that you can bring that ability to….go back to basics….you explain….and help others….that is a way to manage a tricky….or stressful or an unfolding situation….I can hear that I am drawing on something….that I have seen….it feels very spontaneous….that was that incident….I'm just using it in this scenario to try and teach junior nurses how they can assess something or evaluate something or….find a way for them not panicking' (N3)

It was suggested that CCNs can be ineffective if they are too stressed, and that length of experience and the value of sharing these experiences is a positive for the educator role

> 'I do strive to pass that on, to make sure that people get it….because I think that as an old nurse, that is part of my duty now….I'm not doing it because it makes my brain think. But there is an element that says that if I want….people to love CC and for it to continue and for people to be there to look after me in my old age that I have to pass on some of my passion for it and my interest for it' (N3)

N3 also ruminates how the supernumerary period for pre-registration nurses provides protection but does not prepare the individual 'for being qualified'; they were identified as 'unskilled labour', lacking in decision making skills. They had no desire to see pre-registration education return to non-degree level, but highlighted how the transition is difficult, 'unexpected', finding this 'disappointing' and maybe a 'generational factor, relating to their secondary education'. This concept is visited in section 7.8.3.

N3 also refers to the influence of culture on knowledge and clinical decision making, referring specifically to the international nurses. These nurses present from a 'medically driven model' and are 'very task orientated',

> 'it was really interesting that they were okay with the tasks, they were okay when the doctor told them what to do….what do you mean I can change the oxygen, well you've done the gas so you can change the oxygen….very practically based….they were very worried….how they work out what to do' (N3)

7.8.1 Geographic Mobility

N3, N4, N5, and N10 recognised how CC experience and knowledge secures geographic mobility. N4 and N5, shared their experience on the ease of returning to CC due to their knowledge and experience, when a relocation was not as expected. N4 accepted downgrading and financial loss to enable a quick transfer recognising it was more important to be happy in the workplace than being in a senior position. Following a period of 'self-preservation', receipt of external praise and 'recuperation', they recommenced their studies and sought promotion within the local unit (N4).

> 'I didn't want to develop; I was happy as a band 5….I didn't want to do any further study, then after time when you get comfortable, things go well and you get positive feedback from people, I went for my band 6….and I am now sitting here writing my dissertation' (N4)

Similarly, N3 discusses extensively how they were treated as 'second-class' when they relocated due to an organisation merger, reflecting on how their experience was not valued. Unlike the experiences of N10s, whose relocation had been positive and had led to a thirty-year career in CC.

The culture in the 1980's and 1990's saw CCNs gaining ward experience as a 'fantastic opportunity' prior to securing a senior position in CC (N3,N9), before returning 'back to where she loved' (N9). This contrasted with those that experienced the opportunity from the ward to CC; they remained permanently following a finding their 'love' for CC (N2,N5,N7), and valuing its 'support' (N5,N7) rationalising this as their reason not to return to the ward environment. For N5, at the point of gaining promotion on a ward,

the rotational visit to CC highlighted a limited fundamental knowledge and the difference to the culture of knowledge within the CC environment. This realisation led to a 'career change', at eight years post registration. N7 spoke of a similar knowledge deficit on entering CC and how this was 'scary'.

> 'realising I knew so little….I had been looking after these people on the ward and I thought, there is so much I don't know' (N7)

N2 and N3 recognised that they were restricted in geographic mobility which impacted upon their decision to remain. For N3, this reinforced a decision to undertake a change in role to maintain self-preservation and enable continuation of working in an area which they 'loved', despite the culture of limited support. The 'personal cost' was to move away from direct patient contact into an education role (N3). For N2, the logistics of being unable to drive limited their choice of WEs. This CCN linked this to their background, and parental perception of not being able to cope with moving away from home. This CCN recognised that these influences provided personal motivation and challenged her to do well.

7.8.2 Qualification in Specialism

CCNs recognised that the QIS was historically an 'incentive' to remain in CC, as it was rewarded with promotion. Securing a place on the programme was initially a 'waiting game' based on experience and a 'pecking order' rather than being competitive and interview-based, as it is now (N1). Places were limited due to funding, however, post-COVID, there was increased provision and reduced waiting time (N13). Those experiencing multiple unsuccessful attempts at interview shared how they

> ‘started to question myself….and being valued….am I good enough to stay in CC?’ (N15)

Some participants delayed completion of the QIS due to personal and financial constraints; positively impacting on others, with N7 reflecting on how this enabled her to secure a place early in their CC career. Similarly, N8, completed the QIS within three years of being in CC, which was atypical fifteen years ago (N7,N8). Others recognised that they had completed the QIS as a senior member of staff late in their professional career. Typically, as an expectation for the role rather than requiring the knowledge for their professional career (N2) as they had achieved seniority within the unit.

> ‘it wasn’t such a requirement early on, it put everything into place, stamped things we had always done’ (N2)

N2 recognised the change over time, with increased value on educational development and the requirement for the QIS for promotion; highlighting that she had never intended to leave nursing or become a manager and had not considered a career development plan. For this CCN it was a tick box exercise, once again, relating this to complacency and knowing they would remain in CC.

N7 admitted having a ‘naive and basic knowledge base’ prior to entering CC, and the QIS increased their theoretical knowledge to support care delivery. N1 highlighted how the QIS was challenging, whilst providing the knowledge to ensure confidence when teaching students.

Both the band 6s and 7s focused on the lack of educational investment following the achievement of the QIS. However, N9, a band 7, articulated the driving force behind their conscious decision to complete a degree, which related to job security. They acknowledged their academic level did not match their clinical experience/credibility,

> 'I'm getting an old bird, I had better do it because the government is saying everyone's got to be degree trained….the youngsters come through, and they are so bright….have their degree, and I had to do everything after the event because I am old, but in another respect, I have the confidence to know....sometimes it gives them a laugh because I say in the old days, and they say go on hit us with it [laughing]….I….say….how do we use this then….I'm the new girl run me through it….I aren't afraid to say and never have been, I'm not like the dictatorial old person, I've got children that are the same age….I don't sit back on my laurels and think I know it all, I am always looking at different things (N9)

However, N2, who had similar longevity, identified themself as 'less academic….lazy' and had not continued with academic progression following the QIS. N10 suggested that the younger generation recognised the value of education, whereas they had only recently achieved post-graduate level 7 study, aligning their academic achievement with their management and clinical expertise:

> 'I am really old; it was certificate level....I always say to people I have a cycling proficiency and a clear smear test' (N10)

Similarly, N9 compared their knowledge with their length of service, whilst sharing how they had never lost their motivation for working in CC. In addition, a culture of support for knowledge development has not always been sustained, with 'staffing numbers' seen as the barrier (N5)

> 'I didn't have the bums on seats to look after patients, and post-COVID it's not getting much better' (N5)

N1 supported this, adding how post-COVID the commitment to education and development 'has taken a back seat', concentrating on the provision of mandatory training. This contradicted the more recent drive to increase CCN numbers on the QIS post-COVID.

7.8.3 Generational Changes

N13 compared herself to the 'x, y, z generation', highlighting how 'there are a lot of fantastic young nurses' but suggested their work ethic and resilience was different from the older generation.

> 'they have got it right….I will drag myself out of bed if my leg is hanging off, I'm never late, I'm late for things outside of work but never for work, I've got a duty to perform….it was born in me….it was part of me growing up….you have a responsibility to go and do….your work….and get on with it. You've got a cold….get on with it….and resilience is different I think because….they are more aware of mental health issues, they are more aware of the strain that can put on them, and I'm not saying it is a bad thing but it does have an impact on the

workplace and it is tough, CC nursing is really tough. But you know we've got some really tough cookies that are coming through that are still coping with it…., who am I to say what's wrong. Who's the fool? Me for dragging myself to work or saying….I can't work at the moment I'm not well. It took a lot for me to go off….I ended up with….burnout after COVID….it took me two-months to admit, to say I'm not well enough to work. I'm mentally and physically exhausted and recovering from COVID myself as well and of course the pandemic….I wasn't sleeping….I was literally crying all the time. I was so overwhelmed and anxious about everything' (N13)

Similarly, N2 believed that the newer staff behave in a manner where the

'slightest thing and they are ringing in sick and they are off, whereas the older generation….the more mature people don't, we don't go off sick at the drop of a hat….the stamina we had….I am not saying they want an easier life, but they don't seem to be able to take the workload and the pressures in the way we did….I think it is with mental health issues….much more common and obviously we have people that get stressed about things, and have issues, a lot more than we did, maybe we were just good at hiding it, we just got on with it, there wasn't the opportunity to talk and get referred for things….I don't know whether it is a generational thing' (N2)

N2 compared this to the more experienced CCNs, who

> 'accepted things probably that we shouldn't have done, and got on with it….there wasn't anything else you could do. Some people fell by the wayside, some needed more support but….I think because we all knew them so well, you knew when they were slightly off….we would be looking out for them a bit more, supporting….and I think now because of how many there are you don't pick up on those things' (N2)

Both N2 and N13 suggested this relates to loyalty and having always worked and being a role model to her family (N2). She suggests there is a greater commitment to working. N13 admitted retuning to work early because of the 'guilt….the sense of responsibility is quite overwhelming' (N13).

The new generation were portrayed as shaping their career, seeking qualifications and 'climbing the career ladder' (N2). Also suggesting that the newer staff are less likely to ask for support, or don't feel like they can ask, and this demonstrates cause for concern as the workforce is larger and recognition that they need support is sometimes 'missed' (N2).

> 'I think it is a different way they have been raised. What they have been like at school….I am not saying they are not loyal, it's just different, it's hard to explain….like in the war, you would just get on with it, they weren't ill, and I think we just did things. I think we had more stamina. People say why do you keep coming to work, with my knees, but it's not anything I would entertain, that is the way it is, you've got a job, your paid to come, and do it, just do it' (N2)

N3 also related generational differences to school and pre-registration nurse education. Suggesting nurse education is now more discussion based, which was seen as a positive change to have their opinion valued in discussion. N3 suggested that sometimes they just need to get on with it. N3 positively reinforced the importance of having a voice but greater recognition of when to use it is required. Registered nurses were suggested to be

> 'compassionate, very full of wanting to nurse, but because they've been supernumerary for all their time they have a little bit less, grit, get up and go, a little bit more willing to step back….therefore you do have to coach them, support and push them along a little bit more' (N3)

This perceived shift in nursing, with applicants having a greater understanding of the nurse's role

> 'there was a period of time when there was nurses that were very academically minded, oh no, I don't wash and I don't pick people off the toilet….those type of people have either filtered out and we don't see them anymore or I just don't encounter them….because of their selection' (N3)

Similar examples related to,

> 'this patient has poo'd again for the fifth time, you may not want to turn them again but you can't go for your break before we turn them because they come first….I am not saying they all do that, but there is an element, that they have their opinion to say why is their patient pooing again, but that happens….Why

do I have to do nights because there is care to be given 24-hours a day….I just have a feeling that lots of things come at them as a bit of a shock….Whereas at the end of my training I was really aware of what the job was' (N3)

Whereas, N9 affectionately recalls how the millennials

'they socialise together, they are the ones that will help me with the computer and they will love doing it, they say come on Mother' (N9)

7.9 Rewards

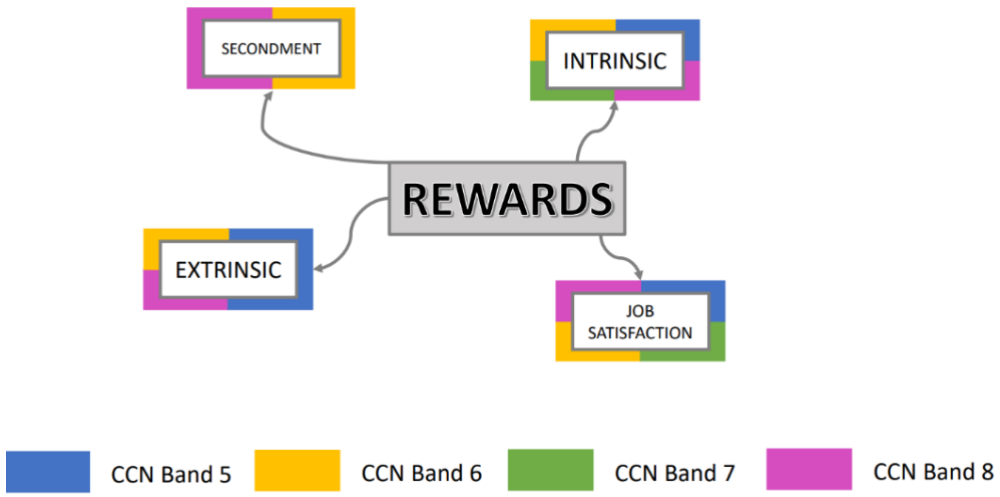


Fig.23: Theme and Identified Sub-themes: Rewards

This broad theme represented the smallest number of sub-themes: intrinsic, extrinsic, job satisfaction and secondment (Fig.23). The focus here relates to the narrative of at least three of the professional groups, job satisfaction, intrinsic and extrinsic rewards (Fig.24).

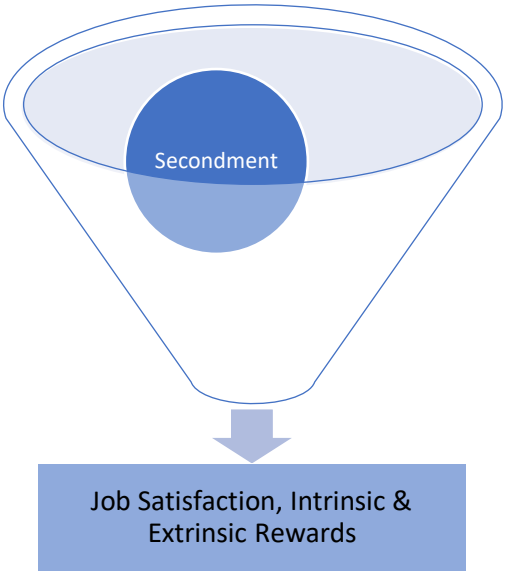


Fig.24: Reduction of Rewards Sub-themes

7.9.1 Job Satisfaction

CCNs perception of job satisfaction varied depending on their seniority, with the senior nurses referring to job satisfaction as 'wins' (N5). N5 spoke of the role 'taking more wins and different wins' to achieve job satisfaction and the feeling of accomplishment. This included seeing the team rewarded by external bodies and receiving accolades which differs to the intrinsic 'rewards received when working clinically' (N5). N14 recognised that they remained in CC initially due to the provision of holistic care, and even though this was no longer part of their role, they remained

> 'passionate about it….now it is supporting the staff to feel the same, and they are as motivated….ensuring they get the training they need, the development….achieving their potential and getting job satisfaction….start that succession planning process' (N14)

N14 particularly found the job rewarding when initiatives make a difference, referring to the introduction of 'wellbeing initiatives' and changing the culture of 'punitive' stressors such as 'incident reporting' and 'sickness and absence' (N14). Now highlighting nurses' development, appropriate leave entitlement and supervision, was seen as a success, increasing job satisfaction:

> 'it is self-fulfilling seeing the unit develop and grow….when people say they have had a good day….we celebrate success rather than fire-fighting and people telling you they are broken and can't do it anymore' (N14)

When referring to their self, N14 identified themselves as striving,

> 'depends on the day….to be honest I feel tired and exhausted….it may be an age thing' (N14)

Whereas the clinical leaders highlighted CC as a positive place to work, typically relating job-satisfaction to autonomy, sharing their knowledge with the team (N3), or to working with the team (N10), identifying it as a 'privilege to work in CC' (N2).

> 'having found enjoyment of the technical side, and the use of detailed information, and detailed understanding of how the body works (N3)

Similarly, satisfaction was linked to their leadership role and the 'responsibility of being in charge', 'enjoying the management', and 'role modelling' (N8,N10). N10 reiterated the importance of 'good teammates and a good bond', suggesting that they 'thrived on that' (N8,N10).

> ‘When the shit is hitting the fan….when it’s all going pear-shaped….the team….work together….I get that enjoyment and afterwards….I can’t explain that feeling….we all managed to get it together and sort it out….it comes good in the end’ (N10)

N16 spoke of thriving within a team,

> ‘it’s more who you work with, it’s not all about the professional development, it’s about the emotional and personal stuff….it is a family environment. You thrive in a family environment rather than competing, or always looking over your shoulder that someone is stabbing you….you have this trust in the people you work around. You are….comfortable in the working environment. You don’t have those what if fears….what will they say….I can work with people who have been there a long time or just started, I’m comfortable in that environment….I don’t have to try harder or work harder to build some relationship its already there, its embedded in here’ (N16)

N12 identified themselves as ‘thriving’ within CC, reflecting on experiences that they had never ‘spoken about’ previously. This included reference to the

> ‘dynamics of the team….psychological safety and haven’t always had the sense that I could disclose in this unit before, but things are changing’ (N12)

N12 spoke openly about the initial difficulties of 'job sharing', when 'setting up new services'. Having a 'sense of you're having an affair, if we ever sat in the same room together', and the lack of shared time to develop the service together. However, she recognised her self-worth and job satisfaction relating to

> 'patient interaction and building rapport with families….this morning taking a patient outside in a wheelchair, he had a really difficult diagnosis and a long stay….and he hasn't been engaged….today he was really smiley, it was….positive, we were able to have a long chat and things he had been worrying about….and I thought what a brilliant day' (N12)

Like the senior team, the clinical leads felt a sense of achievement and 'feeling proud' of working in CC. N13 shared a sense 'of how far I have come and wanting to feel that I am of use' (N13). N16 aligned with the sense of achievement, recognising their job satisfaction related to career progression

> 'I don't strive anymore. I'm thriving in CC otherwise I wouldn't have stayed. Striving is that you are trying to do so, isn't it? You are trying to survive. Thriving you are settled, you grow in the environment….that's me, I don't think I am striving. I'm thriving. I wouldn't be in this position if I hadn't grown. From an overseas nurse to a band 5 to a….[x] to….[x] that's a big growth for me and that's thriving' (N16)

Similarly, N15 related to being valued when their additional skills are recognised

> ‘I feel rewarded when you are allocated a position where I can contribute more like being a team leader….I have the theatre experience, so when there is possibility of a chest opening they would say….this patient is possibly bleeding and they might possibly have an open chest at some point so they would put me next to it so I can team lead the group….they recognise my skills’ (N15)

N7 found job satisfaction and ‘life being better’ when they were

> ‘happy in their work….for most people you are at work a lot of the time, so why you are there you want to feel happy, content, you don’t want it to be like you don’t want to go to work….you are enjoying what you are doing, with nice people, you don’t want to work in an area where people are moaning or arguing or a bad atmosphere....and life is so much better’ (N7)

N4 realised that job satisfaction was more important than seniority; having relocated twice to achieve promotion, at a loss of job satisfaction. On both occasions they demonstrated the ease of relocating back to CC, albeit on a lower professional grade, with an incentive of a quick succession onto the QIS programme. N4 recognised that the variety of care, where no two days are the same’, was a key feature which prevented ‘boredom’ and CC provided an opportunity to expand professional knowledge.

N16 spoke of the reward and job satisfaction of caring for patients and their families during the tragedy of COVID

> ‘During the first wave, when you see people dying, death after death….we didn’t know what to do, that was sad. Sad that in the sense that even if they were young, 10 days, if they were still on the ventilators and they don’t wean, it was morphine and midazolam….the second-wave it got better, we knew that they just needed longer time….the first-wave was very grim….there were only a few survivors, and then in the second-wave more people survived….seeing them out of ITU, whether COVID or not, it was a really rewarding experience because you know them, most of them stay longer….you have invested your time, your emotions, they are not just passers-by….you know their family, you speak with the family, you know how many kids they’ve got….seeing them discharged….is a very rewarding aspect of the career’ (N16)

The clinical CCNs explicitly expressed gratitude for the support they had been given (N1,N4,N7) and the protected environment they worked within (N1,N4). They valued the focus on professional development in terms of the QIS (N1,N3). N7 in particular shared how this had supported their progression to become a Sister,

> ‘which had always been her aspiration’ (N7)

Whereas N4, consistently referred to promotion as a

> ‘waiting game….just have to wait your time….play the waiting game and it will come’ (N4)

N2 recognised that within CC there were some of the nursing team that were 'just surviving', with a need to concentrate on financial renumeration and their reliance of additional agency work. Whilst recognising those striving, they were able to identify many CCNs, that 'cope and progress', remaining in CC for two to three decades. Those remaining in band 5 positions, choosing not to seek promotion, were recognised as potentially thriving. The 'family orientated….off duty' was a reason to remain providing job satisfaction (N2). N15 considered themselves as 'thriving at work' whilst remaining at a band 5, with twenty-four years longevity in CC

> 'I find it more enjoyable now, knowing my value at work I guess. I feel like despite me being a band 5 I know I am contributing more in my role….I am happy where I am. I am happy with what I'm doing. I get satisfaction from my job (N15)

N2 and N7 asserted that as the team gets bigger, this afforded reduced satisfaction due to the lack familiarisation and awareness of the new CCNs capabilities,

> 'we don't always know who people are.…it takes time to get to know people, what they can do and where they are from' (N7)

Job satisfaction was also related to being valued by their peers (N3,N4,N5). N4 felt valued when during an appraisal, when awarded developmental opportunities to ensure they remained challenged whilst waiting for promotion opportunities, whilst others recognised a negative feeling when this sense of value was not received (N5).

> ‘every-time, I tried to make changes or suggestions, up [went] the hoops that they tried to make me jump through to make that or the reception that I got from my band 7 colleagues, about ooh no that won’t work here, rather than, yes’ (N5)

N3’s narrative lends itself to survivor’s pride and a powerful feeling of accomplishment from persisting in the face of adversity. This sense of surviving was linked to being undervalued and lack of job satisfaction during an organisation merger, when having previously felt satisfied, rewarded, with a sense of personal value within their work. Following an organisational restructure, they found themself being in receipt of junior status and professional disregard by the organisation and new peers despite their existing professional role. This left the CCN feeling dissatisfied with their role,

> ‘we didn’t get a very good reception when we transferred across. I suspect we came with more baggage than we realised after having worked at [unit]….felt very undervalued for what we had gone through….and we were tarnished for the fact where we had come from’ (N3)

Similarly, N4 shared how after working in CC for seven years they no longer found CC rewarding or challenging and sought new opportunities outside of the Trust as an ACP. However, realising ‘that the grass is not always greener’ and experiencing workplace bullying, they returned to the CC unit where they ‘belonged’ (N4). They recognised they returned with a reduced level of confidence; however, they had not lost their passion for nursing, they now identified as

> ‘a staff member with ambition….ear marked for promotion….and a career pathway planned out….don’t get me wrong there are days when I hate it, I am sure every job is the same….days when you think….sign me up for Aldi, but….its somewhere that I don’t think I will ever leave….I am happier….my personality is rush, rush, rush, do your courses, get your experience, get the promotion and I think with last year working at [Site]….I have a job I enjoy and that’s enough….it’s a constant tug of war....you have to find a place to sit and kind of ride it because there are times where I feel overworked and stressed and tired….and it’s not a pleasant place, but then there are other times it’s a great place to work and you do feel supported….you have to just kind of find your place’ (N4)

One CCN provided an opposing narrative, highlighting how they were unhappy in their role, suggesting they had ‘no-where to go’, and they were unsure of their next career move, but felt ‘confident to leave for the right role’ (N5). They shared that they had relocated previously, and it required a leap of faith. The rationale for the initial relocation, following eight years in CC, related to a lack of fulfilment in an ever-changing environment; they no longer felt challenged.

> ‘it’s odd….to a non-CCN how can you be bored in a CC job, where two days are never the same, but it was boring, I got bored I couldn’t find a challenge out of it’ (N5)

The second move related to a lack of team cohesiveness, whereas now, their desire to relocate was linked to the relationship with the organisation management (N5).

> ‘I want to come to work and do a good job as I believe in this CC’ (N5)

N5 spoke of the primary factor for job satisfaction. Initially 'fulfilment' came from working with the team, the acuity and nature of patients was rewarding, but the satisfaction of work came from the teamwork. To N5 'friendship circles' were important, saying they are what 'matters', with that aspect 'missing' from the other units. In addition, they voiced disappointment with the lack of feedback and positivity during their appraisal, both before and during COVID, appearing desperate to 'fit' in with the organisational culture and gain recognition for the work achieved

> 'promises of development, it's a right pantsy appraisal with no feedback….I am regularly asking for more support for me to do my role at its best, and I am making it clear with HR that I have not managed to get an audience with [organisation lead]….I am aware I am doing my best….but what is frustrating is that I know my best isn't me….doing my best is actually negative because I know I could do better if I had more time and more resources….I do value rewarding, personal reward, but I do have to pat myself on the back….following [false] promises of development' (N5)

N5 once again sought self-assurance in what they were sharing, 'am I talking like a buffoon'. They were conscious that their narrative may be different from other participants, due to their managerial role which impacted her confidence.

N15 highlighted the rewards they found outside of CC, calling herself 'crazy' for returning to work in CC'

> ‘I think some areas have more rewards at work, they get to go home early if there is no need for them to stay like in theatres, there is no more patients….we sit….sometimes for the remaining two hours of the day if our cases are finished, we set up, if we’ve done what we need to for the following day, whereas compared to ITU you’re there all….the….time throughout the last minute of the hour of your shift sometimes more than that, you extend, staying an extra thirty minutes just to finish your job, that’s how I realised just how demanding and strenuous ITU is….I think….your body is so used to thinking….that you couldn’t just sit down for two hours….it’s a pleasure to sit down but not all the time, it’s not like that all the time, the culture in CC is totally different. You sit down and somebody crashes’ (N15)

However, this CCN returned to CC, having missed the holistic patient care and teamworking.

7.9.2 Intrinsic Rewards

CC was identified as a positive, happy WE (N1,N2,N4,N7) where the nurses felt listened to (N8), and the variety of care increased role fulfilment (N3,N7). N1 spoke fondly of how CC afforded nurses the time to teach students, and the QIS provided the knowledge of what to teach, which was rewarding. N3 explained how the sharing of knowledge had provided additional ways of gaining self-worth, achieving self-actualisation, whilst N9 spoke of how ‘proud’ they were to share their knowledge.

All participants spoke of the role fulfilment of working with acutely-ill patients and their families. N8 appreciated that the patient outcome was not always positive, referring to

end-of-life-care, but found it rewarding to see a patients return, 'looking so well' and the 'relatives are so grateful'. There are instances where CCNs 'achieve beyond the family expectations' (N8)

> 'you're looking after the most-sick patients in the hospital, and you know for a fact that some of them won't make it but….you can save this person's life in their most critical time of their stay in the hospital. And then seeing them recovering and then being discharged….especially during the pandemic when it was almost hopeless….you see people being discharged and waving goodbye….and bells being rung, saying I'm being discharged from CC, I think that was the most rewarding aspect of the career' (N16)

N8 refers to a situation where lengthy consultations with a patient encouraged them to remain in CC. The feeling of value awarded by the family, could not be achieved elsewhere, 'yet it was just my job' (N8).

CCNs described intrinsic reward as

> 'when you get through the shift safely….everything goes to plan, no major dramas, nobody moaning….or being inefficient' (N7)

N2 shared how rewards change over time, initially caring for the 'sickest patients', now valuing their leadership style, with 'fairness', 'being approachable' and support being the priority,

> ‘a long time ago becoming a band 7 was such a reward….they can ask me anything, they don’t feel that I would be scathing, you know they do get snide comments from people if they ask what they consider to be silly things’ (N2)

The few CCNs that spoke of academic achievement, stated that they had a sense of pride in the achievement of their post-graduate studies (N7,N13).

7.10 Frustration

The term frustration[30] traversed all other six broad themes independent of the CCNs experience or seniority.

N1, a band 5, spoke of more frustrations than any other participant. They affiliated their frustration to ‘laziness and cliques’; whilst recognising this trait was not just seen in CC. Frustration was also related to the levels of knowledge on each shift and the link between ‘education and support’, referring to ‘a lack of support for new starters’ (N1). This was associated with the recruitment of large numbers, impacting the ‘competence on each shift’ (N1,N7).

N1 implied the fairness in allocation of shift patterns could be improved in terms of allocation of days and nights, and with patient allocation, inferring ‘favouritism’ occurs. They defined a fair environment as one where they all had the same experience (N1).

[30] Frustration defined, as a collective “emotional response to opposition, related to anger, annoyance and disappointment”, www.definitions.net/definition/frustration. This can result from conflict to fulfilment of an individual’s will or goal and likely to increase when the goal is denied. http://www.psychologistanywhereanytime.com/emotional_problems_psychologist/pyschologist_frustration.htm.

N4 expressed similar frustration in the allocation of patients, albeit for this team lead it related to being allocated a patient in addition to leadership role. This inequality felt like a 'punishment' for those with more experience, presenting a hierarchy within the bands (N4). N4 recognised the need for band 6s to be leaders whilst still being allocated to patients; however, they challenged that this only happened to some of the band 6s (N4).

The band 5s recognised those with effective communication were better leaders, especially in times of crisis, highlighting that they provided a 'calmer experience' (N1), which 'reduces fluster' (N1). The leadership structure

> 'drives me crackers….too many chiefs….too many people telling you what to do, just increases the stress….they haven't noticed, we are doing what the first chief asked us to do' (N1)

Frustration with leaders related to those that were unable to resolve issues, those that

> 'lacked the capacity or ownership to address the elephant in the room….rather than seeking out the individuals….we all endured the same repetitive messages' (N1)

N1 also mooted how their 'appraisal was predictable'; implying this had become more of a 'chat', providing limited value, offering no opportunity for career progression and lacked recognition of positive attributes such as teaching and supporting students. Suggesting this could be due to how being in the later part of their career was perceived.

> 'late phase in their career….and length of service….study days were not career enhancing' (N1)

N15 linked frustration to being sent to support other WE, when the CC patient capacity was reduced, this was linked to increased stress levels and the feeling of being undervalued,

> 'one-thing that frustrates CCNs they get sent off to different wards, that is one stressor….one of the….reasons that you get so undervalued, not recognising your contribution….not being given, not having the support to speak to, voice out opinions, not being listened to….pulling the staff to the wards is happening again and the stress questionnaires are back again….because I am becoming more senior I can see that in the junior staff, I was there….I was there in your place….I can see that is happening to the new staff' (N15)

The CCN band 6 frustrations focused more on the

> 'economy of the NHS….nurses were at their best when it was less pressurised' (N3)

Frequently referring to how the 'pyramid structure' of the nursing workforce affected their promotion opportunities (N4,N7,N8), citing nurses who had

> 'progressed very quickly on the wards….you get promotions much quicker elsewhere….do you remember the student nurse….they are a band 6 and then they are an acting band 7 and they were like 27, that can be irritating' (N7)

Whilst recognising that you should not

> ‘compare yourself to others if you are not prepared to put yourself out there….they are in the right place at the right time and have the guts to do it’ (N7)

N7 states how disheartening this is for the ‘younger ones’ who have more technical skills than those on the ward. The ward nurses were referred to as ‘wild’ (N7), wondering if they recognised their ‘lack of experience’ (N7). The band 7 and 8s also recognised the increased opportunities elsewhere with limited opportunity for senior roles in CC and a very slow professional progress. They suggested that the younger nurses want to progress more quickly, having career plans and aspirations, which are exposed during interviews. Suggesting they leave for promotion, rather than wanting to remain in CC for their career (N5).

Although N7 recognised that since the pandemic, ‘promotional prospects have improved’ with the development of services such as outreach (N7). CC and its large team were highlighted as a cause for concern in relation to

> ‘you can go for long periods without seeing some people….which again is very different to a ward’ (N4)

The large numbers affected the ability to maintain ‘a positive working environment’, smaller numbers allow ‘you know them and they know you’ (N1,N2,N7,N8).

The band 6s voiced their frustrations during COVID related to the 'lack of visual presence of the senior team' (N4), as a band 6 they felt responsible for the junior team,

> 'we didn't see the next level of management….they were predominantly office based' (N4).

Another frustration raised by the band 6s related to knowledge development, conversing about the 'challenge of custom and practice' and the 'slowness of change' (N3). This CCN stated that in the twenty plus years of working in CC,

> 'something's have moved on, but an awful lot hasn't, and that is intriguing' (N3)

The barriers to knowledge development and education opportunity were associated with both professional and personal causes relating to 'time constraints….staffing numbers...putting temporary halts to education events' (N5,N14).

From the senior team, N13 spoke of the organisational frustrations. N5 also expressed frustration towards the organisation, suggesting their management style had less of a corporate view, and being in a position where her job description, position and objectives are at odds with one another. Describing how they feel like they are 'doing her best, but aware it is not the best she could be', and this is because of the lack of organisation support (N5)

> 'the tick box exercises….paperwork is ridiculous….it's time consuming and repetitive….but you have to tow the party line' (N13)

N5 also presented what they considered as an 'age old frustration' with band 7s wanting the senior role but will not 'embrace the responsibility', clinging to the clinical components rather than managerial responsibilities. N14's frustrations were less personal and related to:

> 'easier to make changes in a smaller hospital and unit….less hierarchy and bureaucracy….everybody knew everybody really well….there was more mutual support….I also had a manager who was self-motivated and driven….coming here was a bit of a culture shock' (N14)

Introducing initiatives that worked on a smaller unit 'was frowned upon…. that was frustrating', and processes were complex which provided a different set of frustrations (N14).

7.11 Chapter Summary

Seven themes emerged from the findings: constructs of a CCN; emotions; organisation (including effects of COVID); leadership; knowledge; rewards, and frustrations, each having multiple sub-themes (Fig.11). Due to the plethora of narrative collated, only the central stories from each theme have been presented (Fig.25); redundant data will be disseminated in alternative forums.

The participant findings focused on what they perceived as to be the joy of their work: working in an emotive, intense WE, belonging, and work-family. The challenges related to COVID, and frustrations, due to limited career advancement. As unit size increased,

the sense of belonging was however seen to decrease, typically this was due to 'not knowing staff' and this was attributed to a reason to leave.

> 'you don't know them the same way….you knew people when you were a smaller unit, you knew everybody, you virtually knew everything about everybody….the bigger the unit the more staff you've got, you don't have that….everybody doesn't know each other, everybody's capabilities or personalities' (N2).

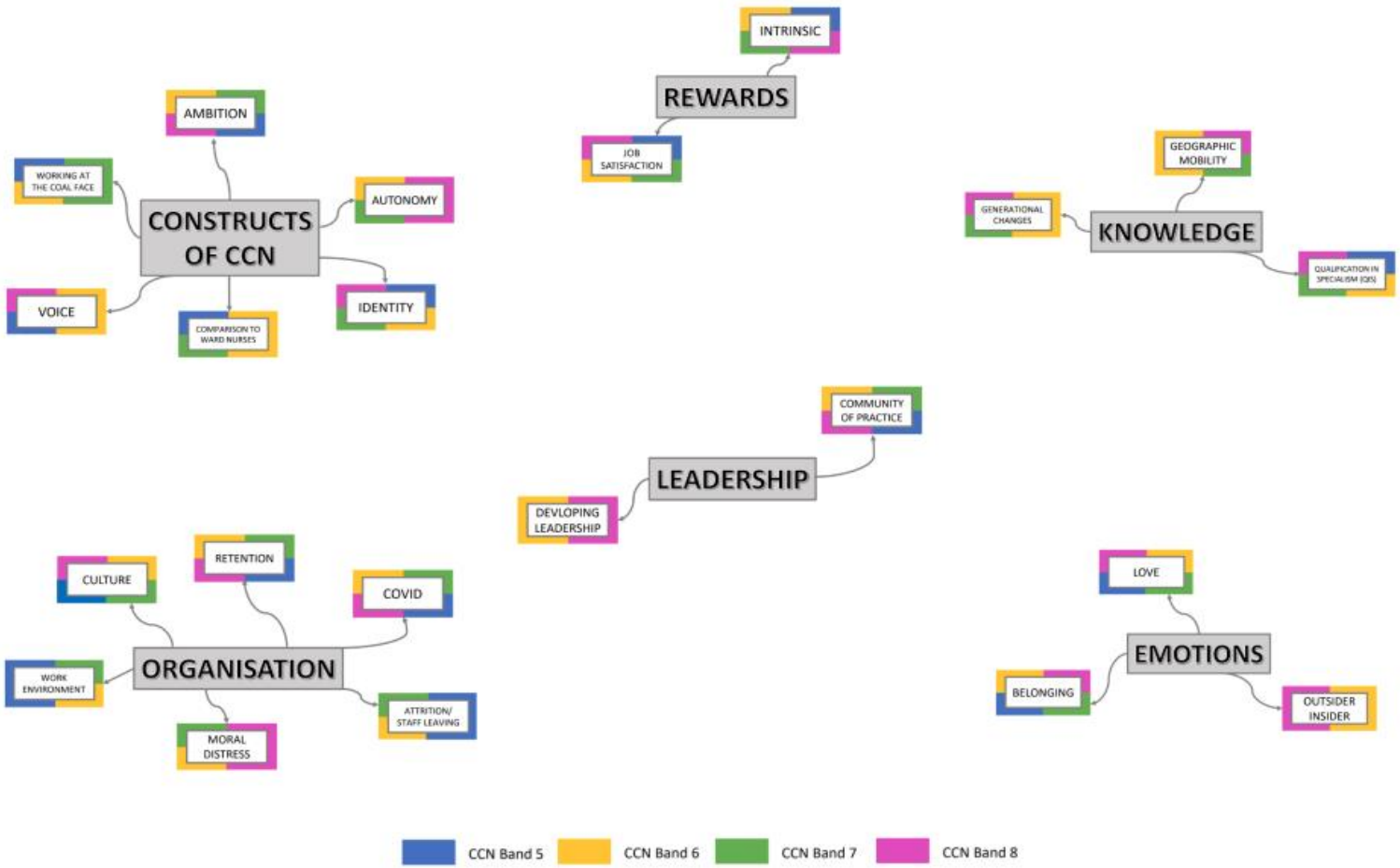


Fig.25: Summarised Findings Infograph

Chapter 8: Discussion

8.1 Introduction

Research has demonstrated that the CCN workforce crisis has been further compounded by the effects of COVID (Rhéaume & Breau, 2022). Underpinned by personal experience, this study was designed to describe and understand why those that remain in CC do so and explore thriving or striving.

This chapter has three foci: the first and second align with the integrative review and FS and the third and primary focus relates to the study findings.

8.2 Implication of literature review findings

The integrative review findings focused on adverse WEs, and emotional wellbeing as causative factors for ITL. With a knowledge gap relating to why CCNs choose permanency in CC, Miles (2017, p.3) defined such a gap as 'knowledge that does not exist in the actual field'. This needed further investigation and was the primary intention of the study; that is, why do some CCNs demonstrate longevity and thrive in CC.

8.3 Feasibility Study Discussion

The FS phase tested researcher skills and ensured the utility of the interview guide for phases 1 and 2, thereby enhancing the quality of the research by ensuring interviews were conducted effectively to gain in-depth narrative. The FS also enabled testing of analysis skills, as suggested by Malmqvist (2019). The FS was not intended for data

triangulation with phase 1 and 2 data; triangulation or provisional data collection in phenomenology is not advised (King, et al., 2019).

However, it became apparent that the appropriateness of the sampling method was a limitation. The direct influence of ethical gatekeeping and insufficient time to apply for HRA approval meant that the CC nursing workforce were not considered in their entirety. Instead, a distinct convenience sample were investigated, atypical in age and years of experience, however, all participants were at similar points in their professional career, undertaking their QIS in HE. It was acknowledged that the inclusion of one population subset may restrict the conclusions that can be drawn; indeed, issues of generalisability have already been discussed (chapter 5). However, this study provides contextual understanding of the social experience of this subset, which can provide case translation and extrapolation to a different setting. The FS, however, did confirm the value of phases 1 and 2, confirming a lack of empirical knowledge relating to ITR.

8.4 Discussion Phase 1 and 2

Between January and November 2020, which included the short, enforced interruption to data collection, due to COVID, seven phase 1 participants shared their work-life experience, focusing on ITR. All levels of RN were interviewed, although the senior team at Site 2 were not representative. From the data analysis, (Fig.11) trends were located, identifying a reoccurring picture of challenges, opportunities and reward.

Phase 2 was conducted between October 2021 and August 2022. There was an initial assumption that phase 2 would focus on a subset of CCNs who had articulated a conscious decision to remain. However, due to an overall commonality across all phase

1 participants, phase 2 used convergent sampling to authenticate participants accounts and gain further depth on the phase 1 themes, rather than purely data chasing. Phase 2 recruited from a wider and more diverse group, including international colleagues. Using a process of reduction, sixty-seven categories were summarised as seven broad themes: constructs of a CCN, emotions, organisation (including the new and timely focus relating to COVID), leadership, knowledge, rewards, and frustrations (Fig. 11).

Recruitment was disproportionate across Sites in terms of participant numbers (Table 22); however, all professional levels were recruited. Appropriate sample size number is dependent upon on epistemological and methodological standpoints and the nature of the research (NCRM, n.d.); it was felt at fourteen, commonality was secured. However, at that point, the overseas nurse account had not been authenticated, thereby two further participants, junior and senior representatives were successfully recruited and interviewed.

One of the additional questions 'what tests you at work?', was modified following the first interview, not working as expected, with clarification required to focus the question, otherwise, the broad questions elicited a plethora of narrative. Interestingly, each interview lasted one hour, coming to a natural end. Participants highlighted how cathartic the experience had been (N5,N7,N10), having shared stories which they had never previously spoken about, and feeling safe to disclose (N2,N10,N12).

The research findings clearly contradict widely accepted conclusions, which present an international view of ITL, adverse WEs and the negative effects of CC on CCNs wellbeing. Müller-Bloch and Kranz (2014) state that when evidence gaps have been revealed,

evidence appears to be contradictory after analysis has taken place. Therefore, seeking this new line of enquiry provided a worthy addition to the evidence base, extending the knowledge relating to why some CCNs remain in CC. This will be important to assist in retention and positive work experience for CCNs.

8.5 Synthesis of Findings

The CCNs experiences portrayed an environment of joy and satisfaction at work, aside from the COVID experience. The central data presented a strong indication of centrality of belonging and the need to feel in a position of safety to thrive. CCN joy clusters around labour of love, the nature, patient acuity, provision of holistic care and its associated knowledge, work-family, culture of support (mothering), recognition (having a voice and involvement in decision-making); and emotional wellbeing (inclusion) (Fig.26).

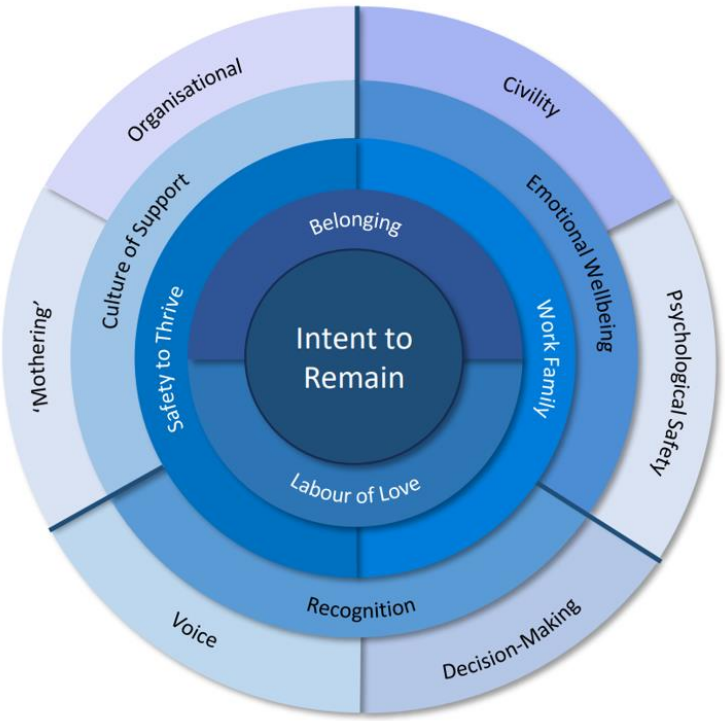


Fig.26: Intent to Remain

The psychological effects of COVID (section 7.6.5) and the wider organisation storyline of leadership (section 7.7.1) negated this feeling of joy and satisfaction at work. In addition, an isolated case, of a senior leader, (N5), was an outlier to the commonality of the other participants. N5 provided an opposing picture on ITR, having previously identified with belonging, and continued affiliation with the love of CC; they spoke of an ITL due to wider organisational issues.

8.5.1 Belonging

The essence of belonging was shared by all participants. Belonging is an innate human need and driving force (Maslow, 1943). Using the lens of Herzberg (1959), and the factors for job satisfaction and dissatisfaction, a sense of belonging was essential to decrease job dissatisfaction. Aligning with Maslow's (1943) single theory continuum, which brings together both personal and professional life, belonging was essential for targeting self-esteem and thriving.

For many, a significant amount of time is spent undertaking some form of work, as such, it is essential to feel belonging. A culture of belonging is when the employee knows that their voice and contribution matter, irrespective of their role, that they feel valued and included (Bevan, 2023). Organisations, that exhibit a sense of belonging demonstrate increased staff retention, engagement and positive outcomes (Bevan, 2023). The findings suggested a richness in the sense of belonging and feeling in a connected place within the team, even in the darkest periods of the pandemic. The authentic stories of genuinely knowing each other, personally and professionally, with clinical and senior

leaders listening and responding irrespective of the individual's role, demonstrating appreciation and recognition.

CCNs that experienced being outsiders (N3,N4,N5) planned their return to CC to achieve a sense of belonging; even though, on occasion it came at personal cost, in terms of financial security. N16 spoke of being a person of colour, perceiving a longer duration before acceptance and identifying with a meaningful connection to the team. This commentary on inclusive workplaces is recognised as workforce diversity (Shore, et al., 2018) and is typically defined as division in the workplace due to perceived cultural differences, capable of negatively impacting on employment values such as promotion and networking. This, however, did not corroborate with the reported experience of these international nurses.

Belonging is more than a connection with colleagues, it incorporates an affiliation to the organisation values and purpose (Bevan, 2023). CCNs were proud of CC and of being a CCN, with strong allegiance to the unit, however not necessarily to the wider organisation. Significantly, those seasoned, in terms of years of experience, compared the current team cohesion with the past, identifying that the culmination of growth in unit size and staffing related to a reduction in meaningful connections and a sense of 'knowing them less' (N2, N14). This unit growth, having a negative effect on belonging in the workplace. Indeed, belonging is a powerful driver for happiness and joy (Bevan, 2023) and this underpinned the findings.

8.5.2 Labour of love

Fineman (2012) speaks of a contrasting feeling of love, hate or endurance to work. The findings illustrated an unconditional 'love for CC'; a term used frequently by all participants.

Self-actualisation was met when CCNs were able to exercise freedom in their delivery of care to patients and families, in a manner which they found satisfying. Aligning with Herzberg's motivation theory (1959), all CCNs spoke of job satisfaction, stemming from the nature of the work, and their responsibility, and 'nothing else [they] would rather do' (N13). CCNs job dissatisfaction was associated with the inability to provide such care, commonly associated with the pandemic, endorsing Vincent et al. (2022) and Calkins et al. (2023) work on describing the impact of COVID on CCNs.

There was a common sense of duty and pride to be part of such a significant event in someone's life. Being trusted to care for someone, delivering intense and supportive care provided intrinsic reward, reaffirming why they had entered the profession; aligning with Atefi et al.'s (2014) and Montgomery et al.'s (2021) review of staff experiences of working in the first wave of COVID. As a community there was a sense of working to agreed high standards. Remaining at the bedside, depicted as the coalface, was extremely important; even those in senior roles alluded to this as a rationale for not seeking further promotion, which would result in a move further from the clinical area or intention to leave.

The current context of work has shifted from the industrial work ethic of 'work to live' (Jaffe, 2021); there was no evidence that financial renumeration was high on the CCNs agenda, unlike that suggested by Atefi et al. (2014). Remaining at the coalface was seen as the trade-off for promotion; whilst a recognition that 'there are easier ways' to earn a living (N10). Additionally, an awareness of the 'grass was not always greener' (N2), meant that many accepted the delay in professional advancement and limited promotional opportunities preferring job satisfaction and a sense of value.

When the relationship between work and satisfaction in CC failed, there was a sense to try harder, with some presenting solutions of changing roles (N3), or for one, an ITL (N5). There was powerful detail wrapped within the stories of what provided meaning to a CCNs work-life.

8.5.3 Work-Family

The workplace community was particularly meaningful, informing ITR for all participants. Within each interview, there was significant reflection on colleagues resembling family, and work as home (N13), with participants defining colleagues as their work-family/work-wife.

The motivation to remain related to concepts of knowing one another, mutual support and life-long bonds. This demonstrated a deep connection with the team and the realisation of a having 'work-family' linked to a sense of belonging and support. There was evidence of authentic human connection, relating not only to each other's capabilities but an intimacy in knowing about each other's personal life, especially major life experiences. It also demonstrated that the phenomenological approach has reached

beyond the forefront of consciousness (King et al, 2019). The description of the lived experience was beyond a superficial account, having time to reflect on their experience rendered some participants quite emotional (N10).

CCNs identified learning together; such tacit[31] knowledge comes from within the WE, learning and engaging in the same social landscape, understanding each other's capabilities, and knowing when support is needed. CC has its own language and technical skill; the knowing is embedded in everyday work, only those that have experience have this knowledge and can prepare others for this. Experience provides the understanding of practice and CCNs identified a duty to share this knowledge with their 'family' as essential as they are the nurses of the future (N9).

Wenger (1998) defines a COP as a voluntary group, with members needing to be supported or they will not remain. A COP identify as a group that learn better when they work together and where they are rewarded together (Wenger, 1998). Similarly, participants felt like they belonged, with a connection between the individual and the community. The noticeable finding was that the CC family or community identified with the unit/department.

This is unlike the sense of community, as defined by Godin (2008), or the 'abunta'[32] as highlighted by Eastwood (2021). These CCNs lack organisation or national affiliation, connection was more insular, to their family. However, CCNs did align to Godin's (2008)

[31] Tacit knowledge represents internalised knowledge, often difficult to express, and often not consciously aware of: Cambridge Dictionary (2024)

[32] Abunta is defined by Eastwood (2021) as those tribes that aspire for the nation.

portrayal of tribes and working on what they believe in, and how this is more satisfying 'than just getting a paycheck' (Godin, 2008, p.8). Working with their 'family' brought an intrinsic motivation; a higher sense of thriving and a care and love for each other was more rewarding than ambition, promoting a personal mission for long-term wellbeing.

> 'those that like their jobs….are the ones who are doing the best work, making the greatest impact, and changing the most' (Godin, 2008, p.9)

It was clear that the family had a shared history and participation which provided a safe environment in times of adversity. CCNs found strength and reward from building such positive work relationships and commonly referred to this during the narrative on COVID. Emotional insight and team integrity was sensed, with the profound nurturing of the young; 'mothering' like your own. These nourishing professional relationships with newcomers, regardless of background, were a means of interpersonal support, which demonstrated kindness, reflection, motivation and enthusiasm; as defined by Jackson et al. (2007). There was a keenness to ensure newcomers know that their voice matters and that they are understood, especially in relation to a sense of belonging.

With rising numbers of international nurse recruitment over the last twenty years (Lanada & Culligan, 2024) it is essential that integration into the workplace is sensitive to their cultural needs. Here, the findings portray a community of international CCNs and their acceptance into a adopted CC work-family. There were some consistencies with Lanada and Culligan (2024) integrative review findings in terms of experiencing prejudice, for these participants this was noted to have occurred outside of CC. Whilst the inconsistent features related to promotion and career progression; with two of the

participants consciously choosing and achieving career progression, and one consciously electing to remain as a band 5. Here, they recognised how UK CCNs work differently in terms of decision-making and autonomous practice, despite recognising all international participants had prior CC experience in their home country. In addition, they suggested, in times of difficulty, or when faced with uncomfortable decisions, they would seek advice initially from their cultural family before the wider work-family were approached for resolution.

The FS referred to longevity and the seasoned nurse and phases 1 and 2 focused on the experiences of the seasoned nurse. It is therefore appropriate to highlight narrative around the generational differences, considering Fineman's (2012) suggestion that the generational effect has a lesser impact on work compared to psychology and personality. The current workforce includes four generations: baby boomers, Generation X, Y and Z (Table 11). The notion of centrality of work and the difference between the seasoned practitioners was raised by some participants, especially those with twenty years plus of experience. The motivation towards career advancement and status was raised, with remarks on some advancing technical skills in CC before relocating to alternative WEs for promotion; suggesting CC skills are a valuable and sought after commodity. Others highlighted concern at the speed of such advancement (N7).

Generational differences, work ethic and attendance was recognised by CCNs, suggesting that the younger team members placed greater emphasis on personal well-being. This notion aligned with differing attitudes by participants, suggesting some younger nurses needed to man-up, whilst others recognised they might be 'the fool'.

This was also linked to loyalty; with the newer generation portrayed as prioritising shaping their career, again focusing on the self. These comments warrant further investigation, to inform generation specific retention strategies as suggested by Lavoie-Tremblay et al. (2010).

8.5.4 Psychological Safety

Psychological safety can be defined as

> 'the degree to which team members feel that their environment is supportive of asking for help, trying new ways of doing things and learning from mistakes' (Agency for Healthcare Research and Quality, 2018, n.p.)

The findings present how most CCNs felt supported to achieve satisfaction, whilst being privileged to care for the critically-ill; this aligned with the work of Sacco et al. (2015). CCNs felt safe to be unwell and have personal problems without judgement, specifically post-COVID.

Senior nurses demonstrated their accountability in the provision of a safe learning environment and voiced their concerns regarding CCN competence in the post-COVID era. When CCNs work within an environment which is psychologically safe they are curious to learn, apply their knowledge and problem solve; again, demonstrated during the pandemic. Compassionate leadership was shown to those who presented with symptoms of burnout, with senior leaders supporting CCNs to locate alternative workplaces and exhibit joy in their work.

The concept of inclusion was threaded through the findings related to the demanding periods; indeed, denoting a sense of togetherness, a camaraderie demonstrated during multiple and sequential admissions, SARS, and during COVID. This was consistent with Guttormson et al, (2020), and their positive recognition of working together during the initial phase of the pandemic and team cohesion identified pre-COVID by Breau and Rhéaume (2014).

The findings suggested that an essential component of psychological safety was incivility; overall, both study sites appeared to promote a civil environment, in that it appeared safe to speak out. There was no reference to group blaming or gossip. Conflicting opinions were minimum, with only one reference to 'cliques' (N1) and N7 implied they lacked confidence to speak out, feeling they would not be 'heard' regarding promotion activity. Alternatively, N5s commentary on their relationship with the organisational team highlighted a confidence to voice dissatisfaction, whilst perceiving it was not recognised. They referred to working in a wolf-pack like organisation, with 'dementors' that 'suck the life away' and being made to feel like a 'buffoon'. This led to a sense of humiliation, and isolation from both CC and the organisation like that found by Ellison (2021). For this CCN, this lack of feeling of psychological safe was a precursor to seek alternative employment.

An overall picture of psychological safety within both sites was presented; most CCNs felt safe to speak up and recognised being heard. Without psychological safety, a sense of belonging cannot be achieved.

8.5.5 Identity

Personal and professional identity changes in time and place (Grey, O'Toole, 2018). This study focused on the professional identity of the CCN; participants were recognised through professional bands and associated titles, clinical nurses, clinical leaders and senior leads (managers). The findings demonstrated that a CCNs identity was multi-layered with autonomy, being valued, having a voice; and being listened to as integral to that identity. This was frequently portrayed as a collectivist view rather than an individual view; their focus was with the team. Eastwood (2022) presented the individual self with a diminished sense of belonging; here, there was a strong sense of reliance on elders and experts. This also relates to Maslow's hierarchy (1943), when one achieves survival, there is a move to support others.

All participants regarded being a CCN highly, recognising that alternative WEs had not, or may not, bring comparable job fulfilment, due to the perceived lack of autonomy and application of specialist knowledge in the workplace. Specifically, those CCNs that relocated to alternate WEs for promotion opportunities shared how this had not provided satisfaction in their work, sometimes experiencing trauma. All made positive adjustments to relocate, retuning to CC to regain control of their work-life. For some, this required a period of self-care for equilibrium to be achieved. The hard-work and commitment of ward nurses was appreciated, however, the CCN was concerned for their professional accountability and perceived they would feel dissatisfied with the inability to deliver holistic care to their usual level of satisfaction afforded to them in CC. Ward nurses were perceived to have low control and little autonomy in the workplace

compared to a CCN, who considered their work to involve high levels of control and autonomy.

A sense of feeling valued was common across all participants, unlike the findings presented by Papathanassoglou et al. (2012). Those that had worked within a culture where value was not recognised had ultimately made a conscious decision to return to CC. CCNs had a sense of identity that was limitless, with significant personal value, especially when linking to their mothering instinct. Similarly, CCNs spoke of pride in their CC identity and the sense of achievement of working in CC. For some this was linked to social background, and family expectation.

Unlike the FS, and Fitzpatrick, et al. (2010) phase 1 and 2 participants were not intrinsically motivated by professional development. Instead, following achievement of the QIS, many had no desire for further formal education. Instead, knowing was linked to sharing tacit knowledge. There was contradictory reference made to the opportunities for continuing professional development post-QIS, with evidence of further study specifically relating to leadership.

This storytelling identified CCNs as adaptable and resilient, noting personal characteristics relating to resourcefulness, level headedness, and problem solving; indeed, comparable to those identified by Giordano (1997). Such a strong sense of self portrayed an ability to overcome adversity, and to thrive by adapting to difficult situations, including COVID.

These values provided a common code for how older, experienced CCNs worked together; demonstrating high compassion levels and lower stress levels, similar to that found by Sacco et al. (2015). Those with increased length of service spoke of being selfless and leaving a legacy within the workplace.

A CCNs identity had multiple meanings, consistently relating to the labour of love, which harnessed a sense of belonging.

8.5.6 Quality of work-life

These experienced CCNs suggest that work-life was good. Their decision to remain had not always been a conscious one, rather, there had been no reason to leave. Associating belonging, inclusivity, and being valued with the CCN being less demoralised and factors essential for health and wellbeing, aligns to the work of Senek et al. (2020) and Grobecker (2016). Participants felt safe, describing CC as like working in a supportive, protective bubble, again linking to the work-family (section 8.5.3).

Unlike the plethora of evidence referring to MD and poor communication within CC, the findings identified only three CCNs that associated negatively towards the multi-disciplinary team. Two referred to experiencing intimidation outside of CC which prompted a motive to return. The third, N5, referred to difficult professional relationships with the medical team, likening them to 'soul-suckers'[33].

[33] A term used in the Harry Potter books, to denote the fictional characters termed dementors. These creatures feed on humans happiness, generating feelings of despair.

Notably, CCNs recognised CC as an environment with rare progression opportunities, creating high competition, especially in comparison to the ward environment. Although this held negative conation, it was outweighed by the 'labour of love' and 'belonging' as a reason to remain.

8.5.7 Intent to Remain

ITR has two strands; those not actively planning to remain but had not actively sought employment elsewhere and those that made a conscious decision to return, and subsequently remain in CC to regain a sense of belonging, joy of work and for self-preservation. Those that had for a period transitioned out of CC shared stories of adverse experiences which instigated their return to CC; participants placed importance on belonging and the work-family in their decision-making.

CCNs that aligned to having no specific career plans, stated they were satisfied with their job. Although, some referred to themselves as 'complacent', and others referred to a 'fear' of the outside world, with a distinct understanding on what they did not want in a workplace. This frequently related to the nature of care delivery on a ward; referred to as the bare minimum, with 'not enough time', 'it's like an absolute storm…running ragged' and 'task orientated'. Alternatively, there was a sense of privilege to work in CC; indeed, a display of commitment to working in a distinct area rather than seeking financial reward.

One CCN spoke of feeling isolated from those inside and outside the CC community, (N5): as a 'compassionate leader', their contribution at organisational level was no longer recognised, and felt out of line with organisational identity. A shared allegiance

with the culture of CC remained; the dissatisfaction was with the role, not the specialism. The resulting isolation from the organisation leads motivated an ITL. These findings concurred with Choe, et al. (2015) on professional relationships, the sense of value and belonging, albeit affecting CCNs on a larger scale. In addition, experienced CCNs recognised that CC was 'like marmite'[34] and did not suit all newcomers, suggesting this was a factor causing some to leave CC early. The FS suggests that those that remain past the initial few years, are more likely to remain.

8.5.8 Psychological effect of COVID

During data collection, COVID spread globally like nothing experienced before, both sites were admission units for COVID patients. Whilst two participants were interviewed prior to the pandemic, fourteen worked at the frontline during this 'horrific time', with some affected directly by the disease, as highlighted by ICN (2021). CCNs raw experiences of COVID did form part of the experience without dominating the discourse.

Whilst coping with the societal disruption, family stress, fear of the disease, fear of being the patient, and working alongside an unfamiliar work-family, these CCNs spoke of the feelings of helplessness and MD due to futility and end-of-life decisions. This aligned to the emerging literature revealing high incidence of psychological disorders, contributing to anxiety and depression (Calkins et al*.,* 2023; Rhéaume & Breau, 2022). It is suggested that the impact of COVID was dependent on the incidence within that geographical area. Whereas here, with a profile of CCNs with increased age and experience, the findings

[34] Meaning, something that people like very much and others dislike very strongly (Cambridge Dictionary, 2024)

reveal a picture of resilience, like that suggested by Peñacoba et al. (2021) where feelings of accepting oneself and keeping calm, were protective factors.

The perception of inadequate care delivery, and heightened feelings resonated with job dissatisfaction and were akin to the findings disclosed by Calkins et al. (2023) and McCallum et al. (2021). Compassion fatigue related to the futility with the unvaccinated, and the fear of one's own health; supported by Ali and Alharbi (2020). CCNs expressed their vulnerability when referring to a limited initial understanding of COVID management and being surrounded by death. Death is part of the nature of CC, but COVID was attributed with younger and a higher rate of deaths (Vogt et al. 2023). CCNs were unprepared and taking the place of families, increasing their emotional labour, a negative psychological factor identified factor by Montgomery et al. (2021).

The destabilisation of the workforce, caused by new ways of working, increased capacity, and the limited skilled workforce revealed how emotionally distressing supervising the redeployed and inexperienced workforce was; CC3N (2020) concurred. Anderson et al. (2022) related this to being fearful of the responsibility, here, whilst concurring, the CCNs admired and appreciated the outsider support at a time when they 'were striving to survive', recognising 'they came back at the worst time'.

Levi et al. (2021) and Vogt et al. (2023) highlighted how repeated exposure to ongoing trauma increases the risk of PTSD. PTSD symptoms were identified here, with participants referring to unforgettable scenes, causing flashbacks, and emotional fragility, and admitting they continued to find it difficult to talk about their experiences.

Novotney (2023) proposes that women are more likely to develop PTSD, a significant factor when women form nearly 90% of the workforce.

The physical and emotional exhaustion of working in 'the war zone' was recognised by each participant, and similarly by Fernandez (2020). Even though there was some sense of grieving for their unit (N13), almost all expressed pride in adapting to new ways of working, with a common sense of duty, teamwork and camaraderie to survive. Montgomery et al. (2021) refers to this as moral density, of having a common purpose. The importance of working together during this time was also noted by Guttormson et al. (2022) and Bergman et al. (2021).

Working with increased patient to CCN ratios and exaggerated emotional relationships due to visitation restrictions signalled that some CCNs may leave the workplace sooner than planned. This is again akin to the findings of Montgomery et al. (2021), who cited these as predictors for increased levels of burnout and ITL, indeed those with PTSD are twice as likely to leave. Cutler et al. (2020) indicates that CC is associated with the most affected area for turnover post-COVID, presenting a damming picture for ITR.

Profound mental health challenges like those uncovered here and by Crowe et al. (2022) suggest an urgent need for initiatives to address these challenges. Small numbers spoke of resilience and the ability to bounce back to maintain their emotional equilibrium, whilst most spoke of this as a continuing trauma and were visibly upset during their discourse. Participants demonstrated an awareness of the wellbeing strategies at Site 2, however the picture of their perceived value and use was inconsistent. Amongst this however, was a need for consistent and appropriate leadership.

Senek et al. (2020) identified that CCNs valued transformational leadership, aligning to managers leadership styles and activities. Here, the findings present a perceived lack of organisational support and dislocation with the senior team during COVID resembling the 'tumbling into chaos' analogy referred to by Bergman et al. (2021). Participants spoke of decreased visibility of the senior team; also recognised and acknowledged by senior team members, whilst defending their actions, reflective of Falco-Peguerdo et al. (2021) findings.

Albeit a small contribution in the findings, reference to community appreciation aligned somewhat with the views of Stokes-Parish et al. (2023). CCNs were appreciative of society's initial endorsement but eventually associated negatively with the labels 'heroes' and 'angels'. Similarly, with reference to the later waves of COVID, CCNs felt forgotten, with COVID now just a problem for CC; similarly identified by Montgomery et al. (2021). Here, findings suggest that during COVID, CCNs used their fright-flight-factor[35] to assist with managing the adversity. CCNs suggested it was their duty to work-on, albeit conflicting with their moral compass, fear for family members and the self.

[35] A physiological reaction, organised by part of the autonomic/sympathetic nervous system, that occurs in response to a perceived harmful event, triggering an acute stress response. Also termed fight-flight-freeze or fawn (Cambridge Dictionary, 2024).

8.6 Contribution to New Knowledge

- The integrative review findings focused on an international view of ITL rather than ITR, identifying a knowledge gap in the literature relating to reasons CCNs remain in CC.
- This study provides a strong pointer to a sense of belonging as the main factor for CCNs choosing permanency in CC.
- Multi-phenomenon supports a conscious decision of ITR: emotional well-being fostered through work-family relationships, labour of love, feeling valued, autonomy and value.

8.7 Summary

This study adds to the evidence base the voice of experienced CCNs, who have remained in CC for a mean of fourteen years. It has provided insight into how CCNs have remained emotionally well and thrive. These findings suggest CC is a positive workplace, known for having a positive outcome for the patient and organisation (Ulrich et al. 2019). Several of the participants highlighted how cathartic the experience had been, especially relating to narrative around the work-family and the effect of COVID. An important note regarding the quality of working-life must relate to COVID. At the time of data collection, it was too soon to detect the long-term effects of COVID on ITR, WE and its workforce. Initial findings highlighted some inference of ITL.

In addition, there is new contribution to knowledge, specifically relating to the CCNs sense of belonging within the domain and how this factor enables CCNs to remain in the specialism against adversity. CCNs felt empowered to provide technical and compassionate care, to act autonomously whilst feeling valued by their work-family; this positively impacted on their ITR.

Chapter 9: Recommendations

9.1 Introduction

The contribution of new knowledge relating to CCNs who have demonstrated longevity in the workplace, whilst remaining highly motivated, will enable an exploration of solutions and the provision of meaningful recommendations to foster and embed positive changes to retain and enhance the CCNs WE. Knowledge mobilisation and further investigation is part of this process.

9.2 Further Research

This study forms the basis for future research. The evidence base is heavily focused on ITL and dominated by a focus on early career nurses. The uncovering of the predictive factors why some CCNs demonstrate longevity in the workplace provides a persuasive incentive to mirror this study on a wider scale.

Post-COVID, further recognition of the workforce crisis that ensued prompted professional bodies to commit to focusing on workforce retention and the core conditions required to thrive in CC (ICS, 2023). This included the provision of workplace resources; these were presented nationally without strategy, evidence base or evaluation. Evaluation of these resources, focusing on belonging, using a mixed method approach would utilise this researcher's skillset, however, it is worthy of note that there is not a gold standard ITL tool (Vogt, 2023). Additionally, there is no evidence that ITL is synonymous with ITR. Consideration could be given to including the Professional Quality

of Work-Life tool (ProQOL-21) (Heritage, et al. 2018) in relation to ITR, combining both qualitative and quantitative research methods. These would be a worthy extension to this study.

In addition to longevity, greater consideration to specific characteristics such as age and culture could be further explored. This broader focus would provide the evidence for a range of wellbeing support packages for a workforce with varying attributes, including international nurses, and would positively influence ITR.

Recognising retention as a wider issue, the Intent to Remain model (Fig.26), could be tested in other settings, such as emergency care and in academia. This would make an interesting comparison, constructively supporting attrition in wider professional groups.

9.3 Practice and Education

There is an intention and enthusiasm to mobilise this new knowledge, informing both political and practical decision making, thus enhancing retention strategies to improve the CC workforce crisis. A multi-modal dissemination plan that focuses on accessible publications in academic arenas, the CC discipline, and wider healthcare community for maximum impact, is essential, including CC networks, study events, social media and conference presentation.

CCNs have a distinct role; they are a professional enclave with a high level of professional expertise. To maximise their retention, thus capitalising on workforce investment, organisational leads must invest in CCNs, ensuring they feel valued at the macro-level, to enhance work satisfaction; findings present that they feel valued at the

meso-level. Autonomy was an important factor relating to job satisfaction, however, this needs to be met at macro-level with managers maximising opportunities to ensure some CCNs are involved in organisational decision-making.

Experienced CCNs need the same educational commitment that is afforded to newcomers. This CoP, a mid-level structure, demonstrated a collective of shared norms of workplace behaviour. A focus on learning together, creating new knowledge to advance the domain whilst ensuring existing knowledge and experience is retained is essential. The ITR model (Fig: 26) should be applied in all educational activities, focusing on the specific needs of the group, age, culture, and experience, providing a sense of common purpose.

Predictors that relate to ITL differ depending on levels of experience, thus, the organisation needs to consider this when determining factors to ensure job satisfaction. CC expertise needs to be recognised and career opportunities established for those that have been invested in and subsequently demonstrate ITL for career advancement in other less intense WEs, due to a lack of career enhancement within CC.

The aim of the dissemination strategy is to harness practitioners, practice leads and educators and share these study findings as a key influence to inspire CCNs ITR. It is essential to promote belonging, labour of love, and the advantages of working in an emotionally safe, work-family environment to assist in the overall challenges associated with the CCN workforce crisis. An awareness of the model, with its ITR predictive factors, will provide educationalists, both clinically and in HE, a focused model for their specific learners.

Chapter 10: Reflexivity

Being reflexive is a skill, consciously critiquing, appraising and evaluating the decisions made (Olmos-Vega, et al., 2023). For this Educational Doctorate, the process commenced with a decision to investigate an alternative approach to a perennial problem; rather than undertaking a deep dive into why CCNs leave or are unhappy in their workplace aligning to work by Buckingham this is a common approach, 'as humans… [we] drill into what's wrong' (Buckingham, 2022, p.4). Instead, my intention was to discover why some CCNs remain, sharing their experiences to enable embedding of the discovered concepts into the education and culture for the next generation.

Connecting with a social science methodology enabled personal orientation to knowledge creation, but this has been demanding. This required acceptance of the limitation of a positivist methodology, opting instead for the richness of a relativist approach. It was a real privilege to understand the CCNs lived experience.

As a qualitative researcher I have been attentive to and conscious of my political, social, linguistic and cultural stance when collecting and presenting data, as suggested by Mahon and McPherson (2014). I have demonstrated my commitment to fairness and have recognised the ease to which I understood the CCNs experiences. Objectivity in this relativist approach required bracketing of personal experience; differing from my prior research experience which focused on the WE and MD, using a quantitative methodology.

Chapter 1 presents my personal and professional background, demonstrating longevity in CC practice from a social standpoint. Association with CC continued as I relocated into HE and research. My assumptions were presented with the intention of eliminating bias, thus preventing the tainting of the study outcomes and providing transparency for the audience. The aim of this situational transparency, revealing my social connection both past and present, was to convince the reader that responsible judgements and care have been exercised in the construction and facilitation of this study. In addition, making sense of the data collection was aided by the personal understanding of CCs language and social situation. However, remaining cognisant of the human factor aspect, which can be both a strength and flaw of qualitative enquiry.

Whittmore and Knalfl's integrative review method, known to be the most comprehensive method (Falatah, 2021), enabled inclusion of the evidence base, incorporating primary and theoretical reports within a timeframe. This method was used to reduce bias and increase rigor, whilst application of Hawker et al*.'s,* (2002) screening tool, titrated the plethora of evidence to a manageable means. Multi-stage governance approval, including HRA application, was timely, albeit an experience previously encountered.

By selecting phenomenology, in particular descriptive phenomenology, readers can achieve the analogy identified by Beck (2021, p.1), to 'walk a mile in the shoes' of CCNs and view via pure description the first-hand experience of longevity in CC. The privilege of hearing CCNs stories, embodies why it is important to redescribe their account wholly and authentically. Using an iterative process, commencing with a FS, demonstrated the

worthiness of the study, and developed personal research skills whilst capturing the emergence of improved research questions.

It is recognised that a self-selecting sample, using only two sites, may not fully reflect all CCNs experiences. However, recruitment was across all professional bands, genders and inclusive of our international peers. Purposive and convergent interviews revealed the CCNs socially constructed world and how they have made sense of their work-life. Positioning appreciates the positivist view and subjective nature of using this method to confer an unbiased and true account. Verbatim excerpts are presented to authenticate the participants narrative and ensure their voice remained central to the study.

Descriptive phenomenology is known to typically combine multiple methods of data sources (King et al*.,* 2019). However, the rationale for using interviews alone was, on reflection, fortuitous, due to the COVID outbreak and subsequent successive waves of the pandemic. The request for additional sources, such as written personal accounts may have reduced the number of CCNs who consented to participate and would have placed additional burden on participants. Additionally, COVID presented a significant challenge to data collection; indeed, the data collection period was prior to and immediately post the first and subsequent waves. This was the most operationally pressurised time for any acute healthcare practitioner, and especially CCNs.

The interviews enabled participants to recollect their experience and probing ensured an in-depth exploration. This revealed the nature of the socially constructed reality, including the context, situation and how CCN' made sense of their social world

experience (Silverman, 2020) and ensured a focus on the lived experience (Husserl, 1970, p.240).

The geographical sites were chosen to support accessibility for in-person interviews. The transition to remote data collection, as directed by governance procedure post-COVID, would have enabled recruitment from a wider geographical area. Conducting remote interviews created no additional challenges, with participants now familiar with online platforms.

Colaizzi's (1978) method of analysis, structured the searching for patterns to find the universal nature of the experience, in a logical sequenced manner. However, method slurring of Colaizzi's (1978) final approach, stage 7, by excluding member checking, diverges against the Husserlian methodology (1983). Instead, sharing verbatim transcripts, initial statements, meanings, and the clustering technique with the supervisory team avoided additional burden to the CCNs who were working at an unprecedented time with additional operational demands and stress during the second and third wave of the pandemic (ICS, 2020). Already indebted to the sixteen CCNs for their commitment, and a belief that thematic analysis should not be tied to one specific framework, this approach captured life experiences and provided situational truth, without causing additional burden for the participants. Decisions on the amendment to the analysis and not seeking member checking, aligns to the work of Lincoln and Guba (1985) and to a relativist approach of authenticity, fitting in the realm of qualitative research (King, et al., 2019). Alternate approaches have been presented, demonstrating how validity has been achieved. The thick detail aims to assist the reader in judging the quality of interpretation of the shared narrative.

By enabling participants to share stories relating to their longevity in practice, the universal commonality was intense and broad. Rather than diluting the main themes with the presentation of all the data, broader additional data will not be wasted; those themes will be shared as opinion pieces at a later point, for example rationale for seeking promotion due to extrinsic rather than intrinsic reward.

As a novice researcher, time has been a challenge; indeed, developing research skills alongside academic commitments has been demanding. Kannangara et al. (2020) refer to the tangible ideas relating to the mindset of students, interrelating resilience, true grit motivation and commitment in the face of adversity. They posited that thriving students are particularly 'gritty and resilient' (Kannangara et al., 2020, p.6).

A personal relationship with a sense of resilience and self-efficacy can be distinguished during the initial period of study, with the challenges of having two family members admitted and subsequently receiving end-of-life care in CC. In addition, my alignment to the CC community, resonated in April 2020, with the need to return to CC when the 'family' was in crisis. Whilst fear consumed the nation, at the time of the pandemic, difficult decisions were made which drew me back to my work-home, the field of study, to support my CC peers. The analogy can be related to a stick of rock, and at a time of crisis, self-efficacy, belonging and resilience were the strong inner thread that pulled me back to support my work-family.

10.1 Strengths and Limitations of this study

- The integrative review located a knowledge gap relating to CCNs ITR.
- International studies have focused on ITL, to address this knowledge gap, this study used descriptive phenomenology to draw together why CCNs demonstrate longevity in the workplace and believe they are thriving.
- These findings present predictors for ITR for experienced CCNs; however, it is acknowledged, predictors for CCNs with less experience may differ.
- The sample was limited due to the fact it was self-selecting and from two sites.

10.2 Summary

On reflection, this was the beginning of my research journey which challenged assumptions regarding CCNs professional work-life; a worthy and valuable outcome. Age is associated with 'grit and resilience' (Kannangara et al., 2020). Whilst this academic achievement, has been completed during my later working years, I am yet to be in the twilight era. The lessons learnt are invaluable to continue my research career and support others to commence theirs; whilst also providing the CC community with new knowledge to assist in the retention of the next generation of CCNs.

Chapter 11: Conclusion

This study was designed to explore and describe the untold story of experienced CCNs work-life and ITR. Demands on the CC workforce due to the nursing shortage, is not new. The literature demonstrated an insufficient empirical base relating to why some CCNs remain in CC, and instead focused on variables including adverse WE, moral injury and the impact of COVID as key predictors for leaving. This provided insight into job dissatisfaction but did not provide insight into how, or if, these factors shaped a CCNs ITR. Using Husserl's (1981) descriptive phenomenology, this rigorous study has illuminated the multiple realities of the experienced CCN, highlighting what is and what is not important in their work-life (Fig. 26). In addition, exploring how these survivors demonstrated longevity and remained highly motivated in an emotive area of work.

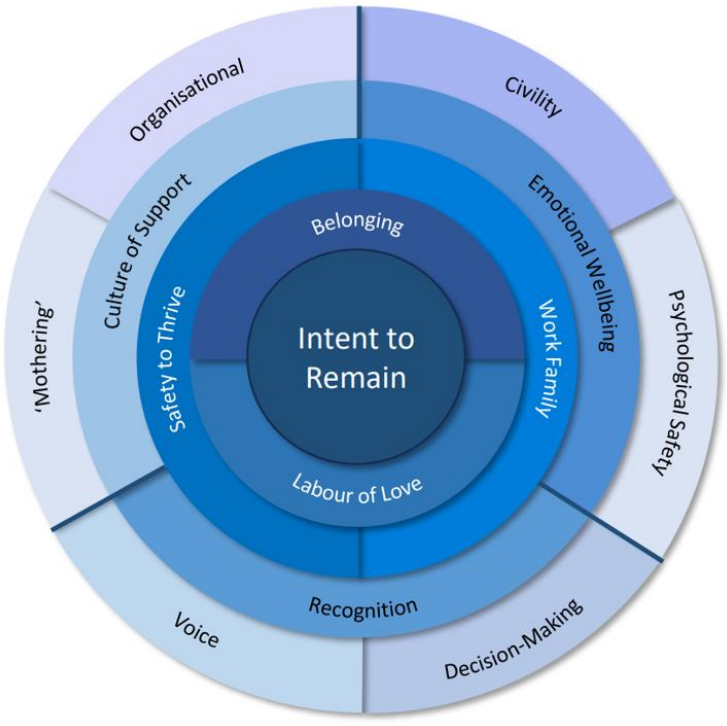


Fig.26: Intent to Remain

The findings, which were full of humanity and utterly absorbing, shed light on CCNs work-life quality and their perception of potential causative factors for ITL. More specifically, the findings describe why they have remained in CC: they have a love for and have found joy in their work, they have found a sense of belonging, whilst preserving their own emotional well-being, within a culture of support.

The value of this research focuses on ITR rather than ITL. The current revolving door of attrition and recruitment requires constant development of professional expertise, which is timely and ultimately financially burdensome. The demand to retain experienced CCNs needs immediate action with strategies developed that instil a sense of belonging and enable thriving.

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Appendices

Contents of Appendices

Appendix 1: Data Extraction Table

EBSCO	Document	Aim	Design, Method & Sample	Results	Comment on Paper
	KEY: Included in chapters				
	Not included: typically, due to lower score on Hawker et al. (2002) Tool				
1	O'Brien, J., Bae, F. A., Kawchuk, J., Reimche, E., Abramyk, C. A., Kitts, C., Mohamad, S., Patterson, C., Palmer-Clarke, Y., & Valiani, S. (2022). "We were treading water." Experiences of healthcare providers in Canadian ICUs during COVID-19 visitor restrictions: A qualitative descriptive study. The Canadian Journal of Critical Care Nursing, 33(2), 24–39. DOI: 10.5737/23688653-3312229	Exploration of the impact of COVID-19 and restrictive visitation policies on healthcare practitioners (HCP's). Canadian	Descriptive study using semi-structured interviews and questionnaires. Data collected June-September 2020 Interviews- 8 Questionnaire responses-187 Thematic analysis	5 main themes: 1) Impacting Healthcare Providers, 2) Communicating and connecting, 3) Perceiving the Impact on Families and Patients, 4) Proposing Solutions with Caveats, and 5) Considering End-of-Life The challenges identified by the HCP's: Managing Work Demands: "There was a lot more work for us" – felt like they were not doing important aspects of their jobs such as assessments. Increased time on phone to families -increasing the advocacy of the nurse. Increased burden as families dissatisfied, with lack of visiting rights.	**good paper but only 1/3 aims apply**- impact on HCW's, others relate to families and recommendations Distress: "We were treading water" – highly charged environment, heightened emotional stress (supporting distressed families, and fear of the virus). Lack of support from leadership, inconsistency of communication. Increased negative coping behaviour from colleagues, additional repercussions regarding emotional health, psychological health, dealt with increased eating, drinking alcohol, and smoking. Moral distress, knowing what was right but not being able to carry it out, stopping family visiting, especially if families distressed. 'Morally challenging keeping them apart', 'inhumane' **Team Morale: "The team coming together"**- saw increased support for one another, saw a closer team, publicly appreciated (cheering for healthcare was emotional' **Heightened stress was causing nurses to leave ICU for other opportunities**
2	Rhéaume, A., & Breau, M. (2022). Antecedents of burnout and	The purpose of this study was to identify	A cross-sectional survey design with data collected during the peak of **the 2nd**	Results indicated that burnout mediates the relationship between moral distress,	**20% of COVID infections were found in healthcare workers. 2,200 nurses died (ICN, 2021). CC at higher risk due to AG Procedures (Mokhtari, 2020)**

	turnover intentions during the COVID-19 pandemic in critical care nurses: A mediation study. The Canadian Journal of Critical Care Nursing, 33(3), 6–16. DOI: 10.5737/23688653-333616	factors that were directly and indirectly associated with burnout and turnover intentions in ICU nurses. Canadian	**wave of the COVID-19** pandemic. Sample- 236 Canadian ICU nurses Online survey and analysed using mediation analysis.	organizational support, resilience, and turnover intentions. **49% of the participants were considering leaving.** The reasons were related to lack of administrative support, poor work environment and safety concerns.	COVID exacerbated already stressful working environment **I2L** -Forty-nine percent (49%) of the participants indicated they were considering leaving their job. Moral distress and futility and burnout led to intent to leave. Moral distress, organizational support and resilience predicted intent to leave through burnout symptoms. **MD positively correlated to burnout and reduced turnover** MD & Organisational support relationship to resilience and intention to leave stronger, burnout less so, weaker, when compared to the other two predictors. CCN's that were supported were more resilient, reduced burnout and less inclined to leave. Recommendations - Managers at all levels must provide support to ICU nurses by being visible and allowing nurses to participate in unit-based policies. Interventions to reduce moral distress must be implemented within critical care units.
3	Rushton, C.H. (2015). Burnout and Resilience among nurses practising in High Intensity Settings. AMERICAN JOURNAL OF CRITICAL CARE. 24: 5	To support creation of healthy work environments and to design a 2-phase project to enhance nurses' resilience while improving retention and	Phase 1: cross-sectional survey to characterize the experiences of a high-stress nursing cohort. Sample: 114 nurses in 6 high-intensity units completed 6 survey tools to assess the nurses' characteristics for burnout and explore factors involved in burnout, moral distress, and resilience.	MD is a significant predictor of all 3 aspects of burnout, and association between burnout and resilience was strong. Greater resilience protected nurses from emotional exhaustion and contributed to personal accomplishment. Spiritual well-being reduced emotional exhaustion and depersonalization; physical well-being was associated with personal accomplishment.	Effects of MD include substance misuse, anxiety and increased job dissatisfaction, disengagement and reduced organisation loyalty and increased intent to leave. Results confirmed relationship between burnout (including factors of hope and resilience) and support the need to develop strategies to reduce vulnerability and emotional exhaustion. Personal accomplishment in work whilst scoring high on burnout scale Hope and optimism drawn upon to cope with stressful environment (form of resilience)

2 Data Extraction Table

		reducing turnover	Statistical analysis determined associations between scale measures and identify independent variables related to burnout.	Meaning in patient care and hope were independent predictors of burnout. Higher levels of resilience were associated with increased hope and reduced stress. Resilience scores were relatively flat over years of experience. scores identified high risk of burnout in CC. Moderate correlation between MD and burnout, therefore maybe a pre-requisite but can contribute to. **Emotional exhaustion greatest predictive validity to burnout**	**Stress and emotional and spiritual exhaustion threaten nurses' authenticity and integrity and their sense of meaning, commitment and hope** **Those scoring low on burnout for emotional exhaustion and depersonalisation scored high on resilience (not associated with age).** **Finding that resilience is relatively constant over years of nursing experience suggests that cultivating conditions of internal resilience to help nurses survive and thrive in high-intensity settings over time may be possible.** Increased spiritual and physical well-being are associated with decreased levels of emotional exhaustion. **Nurses with higher hope scores had the least experience, lower levels of MD, stress and burnout, scored higher on personal accomplishment, therefore hope may fuel work satisfaction**
4	Roney, J., Mihandoust, S., Bazan, G., Patterson, T., Dunkle, S., Whitley, B., Long, J. (2022). Caring for COVID-19 infected patients admitted to redesignated coronavirus ICUs: Impact on nurse stress and burnout. Nurs. Forum. 57:1321–1329	To compare self-reported burnout scores of frontline nurses caring for COVID-19 infected patients with burnout scores captured before the pandemic and in non-COVID-19 units from	Descriptive study conducted using frontline nurses working in eight CC with exposure to COVID-19 infected patients. Nurses surveyed in 2019 & 2020 using Maslach Burnout Inventory (MBI), Well Being Instrument, and Stress-Arousal Adjective Checklist (SACL) instruments. Explored relationships between survey scores	Nurses working in COVID-19 units experienced more emotional exhaustion (EE) and depersonalization (DP) than nurses working in non-COVID units (p= .0001). Pre-COVID nurse burnout scores across six CC units (EE mean = 15.41; p= .59) were lower than burnout scores in the COVID-19 CC (EE mean = 10.29; p= .74). Clinical significance (p= .08) increases from low pre pandemic to moderate during the pandemic.	Locating associations between COVID-19 infection and CCN burnout may lead to innovative strategies to mitigate burnout in those caring for the most C. ill individuals during future pandemics. **More burnout caring for COVID-19 patients** 70% of CCN's worked additional shifts during COVID- stress and burnout may be associated with this Higher emotional exhaustion and depersonalisation scores recorded in those working in COVID 19 CC's Reduction in personal accomplishment not significant but maybe due to helplessness, futile care delivery and unprecedented number of deaths

		two prior studies	and working in COVID-19 units. Sample 51 (female FT, no OT in pre sample,) 52 (male and female in 2020) Control units PICU, NICU	COVID 2019 globally impacted healthcare due to surges in infected patients and respiratory failure. The pandemic escalated nursing burnout syndrome (NBS) across the workforce, especially in CC potentially leading to long-term negative impact, on retention and patient care. **CCN's stress higher in post group-2020**	denial of virus existence, policing of vaccines and mask wearing, lack of public support, led nurses to leave workplace and profession Recommendations for emotional and physical support systems including rest rooms, serenity rooms, guided mindfulness, hydration and nutrition stations. NBS increased prevalence, urgency for preventative measures as NBS a global issue for CCN's Mental Wellness should be recognised by all organisations, as much a priority as patient healing
5	Fitzpatrick, J., Campo, T.M., Graham, G., Lavandero, R. (2010). Certification, empowerment, and intent to leave current position and the profession among critical care nurses. AMERICAN JOURNAL OF CRITICAL CARE. 19: 3	To examine relationships between AACN specialty certification, empowerment, and secondarily, to examine variables as related to intent to leave the current position and nursing profession.	Online survey Sample: 6589 / 44,143 CCN's (15% response rate) USA	Feeling of empowerment differed between those with and without speciality certification 41% intent to leave current position, 18% within the next year. 7% leaving profession Significant between those with speciality course and those not **Education level impacted on those who intended to leave the current position**	**Affirmation of the value of speciality certification** **CCN's are highly skilled and costly to replace** Empowerment based on Kanter theory. **Compared to Ulrich where their findings suggested leaving the unit not the profession – for another position. 94 % would remain in profession** **Empowerment scores higher in those with course** **Those with increased empowerment were more likely to remain** **Younger nurses were more likely to leave, men were more likely to leave, ethnic groups were more likely to leave** - all warranted further investigation Generally satisfied with career
6	Celik, F., Dagli, R. (2021). Comparison of the Mental Status of	Aim of study was to compare the	COVID-19 pandemic may predispose intensive care	Female gender, being a nurse, and working in COVID-19 CC, were associated with higher	The COVID-19 pandemic has adversely affected the mental health of CCN's.

	COVID-19 Intensive Care Unit and General Intensive Care Unit Staff. Duzce Med J, 2021;23(2):197-204. doi: 10.18678/dtfd.915010	COVID-19 fear experienced by COVID-19 intensive care unit staff and general intensive care unit staff, and the effects of this fear on mental health Turkey	staff to experience mental health problems. Quan study Questionnaire (Fear of COVID-19 scale and DASS 21 depression and anxiety scale. Sample 156 CCN's 90- COVID-CC 66- General CC	depression, anxiety, and stress scores. Significant relationship was found between fear of COVID-19 and depression (ρ=0.399, p=0.044), anxiety (ρ=0.456, p=0.019), and stress (ρ=0.418, p=0.033). CCN's in COVID-19 CC who may have high-risk contact were approx**. twice more likely to experience anxiety and fear of COVID-19 and 3.5 times more likely to suffer from depression and stress.**	**Fear of COVID-19 led to an increase of anxiety, depression and stress values.** Attention should be paid to the mental health of females and nurses working in the COVID-19 CC. The mental health of CCN's should be supported to protect the health workforce
7.	Ulrich, B., Barden, C., Cassidy, L. Varn-Davis, N. (2019). Critical Care Nurse Work Environments 2018: Findings and Implications. Critical Care Nurse. 39:2. :67-84	Evaluate the current state of CCN work environments. American	Online survey to collect quantitative and qualitative data for mixed-methods study. Sample: 8080 American Association of CCN (AACN) Comparison for previous studies on HWE in 2008 & 2013	The health of CCN work environments has improved since the previous study 2013. Still areas of concern and opportunities for improvement. Key findings: absence of appropriate staffing by more than 60% of participants; an alarming number of physical and mental well-being issues (198 340 incidents reported by 6017 participants); 1/3 expressed intent to leave their current positions in the next 12 months; and evidence of the positive outcomes of implementing the AACN Healthy Work Environment standards.	Standards est. 2005- outlining 6 essential standards for HWE: skilled communication, true collaboration, effective decision making, meaningful recognition, appropriate staffing, authentic leadership. HWE impacts on nurse outcomes-positively correlated with psychological health, job satisfaction, retention and negatively corelated with burnout and emotional strain Association between HWE and interpersonal relationships- nurse- manager/ nurse/ physician Effects patient care quality Influences incidents at work Largest improvement – RNs are relentless in pursuing and fostering true collaboration. – positively associated with job satisfaction and intent not to leave current position Respect and meaningful recognition- improved and positively associated with not to leave current position. RN report recognition is more meaningful when it comes from patient and families and is positively associated with job satisfaction and not to leave current position.

				Perception of WE- improvement from previous studies, higher in workplace than in organisation, Highest ranking- -as proficient in communication as clinical skills -recognise others for the value they bring to work -decision making processes in place to incorporate families and patients -RN pursue collaboration -Opportunities to influence care decisions lowest ranking: -Nurse leaders engage with others in achieving HWE -RN engaged with selection, adaption of technology to increase effectiveness of work -Staffing ensures effective match between patient allocation and RN -Structured process for resolving disputes among healthcare team -Formal processes to evaluate staffing decisions on patient and system outcomes	**Concern- staffing, nearly 40% saying they have the right nurses with the right knowledge 75% of the time.** 68% - organisation values RN safety and were reported to happen frequently (verbal, physical, sexual harassment and discrimination – 80% reporting verbal abuse had happened in the last year mainly from patients and families **MD increased from 9.4% to 10.6% which related to decreased job satisfaction** **Job satisfaction – high in being a RN lower in current role- 56% would promote nursing as a job role.** **Intent to leave – 54% would leave in the next 12 months- 3 years. Reasons to remain would include – increase staffing, increased salary and benefits, better leadership, increased respect from administration, more meaningful recognition. Nurses in HWE were less likely to leave.** **45% of those intending to leave would remain in profession, 9% would retire**
8.	Guttormson, J., Calkins, K., McAndrew, N., Fitzgerald, J., Losurdo, H., Loonsfoot, D. (2022). Critical Care	To describe the experiences of ICU nurses during the	US CCN's working during the COVID-19 pandemic Descriptive study Survey design from Oct 2020 - Jan	Themes- **burden of COVID-19** due to absent family, patients dying alone. **Feeling helpless-** poor outcomes**, makes you feel like you are failing. Witness**	**CCN report unprecedented and immense burden during COVID-19** CCN's reported stress related to a lack of evidence-based treatment, poor patient prognosis, and lack of family presence in the ICU.

	Nurses' experiences during the COVID-19 Pandemic: A US National Survey. AMERICAN JOURNAL OF CRITICAL CARE. 31:2	COVID-19 pandemic in the United States.	2021 advertised through social media and AACCN. Three open-ended questions focused on the experiences of ICU nurses during the pandemic. Sample 498 CCN- 285 completed the open-ended questions	**suffering- haunting and moral distressing watching patients calling families prior to being ventilated;** causing stress**. Unlike anything experienced before, worst nightmare, utter devastation, Emotional and psychological impact- MD fear and anxiety daily- multiple symptoms- disturbing physically mentally and exhausting. Fear for family and loved ones- petrified going home, causing potential harm, uncertain of effectiveness of PPE, proud to be a nurse but if I lose someone it would not be worth it.** **Lack of social support**-lack of understanding from family, or community, hard to explain how it had been physically and emotionally wrecking **Impact doesn't end for nurses**-long term effects, **can't unsee what we have seen,** **Failure of healthcare system**-lack of leadership, teamwork and resources. **Nurses felt expendable**. No recognition. No encouragement, thank you, threat of losing job if we spoke up.	CCN perceived inadequate leadership support and inequity within the HC team. Lack of consistent community support to slow the spread of COVID-19 or recognition that COVID-19 was really increased CCN's feelings of isolation. CCN reported physical and emotional symptoms including exhaustion, anxiety, sleeplessness, and MD. Fear of contracting COVID-19 or of infecting family and friends was also prevalent. **Understanding these experiences provides insight in areas to address to build and sustain CCN workforce.** Shortage of PPE & ventilators Important point **Did not sign up for this-** never agreed to risk my life. **Regret of becoming a nurse-**some questioned choice of profession, doubted self-resilience, wished I had never become a nurse. Limitation – those feeling more stress may not have responded Good reference to social / community change

				Unsupported HC team- inequity in risk, medical team didn't enter rooms. Not in it together. Inadequate resources and staffing, **partly due to nurses leaving.** 6 CCN for 25 beds. Burden increased by physicians not having CC training. Not enough supplies. **COVID-19** is real emotional response due to public not believing information about the pandemic. **Seeing so much death and having to validate the existence of COVID.** Some live lives like nothing has happened, 'slap in the face to those that have died'. **Positive experiences and outcomes -**personal and professional positive effects- strength in team, positive support from family, recognition from nurses, professional transformation. Appreciation from community- humbling Strength in teamwork – although some wrote about no teamwork others identified immense support, from fellow team/ nurses. Pulling together, part of something important, got through the questioning of our abilities,	

				Personal and professional transformation – finding ways to maintain hope, honest victory for those that made it out alive, revealed my strength, increased skills, Recognition of nurses- elevated recognition in HC system. Nothing positive – some wrote nothing and wouldn't have become a CCN if they had known this	
9.	Ulrich, B.T. Woods, D., Hart, K., Lavandero, R., Leggett, J., Taylor, D (2007) Critical Care Nurses' work environments. Value of excellence in Beacon Units and Magnet Organisations	To examine CCN's view WE and nursing as a career when working in units that are recognised for excellence or pursuing such recognition	Part of a larger study online questionnaire Pilot study completed prior Sample – all AACN 4034 respondents – 3332 responded they worked in a Magnet status hospital and2897 worked in a beacon status of unit	16 survey items – CCN asked to relate to organisation and unit Communication & collaboration Shared Governance, Respect, Recognition and reasons for staying. Skills of staff? Chief Nurse Exec, Support for continuing education, Satisfaction Quality of Care	**Main reason for remaining was the people they worked with (50%+)** **Communication – poor collaboration, effecting patients and families** Positive relationship with working in magnet organisations – staff more satisfied. **Authentic leadership is critical** – impacts on decision to remain. Patient outcomes – increasing evidence that healthy work environment is related to patient safety **<u>Lower score on HAWKER</u>**
10	Milligan, F., Almomani, E. (2020) Death anxiety and compassion fatigue in critical care nurses. BJNursing 29 (15) 874-879	Assess attitudes towards death and dying in a multicultural cohort of CCN's hypothesis-barriers and enablers to compassionate care are	Ethical approval Mixed method approach-quan non-random purposive sampling CCN Participants 255 in Qatar & (no's=8) questionnaire using DAP-R and demographic profile Pearson chi-square Predominantly female – with BSc worked in organisation 2-11 years	Death viewed as a reality, fear of death positively correlated to qualification, gender and time in CC. Neg correlated with time employed in organisation years in CC were associated with approach acceptance. Contributory factors were migration of workers, long time	Background -Provides good definition of compassion, empathy. CC curative rather than palliative- little education on care of dying – leading to compassion fatigue. Can compassion be taught coping mechanisms as a method of survival <u>Female and longer working time in CC were risk factors for presence of compassion fatigue</u> very small sample size, non-UK study **useful for compassion – less so for retention**

		multifactorial and include interpersonal causes	with 7-11 years speciality experience.	away from family support, financial support, qual data surmised that 1-focus was on competent care not compassionate care 2-staff shortages and turnover of patients were barriers compassion fatigue influenced by financial constraints – functional nurses less sympathetic /biomedical approach rather than patient centred - reduce the emotional cost of caring	**<u>Lower score on HAWKER</u>**
11	Bateman, M., Hammer R., Byrne A., Ravindran N., Chiurco J., Lasky S., Denson R., Brown M., Myers L., Zu Y., Denson JL. (2020) Death Cafes for prevention of burnout in intensive care unit employees; study protocol for RCT. Bio med Central. 21(1) 1019	Study protocol for systematic trial of preventing healthcare employee's burnout using reflection and nourishment (STOPTHEBURN) Hypothesis death cafes will lead to lower rates of burnout in physicians and nurses	Single centre RCT 2-arm Evaluation of impact of death café debriefing interventions Detail of interventions, sequencing, blinding, recruitment, data collection data management, confidentiality Sample 200 Using Maslach burnout inventory and secondary scoring using Patient Health questionnaire PHQ-8 and General Anxiety scoring – measured at 1, 3 and 6 months	Implications of protocol- burnout substantial issues that needs interventions in place to reduce burnout – evaluation of death cafes Pilot study plan to focus on multicentre	**Excellent overview of study protocol – no results** **ICU clinician burnout exceeding 50% so relevant protocol** **<u>Low score on Hawker tool</u>**
12	Kelly, L, Lefton, C. (2017). Effect of meaningful recognition	To examine meaningful recognition	multicentred national descriptive online survey	Similar levels of burnout and traumatic stress, compassion fatigue and intent to leave were	**I2L- 40% had considered leaving profession** **Job enjoyment – higher in female and older CCN's**

	on critical care nurses' compassion fatigue. American Journal of CC. 26(6). 438-444	and other factors on compassion fatigue in CCN's American	Sample 726 in 14 hospitals with recognition programmes and 410 in hospitals with no recognition programmes Measured using professional quality life scale – 3-part survey Pro-qual measured compassion fatigue	found in hospitals with or without recognition programmes Meaningful recognition reduced burnout, and increased compassion satisfaction Job satisfaction job enjoyment highly predictive of reduced burnout	**acknowledging and valuing nurses' contribution as meaningful recognition reduces burnout and boosts compassion satisfaction** ******Related to age- inexperienced and younger have increased compassion fatigue ****not burnout** Good definitions of compassion fatigue – reference to chronic emotional stressors **<u>NOT mentioned was career ladder as meaningful recognition</u>**
13	Kagan, I. Lancman, N., Weisbord, I. (2022). Experiences and psychosocial predictors of professional function among intensive care nurses under the shadow of Covid-19: a mixed methods study. Journal of Nursing Scholarship. 55. 787-798	To examine challenges faced by CC nurse managers in operating and managing CC units and the relationship between uncertainly, stress, burnout hope and professional functioning among CCN's during covid pandemic	2 phases- mixed method 2 focus groups with managers (no 15) Questionnaire with CCN (no 145) Descriptive analysis Descriptive statics	2 themes- challenges of COVID-19- physical and emotional overload – working in PPE, distancing, lockdown and fear – mentally home life, emotional strain of death, increased numbers of death. Uncertainly of situations / working environment – adapting to different settings, high concentration, reduced quality of care, overload, mental fatigue, Positive effects of pandemic – empowerment and strengthening of professional values, situation was treated like war, pride in nursing. -leadership and team working, important to be part of a team, managers stated it was important to be a role model for others, making decisions in	**3rd wave sample- maybe effected findings.** **Known- CCN's report physical and emotional stress during pandemic – compounded by fear of contagious disease – sense of professional failure due to mortality, isolation and death of colleagues- lead to decline in professional functioning and suicidal thoughts.** **Intro- good reference to burnout** **Motivation traits – based on personality and situational.** **Hope- positive on stress levels** **higher the emotional stress the higher the more burnout felt, lower professional functioning – high burnout the lower the hope** Qual data reinforced need of rest, nutritional support, and distraction through hobbies, , importance of mutual support, importance of family life **<u>PRIDE in Nursing</u>**

				difficult situations made us grow. Mutual support improvement in resources – increased burden of new staff, positive was the entry of new young nurses.	
14	Steinburg, B.A., (2017). Feasibility of a mindfulness-based intervention for surgical intensive care unit personal. American Journal of Critical Care. 26 (1). 10-18	Pilot Study to determine the feasibility of a work-based intervention to reduce the impact of workplace stress Hypothesis was that increasing resilience through mind-body intervention would decrease the effects of stress and risk for burnout	1 site, approved by ethics. Randomly assigned, to control or intervention group. 2 assessments points – 1 week prior to intervention and 1 week post the final intervention. Participants – 32, mean age 40 years, 78% female, mean time in CC 11 years (.5 – 35 years) Intervention – 1 session weekly mindfulness and yoga, suggested undertaking daily at home Data collection- questionnaire Maslach Burnout Inventory ProQol scale, diaries and attendance recording Scale includes- emotional exhaustion, depersonalisation and low personal accomplishment. Statistical analysis	Participants described their environment as highly stressful, turnover rate was 6% Intervention was well received with 100% retention rate post questionnaire- intervention found to be important, conducting it with co-workers very important, found to reorganise stress, deal with stress levels, all were still undertaking mindfulness 8 months later. no change to missed days from work in control or intervention group. work engagement – increased vigour, dedication to work, for the intervention group – no change to control group. negative correlation to intent to leave – suggesting intervention benefit co-workers, decrease turnover and benefit the organisation as well	**Small sample** Participants considered themselves healthy and satisfied with their quality of life Intervention appears to have increased dedication to work and suggest reducing intent to leave – not sure how this was measured **Limited transferability/ relevance to study - minor reference to intent to remain/ leave** **<u>Lower score on HAWKER</u>**
15	Kester, K., Pena, H., Shuford, C., Hansen, C.,	To implement AACN healthy	Site – cardiothoracic ITU	42% response rate	**Discussion – introducing the AACN HWE structure improved work environment**

	Stokes, J., Brooks, K., Bolton, T., Ornell, A., Parker, P., Febre, J., Andrews, K., Flynn, G., Ruiz, R., Evans, T., Kettle, M., Minter, J., Granger, B. (2021). Implementing AACN's healthy work environment framework in an intensive care unit. Amer Journal of Critical Care. 30 (6).	work environment framework and evaluate staff satisfaction, turnover and tenure two years later	Pre - post intervention design with 2 independent cohorts. AACN HWE questionnaire – Likert scale – 18 questions Sample – 165 Intervention – communication class, increased staff meetings (nights and weekends), monthly newsletter, interprofessional huddles, Collaboration – endorsed handovers, daily interprofessional rounds, daily leadership rounds,	Statistical analysis- 2 tailed t-test Meaningful recognition – lowest scoring rate Improvement in elements scoring not significant – overall significant improvement Nurses stayed in their jobs longer, turnover was stable Topmost reported reason for leaving – was to pursue practitioner level and secondly due to relocation Those that left went for internal transfer opportunities Effective decision making – practice-based evidence, research groups and performance groups, transparent changes to policy/ guidelines, Appropriate staffing – matching patient needs and nurse competence, unit-based scheduling, Meaningful recognition – achievements included on newsletter, increased socialisation, personalised gifts, years of service breakfast, preceptor of the month, self-care and resilience recognition, thank you notes publicly placed,	The survey enables evaluation or progress. **Nurse engagement was improved which may lead to decreased burnout and improved joy in the workplace** **Nurse tenure improved** **Aligned to other studies that involving nurses in activities draws them into the cultural content of the unit** **Education increases sense of ownership of practice** **Meaningful recognition is different for each person – and therefore the most difficult to achieve – honouring personal preference is challenging** **Results noted those that work in healthy environments stay in their jobs longer, experience less moral distress and deliver high quality care** **HWE fosters joy at work and positive relationships, excellent patient care** **EBP allow assessment and identification of gaps** **framework allows for measurement and benchmarking, making improvements more visible** Authentic leadership- promoting staff satisfaction, staff engagement, intent to stay. **Limitation – less than 50% response rate, no allowance for open ended responses**

16	Sung-Heui, B. (2021). Intensive care nurse staffing and nurse outcomes: a systematic review. Nursing in Critical Care. 26. 6, 457-466	Examine nurse staffing in the ICU and synthesize literature to examine the relationship with nurse outcomes such as job satisfaction, burnout, fatigue, and intent to leave.	Systematic review – based on preferred items for Systematic Reviews and meta- Analysis guidelines. Peer reviewed published between 01/2000-09/2020 Quality assessment and validity tool for correlation studies used for quality appraisal. 8 studies reviewed	**8 studies included** 3- found relationship between nurse staffing and adverse nurse outcome (6 outcomes measured - burnout, fatigue, emotional exhaustion, depersonalisation, and stress)- not significant. Staffing levels was negatively correlated to adverse nurse outcomes- nonsignificant	**mixed relationship between nurse staffing on nurse outcomes.** **Burnout had consistent relationship with nurse staffing** positive relationship between nurser staffing and adverse nurse outcomes Nurse patient relationship positively related to burnout, stress and fatigue. Job dissatisfaction and plan to leave were NOT related to patient ratio nurse staffing was negatively correlated to stress, job dissatisfaction, high burnout, plan to leave and back pain COVID hasbeen linked to disconnect and emotional exhaustion. when nursing staffing is worse there are higher levels of nurse outcomes This study nurse outcomes that were significant were burnout, fatigue emotional exhaustion depersonalisation and stress – all related to staffing levels Safe staffing is important – inconclusive evidence found here More evidence needed
17	Yoon, J.E., Cho, O-H., (2022). Intention to stay in specialist trauma nurses: relationship with role conflict, stress and organisation support. Journal of Trauma Nursing. 29.1 21-8.	To examine the levels of and relationships among role conflict, occupational stress, perceived organisational support and intent to stay	Retrospective cross-sectional study 53 CCN from 8 regional trauma centres in Korea. Structured questionnaire - role conflict, occupational stress, perceived organisational support and intent to stay	High intent to stay associated with periodic training, job satisfaction, and perceived high workload Role conflict positively correlated with occupational stress, both negatively correlated with perceived organisational support Intent to stay negatively correlated with occupational	**Small sample size- new trauma centres** **Role of specialist trauma nurse different to that of UK, USA CCN.** They have unclear JD, role conflict, identity confusion, leading to diminished self-esteem, high occupational stress lack of systematic training – turnover rate high in comparison to RN. Enticement gift to complete $8 higher proportion of male nurses, moderate level of job-related stress

			Man-Whitney U test, Kruskal-Wallis test and Bonferroni post hoc test Spearman correlation coefficient used to examine correlation Role conflict measured with Kim & Park (1995)- 34 items Occupational stress- Chang et al (2005) tool- 24 items Perceived organisational support- Korean version of Wayne et al (1997)- 9 items Intent to stay- Cowin (2002) tool 6 items Analysis – IBM SPSS,	stress and positively correlated with organisational support median age 30yrs 93% did not receive periodic job training- intent to stay was higher for those that did 66% job satisfied role conflict positively correlated with occupational stress intent to stay negatively correlated with occupational stress and positively correlated with organisational support	Intent to stay was higher than among general nurses, higher intent to stay for those receiving additional periodic education **professional self-efficacy positive impact on intent to stay** **Higher workload showed higher intent to stay- contradictory to previous results.** **? more pride in role, meaningful job role** **Advanced practice nurses chose more advanced career paths – strong motivation, higher pursuit of self-improvement.** **lower organisational support – causing higher conflict with role and occupational stress** **Good working relations have positive impact on stress- and linked to intent to remain** **Not significant with role conflict and intent to remain like other studies such as O'Brien-Pallas et al 2010** Completion time 25 mins
18	Elpern, E. H., Covert, B., Kleinpell, R. (2005). Moral distress of staff nurses in medical intensive care unit. American Journal of Critical Care. 14. 6 523-530.	To assess level of moral distress of nurses in medical ICU, identifying situations that result in high levels of moral distress, explore implications of	exploratory, descriptive study Questionnaire Ethical review Corley MDS scale – 38 clinical situations Free text response 28/39 responses Analysis- SPSS Pearson for correlation	Overall moderate intensity of moral distress Greatest cause of MD – provision of aggressive care thought not to be in the best interest of the patient – high frequency of MD Years of experience in CC positively correlated with MD MD top score- participate in care for hopelessly ill patient/	**Small sample- moderate levels of stress overall** **clinical situations determined that are associated with MD- intensity and frequency occurred when providing unnecessary care that it would not benefit.** 1/5 patient deaths in USA involves CC- difficulty in differentiating between critical illness and terminal illness **More years of experience – higher levels of MD – suggestive of accumulative weight of burden / distressing situations – arguing against desensitization to MD over time**

		moral distress and evaluate association among moral distress and individual characteristics of nurse	Sample 24 with 11 years + CC experience 72% response rate	follow family wishes to support patient not in their best interest/ prolonging death/ carrying out unnecessary orders, carry out that does not relieve suffering- fear of bringing forth death 20 provided descriptive responses – thoughts of leaving, keeping dead people alive, won't stay here forever Feelings of powerlessness, hopelessness and lack of support No one helps the nurses, continual exposure to this type of care, day in day out	**MD primarily impacts on job dissatisfaction, burnout and loss of nurses in the workplace** **Previously unreported finding – reoccurring association of MD with unwillingness to participate in blood and organ donation – seeing wastage who were not expected to benefit- potential bias noted by researchers due to high numbers of liver transplantation on the unit**
19	Stone, P.W., Mooney-Kane, C., Larson, E.L., Pastor, D.K., Zwanziger, J., Dick, A.W., Stone, P. (2007). Nurse working conditions, organisational climate and intent to leave in ICU's: an instrumental approach. Health Services Research, 42.3 1085-1104.	To investigate cause of nurse intention to leave, simultaneously considering organisational climate in intensive care and identify policy implications (labour market, plentiful alternatives)	Multiple source- surveys, hospital administrative data, 837 nurses, in 39 adult ICUs from 23 hospitals in 20 metropolitan states No research reviewed OC & ITL- poor OC may motivate nurses to leave and high turnover may negatively affect employees' perceptions of OC **11% male** **Mean time in CC 9.2** **15% ITL is next year**	41% response rate – 89% female- aged 30-44 years old OC inversely related to ITL Nursing experience significantly related to ITL, with nurses with less than 1 year or between 10-11.5 years significantly less likely to leave nurse experience significantly related to OC, and reduce ITL No link of hours of work to OC or ITL Wages are not enough to retain nurses – OC may be more of an effective strategy	**CCN Turnover recognised as an issue, nurse turnover much greater than other healthcare professionals** **ITL is the antecedent to turnover (Griffeth et al 2005). Organisation climate is the employers' perceptions of organisational features such as decision making, leadership and norms in the workplace. (Stone et al 2005)** Patient acuity, wagers, nurse patient ratios, agency use are related to OC & ITL **Employer characteristics also relate to ITL and OC- gender, education, job experience and employment status** **SUPPORTS PILOT – over 11.5 years intent to remain- need to keep them value them and then they stay** 15% ITL- causing negative effect of hiring costs, education OC affected by wages, teaching and hospital status

			Tool perceived Nurse WE Scale		
20	Rivaz, M., Tavakolinia, M., Momennasab, M. (2021) Nursing professional practice environment and its relationship with nursing outcomes in intensive care units: a test of the structural equation model. Scan J Caring Sci: 35. 608-615	to investigate the relationship between the nursing professional practice environment with nurses' burnout and intention to leave in intensive care units, using structural equation modelling analysis	Cross sectional, multi-centres trial 320 nurses across 20 ICUs in 5 teaching hospitals Inclusion – 1 year in CC 72% female/ 28% male responses Data collected between 0918-0619 Using Nursing Professional Practice environment questionnaire (NPPEQ) Maslach Burnout Inventory (MBI) and anticipated turnover scale	High level of burnout – emotional exhaustion, personal accomplishment, and depersonalisation High level of intention to leave – significant correlation between burnout and intent to leave Professional collaboration, transcendental professional collaboration and resource adequacy most significantly associated with burnout Improvement in the environment decreased the burnout Inappropriate staffing, and lack of resource led to increased workload, job dissatisfaction and increased burnout- thereby reducing quality of care	**Iran does not have comprehensive data on burnout, shortage of skilled nurses and associated poor practice** 320 response rates ?? from what original number targeted **Strong link between burnout and intention to leave** Good explanation of tools for data collection Improving environmental factors would reduce burnout – and reduce intent to leave by 4 times the amount improving professional collaboration had the most effect **significant correlation between burnout and intent to leave- 93%** 2/3rds of CCN indicated severe burnout Monitoring work environments and making favourable changes is necessary to keep skilled workforce in profession and ensure safe patient care Link to reducing intent to leave by improving environmental factors
21	Levi, P., Patrician, P.A., Vance, D., Montegomery, A., Moss, J., (2021). Post traumatic stress disorder in Intensive Care Unit Nurses: A concept analysis. Workplace Health & Safety. 69. 5. 224-234.	to review PTSD in CCN's and its impact on their lives, patient care and health organisations	Concept analysis using Walker and Avant concept analysis 3 cases demonstrate model case, border line case and contrary case	Attributes of PTSD- physical and psychological symptoms Re-experiencing, avoidance, negative alterations in cognition and mood, hyperarousal Consequences for the patient- poor sleep quality from re-experiencing led to exhaustion, avoidance of similar patients,	**Related to work environment, not so specific in title** **Useful background – CCN's 23% meet criteria for PTSD, general nurses 18%. Burnout caused by excessive stress over extended time** **Turnover currently 18% in CCN (USA),** replacement cost high due to education and training required **Ample research on PTSD limited in unique application to CCN** **<u>Excellent section for search strategy</u>**

				lack of quality care, limited concentration, lack of empathy, medication errors, **Reports of decreased job satisfaction, desire to leave affecting organisation financially**	Relates to the need for a healthy work environment to reduce risk of PTSD
22	Ndlovu, E., Filmater, C., Jordaan, J., Heyns. (2022). Professional quality of life of nurses in critical care units: influence of demographic characteristics. South Afr. J Critical Care 38.1. 39-43.	to describe the demographic factors associated with professional quality of life for critical care nurses working in Gauteng, SA.	cross sectional study in 8 CC units in 3public hospitals in SA. Data collected Jan-May 2020, during 1st wave of pandemic Total population sampled 225, 115 with CC certification, 86 RN's & 24 EN, all FT and worked in CC for more than 1 year. Data collected using PQOL tool – ProQoL-5 (30 items. Validated tool reviewing feelings, of compassion satisfaction, burnout and secondary trauma SPSS used for data analysis	68% response rate – Cronbach reliability -good Age mean 45 years, worked in CC average 12.57 yrs. (1-35) 59% held CC certification Majority of participants experienced low to moderate compassion satisfaction, moderate to high burnout and secondary traumatic stress – no diff across age range, or qualification **More experienced reported higher compassion satisfaction** **More educated reported greater secondary stress** All influenced by number of patients they cared for – those caring for one patient had higher compassion satisfaction and lower secondary stress, those caring for one patient had lower burnout than those	**Abstract good, title not so informing.** Neg professional QOL = compassion fatigue, positive professional QOL = compassion satisfaction. Compassion fatigue can be subdivided into burnout and secondary traumatic stress. QOL especially important in CC due to nature of patient and vigilance required Good link to COVID Chronic exposure to stressful work situations increases risk for compassion fatigue Noted effect of COVID and already higher levels of moral distress

				caring for more than one patient	
23	Bergman, L., Falk, A.C., Wolf A., Larsson, I.M., (2021) Registered nurses' experiences of working in the intensive care unit during the COVID-19 pandemic. Nursing in Critical Care. 26. 467-475.	To describe Swedish nurses' experiences of caring for COVID_19 patients in ICU during the pandemic	Mixed method survey design. Online questionnaire distributed through social media to RN's in ICU during the outbreak. 13 MCQ, 3 open ended – how nursing care has been affected, give example of affected care and detail a significant event that the CCN has experienced during the pandemic Data collected for 1 week (May 2020). Analysed using content analysis and descriptive statistics	282 responses – 54% CCN's (151) Ratio of or care 1:3 Non CCN- 19% received introduction 3 themes- tumbling into chaos, diminishing nursing care and transition into pandemic ICU care. Patient safety compromised, nursing care severely deprioritised, resulting in ethical stress. Increased workload, worsened environment affected health and wellbeing / psychological and physical well-being Being in a war zone- increased patient car, redesign of units, increased bed capacity, lack of resources such as ventilators, sedation Sidestep safety routines prioritisation of resources, lack of support from ICU management Increased responsibility – non-ICU nurses, increased patients,	**5% of COVID cases required admission to CC** (Wu, McGoogan, JAMA 2020), **Prevalence of mortality in CC 39%** **Ethics recognised but not required as no sensitive patient requested** **42% have above 10years experience** 19% of non CCN received preparation training – describing their lack of competence and confidence – informed they would work closely with CCN instead often had 2/3 patients of their own **Only 179 answered 1 or more of the questions** Lack of support from management **Psychological affect** – nightmares, thinking about work, stress, exhausted, physically and mentally demanding **Diminished nursing care –** turned into assembly line, all patients given same kind of treatment – nursing care severely deprioritised due to time competence and resources – care had to be 'good enough' which caused challenges. No contact with relatives or performing nursing duties, such as psychological care including patient diaries – technical and non-technical skills **Companionship was amazing and solution finding – work was surreal, surrealistic and demanding – yet have experienced some of the best times as a nurse** **Query have the strength to carry on in healthcare** **50% of CCN perceived insufficient support during this time.** **Feeling of unpreparedness – more hands is not necessarily the answer when quality is suffering**

				demands of working in PPE- psychological effect of feeling you personally might die Constantly thinking of work	**Limitations – small sample from designated group, early data collection in covid period** **Implications and recommendations- long term effects could be nurse turnover and contribute further to nurse shortages** **Short- and long-term support required to mitigate physical, psychological illness and burnout**
24	Currey, J., Sprogis, S.K., Orellana, L., Chander, A., Meagher, S., Kennedy, R., Driscoll, A. (2019). Specialty cardiac nurses' work satisfaction is influenced by the type of coronary care unit: A mixed methods study	To explore specialist cardiac nurses' perceived work satisfaction across 4 CCU's and differences in satisfaction dedicated and hybrid CCU's	mixed method study, two phases in 4 CCU's (2 dedicated, 2 hybrid) completed professional practice environment scale (38 subscales) PPE- (no 74) Phase 2- 17 cardiac ICU nurses interviewed exploring elements of PPE scale- 1 focus group and 13 individual interviews Descriptive inferential stats for phase 1 – content analysis for phase 2	high levels of satisfaction with workplace One hybrid unit was less satisfied in comparison to the other 3 units No overall significant difference in level of satisfaction between types of units Qual data results highlighted nurses in hybrid unit felt less in control, lacked autonomy, had poor relationship with physicians and experienced inadequate nurse leadership Handling disagreement- highlighted as very important by specialist nurses – burden resulted if not dealt with- mainly between spec nurses and managers, spec nurses and medical team and between colleagues Poor comms with mangers- if challenge or put forward suggestions, managers feel threatened and make life difficult with medical team it	Overall satisfaction is high- no significant different across units structure of units and leadership skill can impact on nurse satisfaction with workplace and collegial relationship Strong leadership and respect of nursing expertise and the importance of patient safety positively impacts nurse satisfaction All participants held a specialist qualification **Motivation was internal and self-generated** **Less identity in hybrid unit- - nature of unit took away some satisfaction – less satisfied in some areas relating to control of practice** **<u>Although initially scored high in validity, not applicable to question, not included in literature review</u>**

				related to nine timely responses internal work motivation – gratification working in spec area, commitment to job role, placing patients at centre of practice – motivation was internal and self-generated Control over practice – dissatisfied with their level of influence, frustrated by level of knowledge of non-cardiac nurses – therefore no strong identity for a cardiac nurse in hybrid unit – insufficient status Perceived less specialist care in hybrid unit Leadership and autonomy – recognised their freedom to exercise judgement in timely fashion Limited opportunity for progression. staff relationships- perceived as important – can aid to feel respected	
25	Breau, M., Rhéaume, A. (2014). The relationship between empowerment and work environment on job satisfaction, intent to leave and quality of care among ICU nurses. Dynamics. Canadian Critical Care Nurses. 25.3. 16-24.	To determine whether empowerment and work environment predict job satisfaction, intent to leave and quality of care amongst CCN's.	online survey 30% response rate 533 responses Respondents- 14% male, 86% female 31% response rate Average age 43yr Nursing worklife model Canadian	**3% I2L unit or employer -** reasons for leaving financial, social benefits, career advancement. Those that worked in healthier environments were more satisfied and less likely to leave, healthier environments, greater empowerment structures Quality of care good	Referred to Aiken where 1:5 nurses were dissatisfied with their work environment. Predictors to I2L- financial, opportunity for advancement and educational opportunity **TEAM COHESION** – most important reason to remain in organisation Generational – younger more likely to move for career opportunity **Excellent paper**

			PES-NWI- measured work environment conditions of work effectiveness - - measure perceptions of empowerment Job satisfaction – Minnesota Satisfaction questionnaire Questionnaire measured Intent to leave (I2L) Quality of care measured by Perceived Quality of Care Scale	**Team cohesion** stronger in ICU's due to intense nature of the work and proximity of work **Generational differences**- baby boomers are devoted to their employers, while generation X&Y desire better professional opportunities and working conditions 87% thought they were providing good quality care	

EBSCO Initial Search Non-Empirical Research Studies

	Document	Aim	Document Type	Comment on Document
1	Vollers, D., Hill, E., Roberts, C., Dambaugh, L., Brenner, ZR., (2009) ACNS-BCAACN's Healthy Work Environment Standards and an Empowering Nurse Advancement System	Prime points to share: Nurse advancement systems provide a process for recognizing nurses who move from novice to expert in providing or influencing patient care.	Cover article by American Association of Critical Care Nurses (AACN)	Discussion on the synergy between healthy work environment, high functioning nurses and how these contribute to optimal care delivery and outcomes. These systems have expanded opportunities for professional nurses and health care organizations regarding recruitment, retention, clinical excellence, leadership development, and professional recognition. A successful nurse advancement system can endorse and facilitate all 6 AACN healthy work environment standards. AACN early developers of work environment standards acknowledging effect on CCN's health and wellbeing, efficiency and retention. Standards for healthy work environment: Skilled communication True collaboration.

				Effective decision making: Nurses must be valued, involved in developing policy, directing and evaluating clinical care, and leading organizational operations Appropriate staffing Meaningful recognition: Nurses must be recognized and must recognize others for the value each brings to the work of the organization Authentic leadership: Nurse leaders must embrace the importance of a healthy work environment, authentically live it, and engage others in its achievement Leading to highly satisfied employees who work in a culture of care and excellence **Lower score on HAWKER**
2.	Dirks, JL., (2023) Alternative Approaches to Mentoring	Approaches of mentoring for CCN's to aid retention and recruitment	For all CCN's, novice to expert	Linked to crisis of workforce especially in high tech areas and high acuity of patients. Preceptor for a specific period, and frequently includes evaluation Mentor – collaborative partnership, who share answerability for mutually defined goals. An evolving relationship, to ascertain opportunities, role modelling Mentoring is 1 strategy to allay stress from psychological impact of working in CC (frequent death, abuse, staff shortages, moral distress, and burnout). Value of setting goals, relationship compatibility, 'toxic mentoring' Continuation of professional growth, preserves commodity of expertise in CC Organisation benefits from engaged workforce and improved quality of care **Lower score on HAWKER**
3.	Alspach, G. (2009). Craft your own Healthy Work Environment: Got you BFF?	Work environment reference to Gallup survey of Industry	Editorial Editorial- although somewhat dated, remains current **Presents Index of Work Satisfaction Tool and Nursing Work Index tool** Recruit and retain workforce	**CCN's own control over their environment at a personal level** Recognises organisational influence on WE and accumulation of factors affecting WE **Lack of influence in studies for influences at the level of the CCN** **Considers caring for the nurse as a person- 22% less likely to leave if cared for as a person- reference to Maslow hierarchy of needs and belonging:** after physiological needs and physical safety belonging is the next most important need Extend effort during recruitment – welcome, support, embrace, performance reviews, communication strategies, pairing to a preceptor, monitoring of mentor/ mentee relationships/ opportunities to get to know co-workers, good listening skills, play to strengths,

			WE not determined solely or predominantly by anyone factor Typically reflect organisational hierarchy and influence operationalised via mid-level or unit managers	**Best friend at work-** predicts employees' performance **–** Gallup was sceptical about this section, scoffing and dismissing, significant statistically undeniable **– friendship trumps motivation such as pay and benefits. Sharing information, suggestions for improvement, critique, non-judgemental, catharsis, solace and a good laugh** **Employees with BF at work are 7x more likely to be engaged, get more done, in less time, innovate and share ideas,** **75% of staff with a BF say they remain in comparison to 51% who don't have a BF at work. BF are good for business.** **Less accidents at work, looking out for each other, work collaboratively,** **Enabling and nurturing- mangers can support and nurture friendships, evolve and thrive – increase time during orientation, pairing those with similar hobbies, self-scheduling, making time for similar professional interests, teambuilding,** Not all friendships are conducive to work- familiarity breeds contempt, socialising at work, camaraderie can socially divide, emotional relationships can interfere with work, hierarchical levels- favouritism, influence Editorial- although somewhat dated, remains current Personal influences **Important to have a supervisor or someone at work who cares about them** (Gallup Organisation results) **– need for bonding / belonging/ supervisor who cares nurtures and enables thriving**
4	Alspach, G (2007). Facilitating the retention of experienced critical care nurses: a survey report on what matters most. Critical Care Nurse. 27 (5)	To report findings	Report of questionnaire 7 items Participants were middle aged as experienced CCN-	Readers invited to complete questionnaire, following issue of journal relating to retention on CC nurse profession. 68% over 45yrs, 50% had 25 years' experience, 75% had 15 years' experience as RN. 64% had 15yrs exp in CC, 42% above 24 yrs. exp in CC **What matters most-flexible working patterns mattered most** **Top 3 to remain in CC- flexible working patterns, meaningful monetary retention, organisation respect, - values one's work,** **Top 10- most important -improved safety and comfort of work environment, physicians who are compassionate, competent, honest and ethical** **Limited, unscientific, small sample but clear messages**
5	Cajanding RJ (2021) Individual and	This article discusses the	Lit Review	**<u>Used for citation searching</u>**

	organisational strategies to develop resilience in the nursing workforce. Nursing Standard. doi: 10.7748/ns.2021.e11678	theoretical underpinnings of resilience, explains what resilience in nurses means, & describes the adverse effects of the pandemic on nurses' mental health and resilience. The article also explores how nurses' resilience can be developed & enhanced from an individual and organisational perspective.		**Challenges during COCID- increased workload, decreased nurse: patient ratios, scarcity of resources, increased risk of safety to themselves and others** **Challenging assumption that nurses are innately resilient** Preti 2020- nurses experienced moral and emotional distress, fear, depression, all intensified by the situation Theoretical Underpinnings- Latin meaning leap/ rebound, **adapting well in the face of adversity**, resilience can be developed and enhanced Resilience can be viewed as a trait or attribute – genetic, biological, demographic, cultural, social, spiritual and economic factors, as a process it can be harnessed and developed as an outcome, it is a positive adaptation in which a person surpasses their previous level of functioning Resilience in nurses- Mealer 2012- found only 22% thought they were resilient, **Rushton in ICU nurses found them to have moderate to high levels of resilience** **Resilience positively associated with years of experience, level of education and social support.** Resilient skills include- willpower, realistic coping strategies, managing and focusing on one's own mental health, seeking recognition, sense of accomplishment, taking pride in owns job. Resilience can be a protective factor, for physical and mental health wellbeing, mitigating burnout, emotional exhaustion, anxiety, stress, and depersonalisation. (Rushton 2015) Resilience- enhances performance, professional efficacy, care delivery and personal development Effects of Covid-19 Adverse- detrimental psychological effects, traumatised, PTSD, depression, anxiety, insomnia and psychiatric symptoms Fear -witnessing colleagues being infected, and dying, compassion fatigue witnessed and burnout (Graham et al 2020) Triple whammy during COVID- caring for patients, their family and children, and social distancing (Odom-Forren 2020). **Shahrour and Dardas (2020) Jordanian study acute stress disorder significant psychological distress in the younger nurses. Fear of transmitting to families exacerbating anxiety** Effect on Nurses Resilience – **50% nurses in UK reported moderate or low resilience during COVID- increased prevalence in younger nurses** (Roberts et al, 2021) Bozdagg and Ergun- agreed finding higher

				quality sleep, positive mood, older age and higher life satisfaction were associated with higher resilience scores – being a doctor, negative state was associated with lower resilience scores Developing and enhancing resilience – Covid led to plethora of resilience related studies, including how this can be developed. Identified Strategies – self-awareness and reflection, critical debriefing, meditation and humour, defuse highly charged and distressing situations, Crane 2019 Time for self-care- using stress management techniques, physical activity, developing positive thinking, Focusing on own strength, cultivating skills, positive affirmations, - overcome feelings of inferiority and shame Supportive network of colleagues, family, virtual chat rooms, judicious use of social media Critical resilience- rather than focus on individual resilience, making nurses responsible to cope with organisations challenges, meaning organisation not held accountable – Traynor 2018, proposed concept of critical resilience, increasing understanding of broader organisational factors, using open, focused and mutually supportive discussions, between the MDT and managers Developing critical resilience – supports nurses to adopt effective work practices, manage daily work, becoming increasing cognisant of broader organisational factors affecting the work environment Role of healthcare organisations- crucial role in fostering resilience in staff, fostering culture where staff fell listened to, taken seriously, and safe to express views, Work with each other to find solutions, to challenges arising in the workplace. Time to discuss challenges- increasing feeling of being valued, enhancing well-being Strategies to develop resilience- risk factor strategies, reducing exposure to these factors, assist focused strategies, - increasing quantities and quality of assets process focussed strategies- mobilising and influencing systems, structures and processes, to enable staff to learn essential skills and mastery of tasks
6	Khan, N., Jackson, D., Stayt, L., & Walthall, H. (2018). Factors influencing nurses' intention to leave adult critical care settings. Nursing in Critical Care, 24(1), 24–32.	to explore factors that may influence nurses' intention to leave adult critical care areas.	Mixed method systematic review – located in initial search Quan data from 16794 CCN's across 12 countries 13/15 identified work environment as a	Review – 2005-2016, Braun and Clarke thematic analysis used **Retention preferable to recruiting – global issue which is exacerbated in CC** **ITL -defined as final cognitive step leading to actual turnover (Mosallam et al 2015)** **To date single factors explored such as working conditions, burnout, empowerment, work pressure- typically single site or region – reducing generalisability.** Organisation aspects- RNs with CC specialist qual perceived more access to resources, felt more empowered and were more satisfied with their job. Opportunities for PD and career pathway enhanced empowerment, produces good teamwork and reduces likelihood of leaving. Nurse managers have

			factor associated with ITL Work environment – social aspects – being able to share feelings increases empowerment and reduces ITL. Reduced recovery time between shifts, inability to share concerns, poor work life balance, lack of social support associated with increase stress and ITL	important role n influencing work environment, failure to do so increases stress and influences ITL. MD caused by pressure from administrators and related to reducing resources. Zhang related pay and Tao lack of respect and recognition to ITL. Lack of autonomy, collaboration, quality of relationships was associated with MD and ITL. Physical aspects- limited working space, poor sleep due to shift pattern and recovery time were associated with ITL. Staffing, emotional demands of work positively correlated with ITL. Nature of working relationships- 8/15 identified working relationships as a factor associated with ITL. **Relationships with patients and families- normally a nourishing encounter- provides inner strength and power to carry on.** Intrinsically rewarding Relationships with managers and colleagues- poor work relationships increased ITL. **Fellowship with co-workers were empowering (Wahlin, 2010), everyone played an important role, increased inner strength, and created healthy work environment.** Relationships with medical colleagues – poor relationship linked to MD and influenced ITL (Karinkola, 2014). Mainly linked to not being involved with decision making, reducing feeling of empowerment, like not being involved inward rounds. Traumatic and stressful workplace- mainly linked to EOL care. – prolonging death linked to stress and ITL. Providing false hope linked to MD and ITL. **VERY USEFUL**
7	Vincent, J.L., Boulanger, C., Van Mol, M., Hawryluck, L., Azoulay, E., (2022). Ten areas for clinicians to be aware of to help retain nurses in the ICU. Critical Care. 26.	Urgent need to cultivate and support strategies that help make CCN attractive and reduce stressors felt by those that remain	Discussion paper	**Related pre-pandemic issues and exacerbation post COVID** **including fear of catching disease, increased workload, strict safety measures which dehumanised care** **Initial appreciation by society led to complaints- not helped morale** Outcomes and staffing have been related to quality care **Responsibilities of CCN are greater than other nurses yet financial reward often remains the same but simultaneous tackling of the other issues must remain on agenda** **Intellectual stimulation – aligns to feeling of self-accomplishment – mentoring, participation in resources or research trials – high level of autonomy, leadership, career enhancing possibilities,** Shortages of nurses not new, but it has been exacerbated by COVID-19. Reasons recognised and included excessive workload, MD, perception of inappropriate care, burnout and intent to leave. nature of work and high death rate 10 areas suggested: **Recognition, respect and value**

				Role and responsibility- with defined boundaries **Intellectual Stimulation and professional development** **Teaching opportunities** **Good leadership and management –** dynamic and motivated leaders **Teamwork/ collaborative practice-** active contribution in ward rounds **Clinical discussion -and exchange** -confidence to raise issue, collaborate in case reviews, open dialogue **Good work life balance-** face paced challenging area – sharing responsibilities**,** **Psychological support –** high level of life-death situation, creating significant emotional and mental stress**, no** stigma association with seeking support, resilience training, **Humane care –** support for patient and families in addition to technical support, discussion on EOL care,	

	Citation Searching - Initial Search				
1	Hamric, A. B. (2014). A case study of moral distress. Journal of Hospice & Palliative Nursing, 16(8), 457–463	Part of an ethics series	Case Studies – acute and palliative Themes drawn from case and effect on healthcare team	**Themes**: false hope, following family wishes when not in best interest of infant, offering aggressive treatment perceived as futile and prolonging suffering – inadequate information given to family, poor team communication **MD at 3 levels- individual, team, organisation,** Strategies to reduce cases: education to speak up, improved comms to families (family meetings, clarify and reclarify, set goals with families), conservations re ethical care (obligation, goals), build comms with teams, seek facilitation to work through cases of MD, debrief (recognising signs of MD), strengthen unit ethical climate, interprofessional rounds, identify RCA, target areas for cultural development, be persistent,	Based in NICU & palliative care **Good definitions** MD occurs when persons moral integrity is seriously compromised: either due to feeling unable to act in accordance with core values and obligations, or attempted actions fail to achieve desired outcome. Recurrent situations can lead to the ‘‘crescendo effect,’’ with buildup of MD and moral residue in care providers. This article analyses a case that led to moral distress in a health care team.

2	Lavoie-Tremblay, M., Gélinas, C., Aubé, T., Tchouaket, E., Tremblay, D., Gagnon, M.-P., & Côté, J. (2021). Influence of caring for COVID-19 patients on nurse's turnover, work satisfaction and quality of care. Journal of Nursing Management, 27, 1–11.	To examine, through jobs resource model, the influence of caring for COVID-19 patients on nurses' perception of chronic fatigue, quality of care, satisfaction at work and intention to leave the organisation and the profession	Cross sectional online survey- June – Nov 2020 Canadian 1705 nurses- 782 cared for COVID patients 87% women, mean age 41years, average years of experience 14 years Tools- Job Demands and resources And Strain and performance And Sociodemographic **Studied independently as the frontline staff**	Chronic fatigue, poor quality of care, lower work satisfaction, and high intention to leave were found for those caring for COVID patients Poorly prepared for COVID – 30% **30% intention to leave setting and profession (22%)– higher for those that felt overwhelmed and poorly prepared** **Additional demands and stressors include PP, rapidly changing protocols, increased capacity, deployment to unfamiliar areas,** Conclusion urgent need to provide support for nurses with long term strategies for retention **Those with transformational leaders more intent to remain**	**Global nursing shortage recognised and worsening post pandemic** Already aware of negative effects of pandemic, with significant impact on physical and mental health, High stress, due to family separation, sleep deprivation, lack of preparedness Adverse impact already seen relates to burnout, stress, depression, anxiety
3	Mealer, M., & Moss, M. (2016). Moral distress in ICU nurses. Intensive Care Medicine, 42(10), 1615–1617. https://doi.org/10.1007/s00134-016-4441-1	Discuss risk factors for MD, its consequences, and potential preventative and therapeutic interventions	**Discussion Paper** MDS most common measurement tool - designed for CCN's	MD requires- Morally responsible action Individual determines best strategy based on their own morality The individual is then prevented from implementing their plan of action due to internal or external constraints **Occurs in up to 80% of CCN's** Due to perceived inability to making decisions and being voiceless Repetitive exposure to MD- leads to persistent feeling of powerlessness	**CC complex and difficult work area – CCN's repeatedly exposed to work-related stressors e.g. end of life discussions, prolongation of life support, potential for delivering inappropriate care** **Futile care, inadequate pain relief, false hope, hastening dying process, working with others perceived as incompetent,** **External factors include- l**ack of collegiality, hierarchy structure, inadequate comms, conflict of personal beliefs with hospital policy, inadequate staffing, compromising care due to cost constraints and concerns

				Long term sequalae leads to withdrawal, emotional exhaustion, depersonalisation towards patients and symptoms of burnout syndrome	MD can lead to inability to perform expected job responsibilities, leaving profession, decreases productivity, and reduce overall quality of care,
4	Woo, T., Ho, R., Tang, A., & Tam, W. (2020). Global prevalence of burnout symptoms among nurses: A systematic review and meta-analysis. Journal of Psychiatric Research, 123, 9–20. https://doi.org/10.1016/j.jpsychires.2019.12.015	**Systematic Review (SR)& meta-analysis (MA)**	113 studies for SR & 61 for MA 45,539 nurses across 49 countries	Burnout out declared occupational phenomenon by (ICD-11) International classification of diseases, recognised as a serious health problem **Prevalence – 11.23%-** highest in sub–Saharan Africa and lowest in Europe and Asia Geriatric nurses had lowest rate highest in CC due to patient characteristics, intense WE, and lack of decision-making Nursing dynamic and high-tech having to adopt new roles and increase time in non-nursing activities – compromising time and quality on nursing care – consequence causes conflict of unfulfilled values	**V Good –** useful paper lining burnout to MD and CC to other specialities One-tenth **worldwide nurses suffering from burnout** **Recognised CCN's steep learning curve as technical environment increases**

	Continual Searching				
1	Mokhtari, R., Moayedi, S., & Golitaleb, M. (2020), COVID-19 pandemic and health anxiety among nurses of intensive care units. International Journal of Mental Health	Letter to editor Summarising overwhelming effect of COVID	Editorial	Nurses' role recognised Psychological effects include increased workload, burnout, inadequate PPE, frequent ethical decision making – **increased health anxiety – caused by misconception of disease - fear of disease, incapacity to cope with disease and inadequacy of treatments** High risk of infection for CCN's due to nature of environment	Focus on disproportionate effect on nurses Health anxiety – excellent explanation **Acknowledged these needs have been required before but recognises impact and the crisis now demands action** **Well written**

	Nursing, 29(6), 1275–1277. https://doi.org/10.1111/ inm.12800			**Need to strengthen psychological resilience** – reduce hours, improve communication, provide adequate PPE, provision of support systems – mental health counselling Targeted interventions to reduce psychological complications such as PTSD- create appropriate environments, education, MH support	
2	Karakachian, A., & Colbert, A. (2019). Nurses' moral distress, burnout, and intentions to leave: An integrative review. Journal of Forensic Nursing, 15(3), 133–142.	Revealing the consequences of MD on the nursing workforce	Integrative literature review Forensic nurses	Focus on burnout and intention to leave Increased cost for healthcare with intention to leave	**NOT CC but these nurses do care for complex patients** Some useful points Interesting to see presentation of integrative review
3	Bruyneel, A., Smith, P., Tack, J., & Pirson, M. (2021). Prevalence of burnout risk and factors associated with burnout risk among ICU nurses during the COVID-19 outbreak in French speaking Belgium. Intensive & Critical Care Nursing, 65, 103059.	To assess the prevalence of burnout risk and identify risk factors among CCN's during the first wave of COVID-19	Web-based survey Belgium Maslach burnout scale Sample 1135 CCN's	Prevalence of burnout was 68% **28% at risk of depersonalisation** **31% of risk of reduced personal accomplishment** **38% emotional exhaustion** Nurse patient ratio increased risk of emotional exhaustion as did perceived shortage of PPE Nurses reporting symptoms of COVID without testing were at higher risk of emotional exhaustion 2/3rds at risk associated with WE during COVID	Reference to many studies Study design clear Recommendation's weaker part – vague to suggest monitor
4	Cacchione, P. Z. (2020). Moral distress in the midst of the	Due to COVID speaking on MD	Editorial	To do no harm is a incredible challenge for nurses. Great expectations from the public.	Paediatric Journal but good definitions and background to MD Symptoms provided

	COVID-19 pandemic. Clinical Nursing Research, 29(4), 215–216.			Advice to the public how to support nurses: including to be kind to nurses. Advie on mindfulness	Short piece
5	Crowe, S., Howard, A. F., Vanderspank, B (2022). The mental health impact of the COVID-19 pandemic on Canadian CCN's Intensive & Critical Care Nursing, 71, 103241. 1-7	Examine the impact of COVID-19 on mental health, quality of work life	CCN's in ICU, step down and high acuity units during the COVID pandemic May-June 2021. Cross-sectional survey design- open and closed questions 4 instruments used- impact event scale, depression, anxiety and stress scale, professional quality of life scale and intent to turnover tool	425 CCN's responded. 74% reported symptoms of post-traumatic stress, 70% depression, 57% anxiety and 61% stress **100% reported moderate to high burnout, 87% were suffering from signs of secondary traumatic stress** 22% intend to quit their current position. Written responses- depicted a MH toll on CCN's stemming from failed leadership, traumatic work environment, sense of disillusionment, defeat and intent to leave	Focus on Canadian CCN **Clear implications for practice** Profound MH challenges related to the pandemic Good design tools
6	Dodek, P. M., Wong, H., Norena, M., Ayas, N., Reynolds, S. C., Keenan, S. P., Hamric, A., Rodney, P., Stewart, M., & Alden, L. (2016). Moral distress in intensive care unit professionals is associated with profession, age, and years of experience. Journal of Critical Care, 31(1), 178–182.	To determine which demographic characteristics are associated with moral distress in ICU professionals. Canadian	Questionnaire in 13 CC units Reported age, sex, years of experience Multivariate hierarchical regression analysis to analyse MD and demographic variables and MD and intent to leave Response rate Nurses- 49% AHP- 47% Medical 44%	Nurses and AHP had higher scores of MD than medical team Highest causes of MD- cost constraints and EOL controversies Age inversely associated with MD Experience directly associated with MD MD directly related to intent to leave	**Conflicts with some findings – supports age and MD inversely associated**
7	Falatah, R. (2021). The impact of the coronavirus disease	Aim of the review is to appraise, and integrate current	43 studies were appraised Primary and theoretical reports	Findings nurses, prevalence and prediction of intention for turnover increased significantly after COVID-19	**Useful definitions** Turnover defined as voluntary and early termination of nurses' employment. This can be

	(COVID-19) pandemic on nurses' turnover intention: An integrative review. Nursing Reports, 11(4), 787–810.	pre and post covid literature on turnover published between 2016-2021	Data comparison discovered similar themes	COVID negatively impacted on nurses' psychological wellbeing No definition of turnover in 28 studies	organisational or professional with the latter being most consequential because of contribution to preexisting nursing shortage. Nurses' turnover intention has been defined as the most accurate predictor of actual nurse turnover. Nurses' turnover intention is defined as an individuals perceived probability of permanently leaving the employing organisation in the near future. Among the identified predictors are job satisfaction, job commitment, stress, anxiety and burnout.
8	Fernandez, R., Lord, H., Halcomb, E., Moxham, L., Middleton, R., Alananzeh, I., & Ellwood, L. (2020). Implications for COVID-19: A systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic. International Journal of Nursing Studies, 111, 103637. Advance online publication. https://doi.org/10.1016/j.ijnurstu.2020.103637	To synthesize and present best evidence on the experience of nurses working in acute hospital settings during the pandemic	**Systematic review** using Joanna Briggs Regardless of methodology, 2005-2020 13 qualitative studies- 348 nurses with 116 findings	Seven categories- based on similarity of meaning Three synthesized were generated from the categories Supportive nursing teams providing quality care (sense of duty, working at dangerous times, professional obligation, eager to fulfil their role, creating ethical and moral dilemma, with family responsibilities, personal sacrifice of isolation) Acknowledging the physical and emotional impact (derived from family concerns, and fear, vulnerability and psychological issues at a time of crisis) Responsiveness of systemised organisational reaction- protection and safety- knowledge and communication – conflicting advice, rapidly changing advice, inadequate training, s**wift and changing policy caused confusion staffing shortages**	**Prisma not very detailed** Recognised nurses' response in public health emergencies and the experience of such has the potential for short- and long-term consequences for nurses, society and the nursing profession

				Collegiality is heightened in a pandemic – recognised importance of caring for colleagues – **referred to like a battlefield** Concerns for personal and family safety, fear of vulnerability issues remain paramount- exposure to patients, new disease, and spread through resources from colleagues, powerless under extreme pressure, **community fear**, Nurses are willing to accept risks of their occupation in pandemic situation Significant impact of nurses' experiences highlights a need for strategies around self-care and ongoing support to ensure the health of nurses is maintained	
9	González-Gil, M. T., González-Blázquez, C., Parro-Moreno, A. I., Pedraz-Marcos, A., Palmar-Santos, A., Otero-García, L., Navarta-Sánchez, M. V., AlcoleaCosín, M. T., Argüello-López, M. T., Canalejas-Pérez, C., Carrillo-Camacho, M. E., Casillas-Santana, M. L., Díaz Martínez, M. L., García-González, A., García-Perea, E., Martínez Marcos, M., Martínez-Martín, M. L., Palazuelos-Puerta, M., Sellán-Soto, C., &	To identify needs related to safety, organisation, decision-making, communication, psych-socio-emotional needs perceived by CC and emergency nurses in Madrid during the acute phase	Cross sectional study- questionnaire and interviews 26 public hospitals Sample 557	37.5% reported working n with a fear of becoming infected and its consequences 28.2% elevated workloads – high patient ratios and shifts that did not allow disconnection or rest. Taking on additional responsibilities Deficiencies with communication with middle management, inability to provide psycho-social care to patients and families Exhaustion 53% and difficulty in venting emotions 45%	Recommendations based on wellbeing both physical and mental Communication is key to ensure efficient care management in times of crisis

	Oter-Quintana, C. (2021). Nurses' perceptions and demands regarding COVID-19 care delivery in critical care units and hospital emergency services. Intensive & Critical Care Nursing, 62, 102966. Advance online publication				
10	Heesakkers, H., Zegers, M., van Mol, M., & van den Boogaard, M. (2021). The impact of the first COVID-19 surge on the mental well-being of ICU nurses: A nationwide survey study, Intensive and Critical Care Nursing, 65. Advance online publication.	To determine the impact of COVID surge on the mental wellbeing and associated risk factors for CCN's Dutch	Nationwide cross-sectional survey to CCN's Tool HADs IES-6 & NFR Multivariate regression analysis Sample 726	Prevalence of symptoms of anxiety, depression, PTSD and the need for recovery **Reported - Anxiety 27% 1:4 symptoms of anxiety** **Depression – 19%** **PTSD- 22%- 1:5** **Positive NFR- meaning not recovered from work – 41.7%** Afraid of infecting relatives, insufficient numbers of work colleagues with more MH problems Whereas being on holiday associated with reduced depression symptoms and need for recovery High impact on MH wellbeing, increasing risk of 'drop-out' Recommendations to improve working conditions, and decrease workload	New term – not recovered from work **Acknowledged variance due to worldwide effect on CCN's – strain at differing times** **Similar findings to** González-Gil, but not the French studies

11	Leng, M., Wei, L., Shi, X., Cao, G., Wei, Y., Xu, H., Zhang, X., Zhang, W., Xing, S., & Wei, H. (2020). Mental distress and influencing factors in nurses caring for patients with COVID-10. Nursing in Critical Care, 26(2), 1–8.	To quantify the severity of nurses' post-traumatic stress disorder symptoms and stress and explore the influencing factors of their psychological health when caring for patients' with COVID-19	Questionnaire – PTSD checklist- Civilian and perceived stress scale, Sample 90 CCN's Plus 2 open questions 83% response 72% female with 70% between 20-30 years	PTSD and stress were positively correlated Those who came from ED had lowest related stress **8 themes from open ended questions:** Sources of stress included isolated environment, concerns of PPE, physical and emotional exhaustion, (sleep problems) intensive workload, fear of being infected and insufficient work experience with COVID, cultural and language barriers, lack of family support Offer disaster emergency preparedness, caring and authentic leadership- offering ongoing support **Evidence that CCN's had reported high levels of job-related stress before the pandemic** Findings from two perspective- resilience and ongoing psychological support	What is the ongoing support that is suggested as a recommendation **Study design brief – 32 days working with COVID- quite limited** **This study demonstrates that highly skilled and experienced nurses experience some degree of mental distress Leaders provide a significant role in providing that support**
12	Mihalache, M., & Mihalache, O. R. (2021). How workplace support for the COVID-19 pandemic and personality traits affect changes in employees' affective commitment to the organization and job-related well-being. Human Resource Management.	To understand the different types of work support, perceived organisational support and supervisor accessibility, in response to environmental disruption interact with personality traits to influence changes in	Online questionnaire Sample aged 25-65 years Paid respondents Pilot with 25 participants Data collection May- June 2020- when cases were 4000 per day Two phases Phase 1 -350 respondents Phase 2 324 invited to phase 2 Response rate – 95% 307	**Environmental disruption -three types of crises economic, natural disasters and political – COVID was a combination of all 3** **Organisational responses to ensure employee well-being does not suffer** Important to employee and employer- lower staff absenteeism, ITL**,** **Supervisor support – increased communication, accessible** Environmental crisis- causes employees to experience negative consequences – work	**Reference to advancing evidence on organisational support by studying in an extreme context** **Reliability – paid respondents** **Good re support mechanism are a one size fts all – but not specific about the support**

	Advance online publication. https://doi.org/10.1002/ hrm.22082	employee's affective commitment to their organisation and in their job related well being UK	Total 295 used 72% female Mean age 35	support should be in place including improved communication – flexibility in scheduling, conditions of employment that combine work and care Not a one size fits all- solutions	
13	Moradi, Y., Baghaei, R., Hosseingholipour, K., & Mollazadeh, F. (2021). Challenges experienced by ICU nurses throughout the provision of care for COVID-19 patients: A qualitative study. Journal of Nursing Management, 29(5). Advance online publication.	To explore the challenges experienced by CCN's throughout the provision of care for COVID patients	Qualitative descriptive study Purposive Sample 17 **CCN's with at least one year experience** Semi-structured interviews Content analysis	4 challenges: **Organisational inefficiency in supporting nurses –** subtheme-poor organisational support, excessive workload, shortage of PPE, discrimination in provision of PPE **Physical exhaustion-** exhausting protective covers, physical complications, (tiredness, hormonal, skin damage) **Living with uncertainty -**unclear nature of the disease, fearing oneself and family being infected, desire to quit, **Psychological burden of the disease -**domestic distress, psychological turmoil Approached need to be adopted to resolve the challenges, provide healthcare facilities, support the workforce, provide accurate evidence base information and perform psychological intervention I how to handle the crisis	?? recommendations about evidence-based practice- new disease no information at the time Comprehensive backdrop to COVID Very similar findings re fear and exhaustion **Very similar methodology- phenomenology- research question then exploratory questions – how why, can you be more explicit** **Really useful – results and discussion** **No discrimination between staff as suggested in this study**
14	Nowicki, J. N., Slusarska, B., Tucholska, K., Naylor, K., Chrzan-Rodak, A., & Niedorys, B. (2020). The severity of	Investigation of the levels of post traumatic stress, sense of security, and sense of meaning in the face	Web interviews May 2020 Tool- Impact event scale-revised, Perceived Social Support scale, The changes in Outlook scale	Highest scores in avoidance and support was provided by significant others Sense of security lowered during COVID Current sense of meaning of life remains higher than searching for it	**Different tools used for data collection** **Not clear where these nurses worked** **Useful study relating to age**

	traumatic stress associated with COVID-19 pandemic, perception of support, sense of security, and sense of meaning in life among nurses: Research protocol and preliminary results from Poland. International Journal of Environmental Research and Public Health, 17(18). Advance online publication.	of the new global pandemic Poland	Safety Experience Questionnaire Meaning of life questionnaire Sample 325	**Increased age correlated with lower support from significant others** **Negative correlation between age and effect of epidemic** **40% experienced PTSD after SARS- less so for** COVID – supported by multiple studies Still high intensity of PTSD due to lack of experience in infection control procedures Social distancing and effect on social support **Post traumatic growth – highest support from those they worked with – due to restrictions and social distancing elsewhere**	**Positive changes resulting from painful experiences, characterised by the adaptation in the form of post-traumatic growth**
15	Peñacoba, C., Velasco, L., Catalá, P., GilAlmagro, F., García-Hedrera, F. J., & Carmona-Monge, F. J. (2021). Resilience and anxiety among intensive care unit professionals during the COVID-19 pandemic. Nursing in Critical Care. Advance online publication.	To explore a: prevalence of symptoms associated with generalised anxiety disorder, b- the relationship between GAD symptoms and resilience skills c- which of the resilience skills were associated with probable GAD among the ICU professionals during COVID pandemic	Cross sectional survey design Sample 448 ICU health workers Online survey	Results- high resilient levels, more than half presented with symptoms consistent with GAD **More prevalent amongst women**, nursing assistants, interns, staff on rotation and those who have cared for more than 20 COVID patients 59% presented with symptoms of GAD **Significant neg correlation between GAD and resilience skills** **Taking things in my stride-ability to differentiate between those that exceed the cut-off point established for diagnosis of probable GAD and those that do not** ICU professionals develop GAD when exposed to extreme stressful situations – resilience skills acted as a protective factor	**<u>Really useful</u>** **Prevalence of symptoms consistent with GAD- confirming impact and challenge face by workers during COVID** **To be able to take things in their stride was the most effective protective skill against development of anxiety** Emerging literature reveals high incidence of the psychological impact of COVID

				Organisations should provide	
16	Rhéaume, A., Breau, M., & Boudreau, S. (2021). A critical incident study of ICU nurses during the COVID-19 pandemic. Nursing Ethics, 5. Advance online publication.	To describe Canadian CCN experiences of providing care to COVID patients during the second wave of the pandemic	Qualitative descriptive within a larger mixed-method study Written experiences which distressed them during provision of care Thematic analysis Sample 111 incidents from 108 CCN's Typically, 11 years' experience	Four themes: managing the pandemic, witness to family's grief, our safety, futility care Plus, organisations preparedness and concerns for their own safety – lack of PPE guidance Limited resources and high demands Deep moral distress centred around two situations – patients dying alone and the inability to prevent patients receiving lengthy painful treatments with questionable benefits-detrimental effect on the nurse's well-being Sese of powerless ness, wanted voices heard, lack of work control,	**Supported by other papers** **Excellent discussion**
17	Shen, X., Zou, X., Zhong, X., Yan, J., & Li, L. (2020). Psychological stress of ICU nurses in the time of COVID19. Critical Care. 24(1), 200.	Discussion piece on survey results	Short discussion piece on CCN's in Wuhan survey 85 CCN's	**Frontline nurses experienced huge workload, long-term fatigue, infection threat and frustration with patients with whom they care for**. Initial feelings on loneliness and worry for their families resulting in high impact on psychological pressure **Main manifestations**: decreased appetite, fatigue, difficulty in sleeping, nervousness, frequent crying and suicidal thoughts **Younger nurses with no experience faced greater psychological crisis** **Early measures initiated**- psychologist and psychological assessments, - guided to understand pandemic and avoid excessive panic and anxiety	<u>One of the few that cite what measures were put in place during COVID for CCN's</u> Early assessment and active resolution of psychological stress long term follow-up recognised,

				Familiarize with WE. Express emotions, draw, sing, deep breathing exercises, relaxation exercises, **Communication and talk to team, heal each other – not forced to forget experiences –** online chat, recognise these experiences may last a lifetime, Regular meetings, to source and target solutions – education on infectious diseases – education strengthened Expert opinion cases shared, allocation to patients according to experience **Shift rotation reduced from 6 to 4 hours** **Improved social support system**	
18	Sriharan, A., West, K. J., Almost, J., & Hamza, A. (2021). COVID-19-related occupational burnout and moral distress among nurses: A rapid scoping review. Nursing Leadership, 34(1), 7–19. https://doi.org/10.12927/ cjnl.2021.2645	To synthesise existing literature on COVID-19 related burnout and moral distress among nurses and identify recommendations for nurse leaders to support the psychological needs of nursing staff	Comprehensive search Rapid review Using WHO Rapid Review Guide Thematic analysis	Findings- nurses at risk of stress burnout, and depression during the ongoing pandemic **Younger female nurses with less clinical experience are more vulnerable to adverse MH conditions**	
19	Wiegand, D. L., & Funk, M. (2012). Consequences of clinical situations that cause critical care nurses to experience moral distress. Nursing Ethics, 19(4), 479–487. https://doi.	To identify clinical situations that cause moral distress and to understand the consequences of those situations and to determine whether nurses	Descriptive approach Open ended surveys Sample of 49/ 204 CCN's Thematic analysis	MD had detrimental effects on CCN's Majority experienced MD and the majority of these related to end of life Negative consequences for themselves families and patients **Response to MD- anger, anxiety, depression, disgust, guilt, sadness and worry**	**Poor response rate** **Small sample size** Good background to MD

	org/10.1177/0969733011429342	would change their practice based on their experiences		**Leaving a feeling of frustration, helpless, hopeless, and powerless** Moving on and learning from MD- self-care important to enable caring for others Debriefing a useful strategy MD can have a lasting effect – need to rejuvenate – take time to heal	
20	Calkins, K., Guttormson, J, McAndrew, N., Losurdo, H., Loonsfoot, H., Schitz, S., Fitzgerald. (2023) The early impact of COVID-19 on intensive care nurses' personal and professional well-being A qualitative study. Intensive & Critical Care Nursing. 76. 1-7.	To describe the impact of COVID-19 on ICU nurses personal and professional well-being **Part of parent study**	Descriptive qual methodology. Interviews with semi-structured interview guide. Conducted on teams Convenience sample – 13 CCN -	**we are not heroes** – would rather have necessary supplies and support inadequate support – felt underappreciated, betrayed by the systems that were supposed to keep them safe – worked understaffed and without PPE. Initial support from community, but then forgotten, Belief that Covid is not real helplessness – uncertainly on how to care for these patients, distress from so many deaths, surrounded by death exhaustion – physical and emotional exhaustion, by almost every participant nurses are the second victim	Small sample Really useful resource for content analysis – used to describe a phenomenon **Very useful study ******* **Heros terms** **Nurses are victims**
21	Cortese, C.G. (2012). Predictors of CCN's intention to leave the unit, the hospital and the nursing profession. Open Journal of Nursing. 2. 311-326.	Aim to gain insight into factors for intention to leave – the unit, hospital and profession.	Site: Two hospitals – questionnaire 512 responses (89.4%)	low job satisfaction relating to interaction with medical team seniority above 20years had greater intention to leave JS low relating to organisation and education, ITL profession around 20%- consistent with other studies and relate to pay and work policy	**Good for definitions – JS, I2L**

				I2L CC 17%- less than other studies Work experience has a negative correlation with I2L the unit and hospital Age negatively linked to I2L the profession	
22	McCallum, K.J., Walthall, H., Aveyard, H, Jackson, D. (2021) Grief and Nursing: Life and death in the pandemic. Journal of Advanced Nursing. 77. 2115- 2116	Editor view of CCN's during the initial wave of the pandemic	Editorial	Editor view of CCN's during the initial pandemic. Grief and Loss, examples of nature of patients who are dying. Reference to higher mortality in BAME patients Nurse shortfall details – nurse to patient ratios Inability to provide fundamental care Despite this tragedy- CCN's continue to work, care	Well written editorial on impact on COVID and society **Good points raised**
23	Anderson, M., Nordon, A., Engstrom, A. (2022) CCN's perception of moral distress in intensive care during the COVID 19 pandemic – a pilot study Intensive and Critical Care Nursing. 72. 1-7	To describe CCN's perception of moral distress in intensive care during the COVID_19 pandemic- a pilot study. Sweden	Cross-sectional study Survey design- on ethical, deceptive communication, poor teamwork, Qualitative responses also added Descriptive analysis Sample 71 CCN working in	MD experienced at highest during futile care Assisting with incompetent care 39% considering leaving current position Communication needs improving and this plays significant role in situations that are leading to MD	Influences on doing and not doing a good job **Healthcare organisation needs to be more supportive**
24	Witton, N., Goldsworthy, S., Phillips, L. (2022). Moral distress does this impact on intent to stay among adult CCN's. Nursing in Critical Care. 1-7.	To explore CCN's moral distress levels and its relationship with intent to stay. UK	Part of a parent study Cross sectional survey design Survey using MDS-R scale for analysis Quan study Sample 266 CCN's in midlands UK	Age and MD were significantly correlated with intent to stay. Signifying older nurse are more likely to stay MD negatively correlated with intent to stay	Quan based, Linked age with intent to remain but lacked descriptive as to why Findings correlated with previous studies

25	Vogt, K.S., Simms-Ellis, R., Griffiths, M.G., Coleman, R., Shearman, N., Horsefield, C., Budworth, L., Marran, J., Johnson, J. (2023). Critical care nursing workforce in crisis: A discussion paper examining contributing factors, the impact of the COVID_19 pandemic and potential solutions. J Clin. Nurs. 32. 19-20. 7125-7134.	To examine the problem from a well-being perspective offering implications for research and potential solutions for organisations.	Discursive/ position paper Based on well-being and nursing literature, empirical, surveys and gov. think-tank publications/reports	CCN's disproportionally affected by COVID-19- with symptoms including burnout, depression and PTSD which are all linked to intention to leave profession Resilience techniques Need organisation change- interventions to correct workforce crisis plus turnover data – invest in resilience, well-being strategies COVID -increased the occupational stressors – high psychological demand with poor support, low flexibility for shift scheduling, 5-10% affected by covid required CC- 42% mortality rates in first wave – CCN's took the places of family (Chen et al, 2019)	**Useful doc** Global deficit of 9.9 million nurses / midwives and healthcare professions by 2030 (WHO, 2016) Intention to leave predictor for turnover (Cohen eta l 2016, Lazzari et al 2022) Cutler CC turnover 20-42%- 2022
26	Montgomery, C.M., Humphreys, S., McCulloch, C., Docherty, A.M., Sturdy, S., Pattison, N. (2021). Critical care work during COVID-19: a qualitative study of staff experiences in the UK. *BMJ Open*. 11, 1-10	To understand NHS staff experiences of working in CC during the first wave of COVID-19. UK	Qual study, telephone interviews, rapid analysis Baehr's sociological leans 'communities of fate' Sample 21 nurses, 10 doctors/ ACCP, 4 AHP's, 3 ODP, 2 ward clerks Aimed for redeployed and trained and untrained workforce Four hospitals	COVID-19 presented staff with extreme stress, duress and social emergency, - shared set of experiences characterised by community of fate, Fear and dread of working in CC, and collective sense of duty and vocation Changed ways of working, equipment, treatment management (lack of evidence for treatment), reorganisation of person and place, families lack family presence, extreme patient acuity witnessed and death on a large scale Stress and isolation of working in CC was mitigated by strong teamwork, camaraderie, pride and fulfilment	**Excellent paper, very pertinent** Emotional Labour Strong sense of duty- simply did their job, doing what they are trained to do **Moral density- purpose and duty- Common sense of purpose, across the hierarchy** Need to facilitate teamwork
27	Roulin, N., Mayor, E., Bangerter, A. (2014). How to satisfy and	Examine predictors of nurse satisfaction, at	Sample 1547 nurses in 245 healthcare units in public and private hospitals	Predicted job satisfaction at individual and group level predicted job satisfaction	Job satisfaction and intent to leave not always linked

	retain personnel despite job market shortage. Multilevel predictors of nurses job satisfaction and intent to leave. Swiss J. Psychol. 73.1. 13-24.	individuals, group and organisation level Secondly – links between job satisfaction and intent to leave SWISS	Participation rate 37% Age 26-50 Questionnaire SPSS for analysis	organisation level did not predict job satisfaction **Individual level of job satisfaction related to work-family conflict and burnout strongly related to work dissatisfaction** No commitment to organisation and this related to organisation priorities – not always the same as the nurses	**No commitment to organisation** Tiem to retain workforce especially at this time when nurses are in demand Perceived differences between employer and nurses in priorities
28	Senek, M., Robertson, S., Ryan, T., Wood, E., Taylor, B., Tod, A. (2020). Determinants of nurse job dissatisfaction findings from a cross-sectional survey analysis in the UK	Secondary analysis to assess self-reported individual and organisational predictors of intent to leave Exploration of job satisfaction Pre-covid UK	Cross section survey – mixed method developed by RCN and administered across all four UK nations to explore demoralisation and dissatisfaction – as predictors of intent to leave Logistic regression analysis to determine what impacts job dissatisfaction Response 1742-	**2/3rds reported being demoralised** and 5 x more likely to report this if they missed care Perceived lack of support has the same effect **Staffing issues and failures in leadership left them feeling demoralised and disempowered** More the lack of support or pre-empting of these issues were the concern **The inability to provide care impacts on nurses physical and mental wellbeing- leaving them undervalued, intimated, disempowered and vulnerable to committing errors** Affects relationships outside of work and ultimately leads them to consider whether to leave their job and even the professions Ethical leadership – those that lead with kindness and respect was more likely for nurses to demonstrate this behaviour towards their patients Transformational leadership involve respect and impact on job satisfaction	**Cannot predict intention to leave** This was pre-covid Age, gender and experience not examined
29	Cicho'n, J., Ptaszewska- Z˙ywko,	Examine the relationship	Cross sectional survey design	114/543 completed the survey	<u>Poor response rate</u>

	Kózka, M. (2022). Emotional intelligence and coping strategies among intensive care unit nurses. Nurs. Crit. Care. 1-7.	between emotional intelligence and coping strategies among adult ICU nurses in Poland Poland	9 Polish Hospitals invited to participate Instruments Scuttee Self-report emotional intelligence test, inventory to measure coping strategies with stress (Brief-COPE) and self-constructed questionnaire	Coping strategies included active coping and planning- positive reframing and religion rarest was substance misuse, behavioural disengagement and denial Nurses were less likely to use self-blame and disengagement Training in coping with stress may positively impact on reducing burnout and thus improve quality of care delivered EI is a trait and one of the predictors of the ability to cope with stress EI may have a positive impact on job satisfaction	**Emotional intelligence increases with life span** Link to quality-of-care provision **Link to traits**
30	Stokes-Parish, J., Barrett, D., Elliot, R., Massey, D., Rolls, K., Credland, N. (2023). Fallen angels and forgotten heroes: a descriptive qualitative study exploring the impact of the angel and hero narrative on critical care nurses. Australian Critical Care. 36. 3-9.	Explore the perspectives of CCN's and their perceptions about the angel/hero narrative and its impact on their clinical practice, safe working environments, professional development during the COVID_19 pandemic. Australia, America, UK	Semi-structured qualitative virtual interview for CCN's in UK, Australia, and North America. Thematic analysis – Braun and Clarke Sample 23 CCN's participated	**Four themes were synthesised- history repeating, gender stereotypes, political prawns, and forgotten heroes** **CCN's did not perceive the labels as positive**, they were concerned about unrealistic expectations, workplace safety, and poor renumeration. Participants perceived context and intention as important, they were proud of their work and called for improved representation of their role, recognition and work conditions. **Considered the term angel as passive, submissive and disempowered rather than being proactive, responsive and autonomous** Fear that label will lead to unsafe staffing ratios, 'be trodden on as it is a calling', unrealistic expectations and resources including education	Short interviews- average 19 minutes, small sample size, including 1 from North America- not homogeneous Reinforced nursing as calling rather than profession with scope of practice Impact on professional identity **History repeating – self-sacrificing like nuns- rejected the term angel, discomfort with the purity, doesn't link with the dark humour, not handmaidens** **Gender stereotypes, angel is gendered,** construction of a nurse, as a mother, caregiver, surrogate, - feminine roles, women's work, **Skills, capability and professionalism not recognised**

				Unique feminine role – sexism, sentiment is right but hard to identify with (male commentary).Acknowledge that not always meant the terms as derogatory Struggled with being under resourced at a time when no one else would want to do this 'dirty work' Political pawns – sense of dismissal and betrayal from employers and politicians – overwhelming sense of tokenism, publicly acknowledged with clapping from doorsteps followed by protests- which has neg impact on safe working conditions and fundamental work lobbying for these Forgotten heroes – conflicted about the term, they did suit up in armour and respected initially by community, when no one else would do their job, respect dwindled, nurses were abused, and disrespected, sense of being forgotten	Term was an inaccurate portrayal of a CCN Link to reward, mental health due to poor communication and effect on patient safety Politically written
31	Greenburg, N., Weston, D., Hall, C., Caufield, T., Williamson, V., Fong, K. (2021)	To identify mental health disorder in staff working in ICU's in 9 English hospitals in June-July 2020	Web-based survey examining depression, anxiety, PTSD, well-being and alcohol use Sample 709- 41% doctors, 49% nurses (344),	45% met threshold for probable clinical significance in one measure- severe depression (6%), PTSD (40%), severe anxiety (11%), problem drinking (7%) 13% had thoughts of feeling better off dead, or self-harm, Doctors reported better MH than nurses across a range of measurers Range of MH disorders, esp. in nurses. Need for preventions to protect MH, reduce risk of functional impairment	**Stressors related to long shifts, caring for dependent children, regular exposure to ethical dilemmas** Interesting nurses experienced MH issues more than Doctors, as this time both were in units **?? Younger and female, this demographic has shown to be at increased risk of suffering poor MH in comparison to general population** 1:5 reported feeling like self-harm/ suicide – highly concerning

				Typical military demonstrate up to 17% PTSD, during COVID up to 40% of practitioners experienced PTSD No association of MH and alcohol misuse	
32	Choe, K., Kang, Y., Park, Y. (2015) Moral Distress in critical care nurses: a phenomenological study. Journal of Advanced Nursing 71 (7) 1684-1693	To explore moral distress from the perspective of and experienced by CCN's.	Phenomenology design – purposeful sampling – 14 interviews	5 themes relating to MD emerged Ambivalence towards treatment and care- tasks rather than human dignity Suffering from lack of ethical sensitivity Dilemmas resulting from limited autonomy Conflicts with physicians Conflicts with institutional policy	**Good background, with useful definitions**
33	Dimino, K., Learmonth, A.E., Fajardo, C.C. (2021). Nurse managers leading the way: reenvisioning stress to maintain healthy work environments. Critical Care Nurse 41.5. 52- 58	Opinion Piece Recommendations for nurse managers and how to use the CC HWE standards to make the experience of stress more productive	Discussion paper	Typical drivers of stress: work hours, overload, time pressures, exposure to infection**, work-related incivility,** violence, sleep deprivation, understaffing and perceived lack of support **COVID adds to this list –** fear of taking it home, feeling under prepared, and a new feeling of helplessness Managers handed burden of managing crisis operationally, mentally and emotionally – typically not trained or prepared Attributes of the manger – patience, compassion, forgiveness. **Support of safe and respectful WE** Need clear communication – resources to meet physical and psychological needs Support for managers Nurse centred stress care – not one size fits all, diverse group with specific needs	Focus on managers perspective HWE standards- **contain the human factors which are commonly** overlooked and include satisfaction in the workplace, reduce costs, improve patient outcomes Science of stress included Stress plus COVID exacerbate issues leading to professional burnout and lack of joy in work

35	Rushton, C.H. (2021). Mindful practice and resilience academic: equipping nurses to address ethical challenges	To examine impact of a longitudinal, experiential curriculum to enhance nurses' skills in mindfulness, resilience, confidence, and competence to confront ethical challenges in practice	prospective repeated measures study before and after curriculum intervention. Two hospitals Participants- Intervention= 192 Comparison = 223	mindfulness, ethical confidence, ethical competence, work engagement, and resilience increased significantly post the intervention Resilience and mindfulness positively correlated with moral competence and work engagement. As resilience and mindfulness improved turnover intention and burnout (emotional exhaustion and depersonalisation decreased. Improved symptoms of anger and depression. Effective for CC nurses (exception of emotional exhaustion) and for nurses with different years of experience (exception turnover intention)	**Length of service** **Useful points but not aligned to findings or lit review**
36	Mahon, P., McPherson, G. (2014) Explaining why nurses remain in or leave bedside nursing: a critical ethnography. Nurse Researcher. 22. 1 8-13	To describe the application of critical ethnography to explain nurses' decision to remain in or leave bedside nursing, and to describe researcher positioning and reflexivity	31 PICU nurses- using semi-structured interviews and unobtrusive observation	Challenged assumptions why nurses remain, exploring issues of fairness and equity and how they contribute to these decisions Critical social theory discussion – useful – knowledge not value- neutral – seeking knowledge and dissemination can be impacted by this Power dynamics, culture, - which is dynamic Healthcare not a social vacuum – influenced by culture, gender class- influenced by peers 3 processes important- sensitisation to manifestations of power, attention to researcher stance, reflexivity	**PICU nurses** **Useful on social critical theory**
37	McAllister, M., McKinnon, J. (2009). The importance of teaching and learning resilience in the health disciplines: a critical review of the literature. Nurse Education Today, 29, 271-379.	Examination of resilience and application of resilience research in nurse education. Aiming to give students strength, focus and endurance through	Literature review, to advance education discourse.	Recommendations to build resilience in healthcare professionals through education, training and modifications in the workplace culture Characteristics of resilient individuals – locus of control, positive self-image, optimism, ability to organise daily responsibilities, empathy. More adaptable to change,	Good explanations of nature of resilience Resilience can be learnt **NO explanation of review- unable to validate findings** Excellent recommendations

		reflection and application.		Connectedness to environment and family and social environment, sese of inner wisdom, supportive mindset Recommends professional generativity should be engineered – setting good examples asset for professional cultures Opportunity to reflect within workplace – exposure to positive role models Taught in education programmes - identity building – coping and capacity development	
38	Ellison, J. (2021). Why are experienced nurses leaving work? *Kai Tiaki Nursing New Zealand*. 27(4), 22-31.	Provides overview of nurse retention in NZ	Results from research	Causes for attrition Organisational and managerial support, workload management and professional development	**Organisation support common the results** **Professional development – common to feasibility study**
39	Lavoie-Tremblay, M., Gélinas, C., Aubé, T., Tchouaket, E., Tremblay, D., Gagnon, M.-P., & Côté, J. (2021). Influence of caring for COVID-19 patients on nurse's turnover, work satisfaction and quality of care. *Journal of Nursing Management*, 27,1–11.	To examine, through the lens of the Job Demands-Resources model, the influence of caring for COVID-19 patients on nurse's perception of chronic fatigue, quality of care, satisfaction at work and intention to leave their organisation and the profession Canadian	Cross sectional survey 1705 nurses- 782 cared for COVID patients RN & LPN's	High chronic fatigue, poor quality of care, lower work satisfaction and higher intention to leave their organisation were found for nurses caring for COVID-19 patients**. No difference in ITL** **ITL- 22-29%- two factors chronic fatigue and low work satisfaction** Poorly prepared and overwhelmed nurses showed higher turnover intention than those well prepared and in control. Job demands/ Starters and performance Urgent need to support CCN's with a long-term strategy to increase retention	Good explanation of models used Reference to global nursing shortage Main focus on COVID information

				Nurse administrators play an important role in supporting nurses – education, training and policy development to positively impact quality of care and retention **Less transformational leadership observed**	
40	Özden, D., Karagozoglu, S., Yildirim, G. (2013). Intensive Care Nurses' perception of futility: job satisfaction and burnout dimensions. Nursing Ethics. 20.4. 436-447	To investigate the levels of job satisfaction and exhaustion suffered by intensive care nurses and the relationship between them through the futility dimension of the issue Turkey	Data Collection – Futility questionnaire Maslach Burnout Inventory and Minnesota Satisfaction questionnaire Sample 206 CCN's Mean age 22-48, 95% female	Moderate levels of job satisfaction, emotional exhaustion, and personal achievements but high levels of sensitivity Job satisfaction and sensitivity are positively affected when they consider that futility does not contradict the purposes of medicine Futility- 30% applied futile care each month, 17% every day- 78% on physician demand, 47% on family demand, 33% hospital management demand Job satisfaction – correlation between job satisfaction and emotional exhaustion, UG education nurses had higher burnout scores, and lower for personal achievement, Those worked less than 4 years had higher emotional exhaustion levels – but insignificant Relationship between futility, job satisfaction and burnout, - those that identified futility demoralises health professionals had significantly lower JS scores	Important for nurses to be satisfied with their jobs to be productive, happy and efficient – In turn this improve the quality of care they provide Moves between scores and % Overall moderate levels of job satisfaction **No significance between age, marital status, or working hours**
41	Atefi, N., Abdullah, K.L., Wong, L.P., Mazlom, R. (2014) Factors influencing registered nurses'	The purpose of this qualitative descriptive study was to explore factors related to	Sample 85 medical, surgical critical care work environments Ten focus group discussions	Three main themes that influenced job satisfaction and dissatisfaction: spiritual feeling, work environment factors, motivation.	Job satisfaction strong link to turnover or ITL **Being involved in patient care provided a strong spiritual job satisfaction**

	perception of their overall job satisfaction: a qualitative study. International Nursing Review. 61, (3). 297-440.	critical care and medical-surgical nurses' job satisfaction as well as dissatisfaction. Iran		**Helping and involvement in patientcare contributed to the spiritual feeling influenced nurses' job satisfaction. Involvement in patient care was important** For WE factor team cohesion, benefit and rewards, working conditions, lack of medical resources, unclear responsibilities, patient and doctor perceptions, poor leadership skills and discrimination at work played an important role in nurses' job dissatisfaction. Motivation factors: task requirement, professional development and lack of clinical autonomy contributed to nurses' job dissatisfaction. **Lack of clinical autonomy led to job dissatisfaction** **Suggestions for managers**: ensure a flexible practice environment with adequate staffing and resources enabling nurses to participate in hospital's policies and governance. Policy needs to consider nurses' professional development needs, implementing initiatives to improve nurses' rewards and other benefits as they influence job satisfaction Autonomy was important for job satisfaction – important to maximise opportunity to be involved in decision making	**As was teamwork and relationships –** needs to be built on by managers **Nurses were dissatisfied by reward, promotion, and fringe benefits** – suggestion policy makers should concentrate on initiatives for pay and incentives
42	Roulin, N.R., Mayer, E., & Bangerter, A. (2014). How to satisfy and retain personnel despite job market shortage. Multilevel predictors of nurses'	Examination of predictors of nurses' satisfaction at unit, organisational and individual level	Sample 1547 nurses, in 17 hospitals 81 % female 79% age between 26-50 13.9 years in n nursing	Important for organisations to determine which factors predict personal satisfaction and intent to leave at various levels Results suggest multilevel analysis, job satisfaction is predicted by individual-level (burnout and work-family conflict, and group level group cohesion and unit effectiveness	**Experienced nurses** **Specifically reviewed the difference between priorities for the individual and the employer**

	job satisfaction and intent to leave. Swiss Journal of Psychology. 73 (1). 13-24.	Secondly to better understand what factors moderate the relationship between satisfaction and intent to leave the organisation. Switzerland		whilst organisational level autonomy have less impact Individual predictors for job satisfaction – burnout and work-family conflict – burnout caused by complex schedules and working with illness and death frequently Those that were dissatisfied tended to leave - Burnout- emotional exhaustion, depersonalisation and reduced personal accomplishment EE and depersonalisation and work family conflict negatively related to job satisfaction Personal accomplishment positively correlated to job satisfaction Group level predictors – group cohesion/ team effectiveness Individual and group factors led to JS	Job dissatisfaction may not lead to turnover – other impacts may moderate the relationship **Autonomy not strongly related to job satisfaction** **<u>hypothesis clear – Not all CCN's</u>**
43	Sacco, T.L., Ciurzynski, S.M., Harvey, M.E., Ingersoll. (2015). Compassion satisfaction and compassion fatigue amongst critical care nurses. Critical Care Nurse. 35 (4), 32-43.	To establish the prevalence of compassion satisfaction and compassion fatigue in adult, paediatric and neonatal nurses	Cross sectional design, survey design, and professional QOL Scale levels of compassion – based on age, gender, education level, acuity, change in nursing management, system changes fatigue and compassion satisfaction Sample 221	Greater understanding of professional quality of life and standards for healthy work environment requires more investigation	<u>Consideration of using the professional Quality of Working Life Tool in future studies</u>
44	Bruyneel, A., Smith, P., Tack, J., & Pirson, M. (2021). Prevalence of burnout risk and	To assess the prevalence of burnout risk and identify risk factors	Web-based survey using Maslach Burnout Inventory Scale Sample- 1135 nurses	Prevalence of burnout= 68%-29% at risk of depersonalisation. 31% reduced personal accomplishment. 38% emotional exhaustion	Burnout global work issue <u>Excellent methodology presentation</u>

	factors associated with burnout risk among ICU nurses during the COVID-19 outbreak in French speaking Belgium. Intensive & Critical Care Nursing, 65,	among ICU nurses during COVID-19 pandemic. Belgium		Patient ratios affected emotional exhaustion and depersonalisation Those that perceived higher workload during COVID were at greater risk for all dimensions of burnout. PPE and shortage increased risk of emotional exhaustion Symptoms of COVID without being tested was also a main factor for burnout	higher than previous studies – COVID is the main explanation for this

Appendix 2: Quality Appraisal of the Literature

Appendix 2 Quality Appraisal of the Literature (Hawker *et al*., 2002).

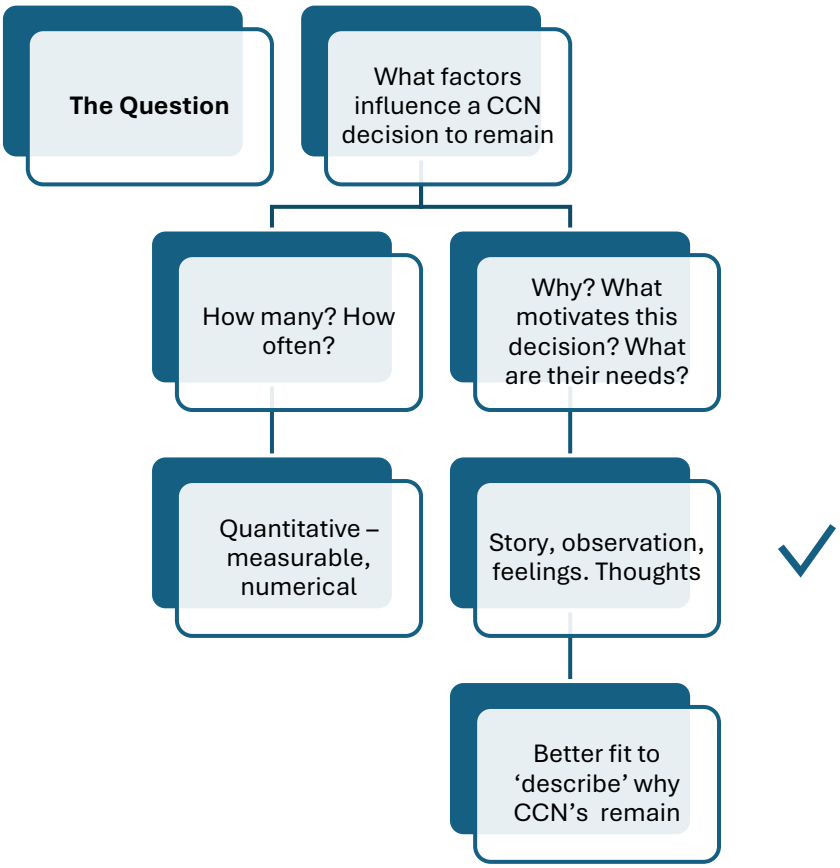
Total Score: 90 – Very Poor. 100-180 – Poor. 190-270-Fair. 280-360 – Good.

Author & Year	Abstract & Title	Introduction & Aims	Methods & Data	Sampling	Data Analysis	Ethics & Bias	Findings/ Results	Transferability/ generalisability	Implications & usefulness	Total Score (Range: 90-360)
O'Brien et al (2022)	38	38	35	30	35	25	35	30	15	281
Vollers et al (2009)	10	10	10	10	10	10	20	20	25	125
Dirks (2021)	15	10	10	10	10	10	10	10	10	90
Rheaume et al (2022)	38	38	38	32	38	35	38	38	38	333
Rushton et al (2015)	35	35	38	30	35	30	32	35	35	305
Roney et al (2022)	36	35	35	34	35	30	35	35	34	309
Fitzpatrick et al (2010)	28	30	8	25	32	20	32	28	28	251
Celik et al (2021)	32	35	34	28	38	30	34	28	28	287
Ulrich et al (2019)	32	32	28	30	28	20	32	32	32	266
Guttormson et al (2022)	35	32	28	22	25	28	30	30	30	260
Ulrich et al (2007)	10	12	12	20	15	12	20	18	18	137
Milligan et al (2020)	15	12	10	8	15	8	20	18	15	121

Bateman et al (2020)	30	30	25	0	0	0	0	0	5	90
Kelly (2017)	35	35	34	36	37	34	38	38	38	325
Kagan et al (2022)	38	38	38	36	38	30	35	34	35	322
Steinburg (2017)	20	20	30	18	25	25	20	16	15	189
Kester et al (2021)	31	22	29	21	25	28	28	25	25	234
Sung-Heui (2021)	36	34	36	38	36	34	35	30	34	313
Yoon et al (2022)	38	38	36	20	35	28	34	23	32	284
Elpern et al (2005)	25	32	32	24	31	31	23	20	28	246
Stone et al (2007)	36	38	38	36	36	32	35	35	34	320
Rivaz et al (2021)	29	34	35	35	35	30	37	35	35	305
Levi et al (2021)	29	32	36	0	35	22	37	35	33	259
Ndlovu et al (2022)	32	35	35	33	34	34	37	36	38	314
Bergman et al (2021)	35	35	32	27	31	30	32	35	33	290
Currey et al (2019)	35	35	35	32	36	32	36	34	33	308
Breau et al (2014)	37	36	38	36	38	30	36	35	36	322

Appendix 3: Decision Tree

Decision Tree (Terry, 2018)



Appendix 4: Feasibility Study University Ethics Agreement

SCHOOL OF SOCIAL SCIENCE AND PUBLIC POLICY

Date: 13 February 2017

Dear Nicky Witton

Thank you for resubmitting the research proposal of your pilot project proposal for ethical review by the School of Social Science and Public Policy *Student Project Ethics Committee* (SPEC). The Student Project Ethics Committee (SPEC) is responsible for ensuring that all research, **involving human participants**, and conducted by undergraduate and postgraduate taught students in the School of Social Science and Public Policy, takes due consideration of the relevant ethical and safety issues in social research.

The SPEC is part of the University's research governance framework, which may be consulted @ http://www.keele.ac.uk/researchsupport/researchgovernance/researchethics/

Researching the ethical statements developed by relevant professional associations (e.g. the British Sociological Association, the Social Research Association, the British Society of Criminology) forms one way in which students can inform themselves about research ethics and apply this awareness in their proposed research project. If you are looking for relevant statements and guidance, you may wish to visit this Economic and Social Research Council resource at http://www.esrc.ac.uk/funding/guidance-for-applicants/research-ethics/useful-resources/. The SPEC would like to remind students to familiarise themselves with these ethical statements, along with other pedagogical materials on their programme of studies, prior to commencement of any fieldwork and the submission of their case for ethical approval.

I am pleased to say that your project proposal has now been reviewed by the School SPEC. On the basis of our discussion on your submission, I am pleased to say that you may proceed with your project, providing you address the following minor points:

- I have attached an annotated version of your documentation, itemised are three notes. Can you ensure that you attend to the minor questions asked there.

Once you have completed the changes, please ensure that you run them past your supervisor, and that both you and your supervisor sign and date the updated documentation. Please then forward all the documentation (the research ethics form, your participant information sheet(s), the consent form(s), and where relevant a copy of your research instrument– e.g. questionnaire schedule or aide memoire for qualitative interviews) in hard copy (not as attachments to emails) to the administrator of your programme in the undergraduate or postgraduate office.

There is no need to run the changes past the SPEC again, we expect that you will do the asked for minor changes in consultation with your supervisor before proceeding with your work.

Where relevant, also update your documentation on the KLE, ensuring that it is clear that this is the SECOND version of your documentation.

[redacted] Head of School
T: [redacted] E: [redacted] F: [redacted] W: www.keele.ac.uk/socrim/
Keele University, Staffordshire ST5 5BG, UK
www.keele.ac.uk +44 (0)1782 732000

SCHOOL OF SOCIAL SCIENCE AND PUBLIC POLICY

Please note that it is university policy that no persons may be contacted or involved in empirical research prior to acceptance of their research ethics documentation. Also note that if your research design changes subsequent to approval and in a way whereby the ethical questions of your work change, you will need to discuss this with your supervisor and submit an amendment document for further approval by the School's SPEC committee.

Finally, please note that this approval is only applicable for the pilot stage of your work. Once you move on to the full research on your programme of studies, you will need to seek further research ethics approval through the University's ERP system that applies to staff and postgraduate research students.

If you have any queries about the ethics relating to your project please do not hesitate to contact me, in writing, at [redacted]. For minor queries, please talk with your supervisor.

Best wishes,

[redacted]
Chair of the Student Project Ethics Committee
School of Social Science and Public Policy

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Appendix 5: Feasibility Study Focus Group Transcription (Focus Group 1)

Pilot Study Transcription

Focus Group 1 28.03.17

Participant	Gender	Type of ICU	Length of Time in ICU
1	F	Cardio thoracic	4 years
2	F	General ICU	21 years
3	F	General ICU	7 years
4	M	General ICU	4 years
5	F	General ICU	16 years
6	F	General ICU	3 ½ years

Length of focus Group: 69:19 minutes

I: Ground Rules defined, confidentiality highlighted, introduction of study, reminder that audio tape is playing.

I (1:21): Demographics of group identified

I (2:26): what does adversity mean? And what does adversity mean to you?

P3 (2.48) not enough teaching, because of the staffing levels and pressures from the hospital, not enough teaching able for new starters so it frightens them more

P5 (3:02) the lack of sort of people in the professional development roles, there aren't actual people within these roles in an ongoing basis

P6 (3:10) that aren't away from clinical, not separate role

I (3:15) so you don't have PDN's in your area?

P3 & P6 (3:18) no, no

P2 (3:19) we've got three people pretending to do one person's job, but they just do off duty

I (3:29) so in the room we only have one saying that says that you have PDN's officially in the role

I (3: 37) so when you talk about there not being enough teaching, what stops there being the teaching?

P3 (3:38) because the staffing levels are shorter, and units are too busy and also the hospital takes staff from the critical care unit to staff wards which are short if we are up to dependency

P5 (3.56) and so you find that in the quieter periods you find that when you have got the opportunity to maybe work through competencies, competency books or actually work alongside somebody

P6 (4:04) you're taken

P5 (4:06) … you're actually then moved to work within another area within the trust. Because of you know

P5 (4.11) I think it's very much seen as they don't like to see ICU having very few patients and staff been there doing nothing, I think that there is quite a stigma

P6 (4.18) they already think we do nothing, so then to have no patients and also be doing nothing, not .

P5 (4.25) and that an Intensive Care, critical nurse you should be able to work anywhere, because you're an ITU nurse, there's that sort of preconceived idea that you know everything and often be put in situations where you know. It's not good for your own morale as well

P5 (4:47) if you're sent to A&E confidence can be knocked we are not A&E nurses but it's ok for them to say I can't go to ICU if they are not busy because I'm not an ITU nurse, it's very much that an ICU nurse can go here there and everywhere, you can go to AMU, everywhere don't we

P6 (5:0) yes

I (5:05) and who is it that says that, the stigma, that you are capable to go elsewhere

P3 (5:9) clinical sites, matrons

P6 (5:16) anyone, anyone really. Even our management sometimes, anyone

P5 (5:20) our managers have very little power, they want you to be doing your competencies doing that extra work, supporting …. And they are not able to stop it really

P2(5:35) when you go to, well we have a standard operating procedure and wherever we go we go as a pair of hands we don't go to an end or we don't go to take a bay, we go

P4 (5.40)

P5 (5.42) but when you get there and it's like oh you're in that bay up there

P2 (5:48) well we go well the policy says no, just incase we have to be called back, so you have no protection at all then

P3 (5:52) speaking up for yourself

P6 (5:55) yes stick up for yourself, I do. I don't take an end I will just wash or do obs or something

P1 (6:00) we are sent as a nurse and expected to do a ward round, like erm the medication, do all the drugs, and things which obviously you don't do in ITU, you don't do drugs

Mm, mm

P2 (6:10) its discharges and referrals, social work team, we don't do those sort of things

I: (6:18) Ok so you sort of highlighted there being moved elsewhere at a time that you think affects your education

Mm

P2 (6:23) I think that's because they have come off the area, they have come off the wards because they don't want to be on the wards. They come, and they realise oh that they will be sent to the wards and they could, so the junior staff come in and they are always the first to be sent back out because they have just come off the wards

P4 (6:33) we have actually lost a few staff because of that, well one in, yeh

P3 (6:38) well a lot, we have lost near about 20 in the last year, haven't we?

P4 (6:44) it's because of the stress and strain of not being, not knowing where you are going to be working on that day whether you'll be in another Trust, across site or whether you will be on a different ward or it's just the not knowing where you will be working

P6 (6:58) it puts people's' anxieties up, anxiety through the roof

Mm, mm

P2 (7:04) from the education point of view we have gone from eight hours to 12 ½ hours and we have now lost the 2 ½ hours or the hour and half in the middle to do any teaching so we have half an hour crossover and that's it

(small commentary difficult to decipher)

P5 (7:17) that's interesting with the change in shift pattern I think it's when you've had your earlies and lates coming on there was always that overlap because there was more staff on so that time was there to say right the people that have been on the early after handover, even if you've just got twenty minutes for an each individual at different times to do a short presentation on, that's how it used to be many years ago didn't it,

P6 (7:32) yes

P5 (7:36) you went a did a little bit of don't know, transducing a CVP line something quite straightforward, condensed down and you learnt from it didn't you, and you learnt, there just isn't that time to do that now and it is because of the change of the shifts definitely

P2 (7:50) and the golden time that you can't give to the students anymore and that protected time they are not getting because you haven't got time, off away

I (7:56) followed by that you talked about that the early and the lates that gave you that time that you have talked about going down from 12 hours to eight

P2 (8:00) no, the other way round

I: (8:04) the other way around, ok that's fine

P2 (8:06) yes

P1 (8:09 when I started I started on long days, erm so we do 7.30 till 21.00 and I found it very stressful and the only reason I stayed was because I swopped and did short shifts. Because you have that overlap and from an education point of view but also from a support point of view, if I was on an early I knew I only had to work till 13.00 and someone else would come on and if I was on a late shift, the earlies didn't go home till 15.30 so I had that overlap to just get people to just help with turns and anything you've got that time and I'm back on long days now due to childcare and I've been qualified four years and now I don't mind doing long days at all but I found a lot of our new starters erm start on the long days and do drop down to the short shifts because we have got that flexibility on our unit and that has kind of helped us out and if not I think a lot would have left due to them being stressful

P5 (9:07) I think that is a big thing, the shift, the length of time the shifts everybody is exhausted really and if you've got a very busy unit particularly busy mmm and you get to sort of four o'clock in the afternoon you might may not have even have had a break you might have been to the toilet once or you haven't had a break and you actually get to that point that you think gosh am I doing my absolute best. You know sometimes, yes but it all comes down to cost though at the end of the day that's why

that's happened isn't it, the shifts have been changed because it's all cost related at the end of the day. And that comes back to the education and the teaching all that's going back because there isn't the money there to give time and I'm sure that across all Trusts

P3 (9:54) and the ideas of dependency, some people you would like get an ITU patient and you treat them as a one to one but actually someone will come in, matron, or someone and say no they are a half but they are not because they are taking one nurse to look after but because there's a lot going on and I think that's stops it as well because it then takes people another member of staff to the ward or something because they say that patient is that dependency but it's not actually because the CMD form and things like that might say that but it isn't actually that isn't it

P5 (10:31) and having a dependency, you have a dependency of six, but we always go over that dependency

P3 (10:38) mm

P5 (10:44) inevitably go dependency don't we

P3 (10.46) and that takes the charge nurse, coordinator to have to have a patient then as well at times, then they are not able to support the new starters and newly qualified and things like that so it's putting it down to their, more experienced staff nurses to that pick up on that. But then also you be got a really poorly patient yourself and it's, added stress and you're given a student to look after and you're just being pulled from here, there, its pressures isn't it

P4 (11.21) I think those pressures are increased because of the criteria for ITU, for a patient to come into to ITU is changing all the time, and sometimes because they will say they need to come here for closer monitoring because the ward can't, come to that level of support and so they will come to us and actually they probably don't need to, don't need to come, don't need an ITU bed, they need an intermediate care area or something like that. So that's sometimes where the pressure comes from and the dependency goes over

P5 (11:56) ten years ago some of the patients that now that we are getting to ITU wouldn't even have been entertained to even have come through the doors

P4 (12:02) no

P2 (12:02) we find that change depends on which consultant, we have nine consultants and it depends on whose week it is, there you go I have soft admission

P5 (12:11) which have been due to place which we didn't always have so some of these patients are sort of not coming through but there are so many that come through, and we think actually why are we admitting them I'm not saying don't treat the patients obviously but you have to be sensible on how far a 96 year old who's got a generally good quality of life is coming through to the unit to be ventilated, sedated, possibly renally supported. Is that what we have to question – is that in the interest of the patient or are we just doing it because the consultant, the consultant level won't actually say

P6 (12.470 won't make a decision

P4 (12:49) I think it comes down to the wards as well because I don't know what it's like at X but at x mm for example epidural training things like that

P2 (12:58) mm. yes,

P4 (13:00) if they have got an epidural mm often they need blood pressure support anyway, but they was a time where they were coming to us because of that

P2 (13.11) we are the only unit that, there is no training throughout the rest of our Trust for epidurals. So, we get everyone

P6 (13:17) really, crickey

P2 (13.19) and they put arterial lines in to make them level 2

P5 (13:220 so you get paid, so you get some funding for them

P2 (13:26) sometimes

P5 (13;27) Mm, sometimes. Otherwise you don't get paid

P2 (13:28) no otherwise you don't get paid

P4 (13:33) so if the wards were better, well equipped and had more training and education and time. And we've got a four-bedded bay that's mmm monitored in the whole of the Trust, so they are probably more if there were more beds like that would save on Critical Care admissions, it would release some of the pressure

I (14:02) ok you've talked about some of the adversity and your welcome to bring some of those up, So why do you think some people stay around a long time and others leave?

P2 (14.15) ours is because people are comfortable

P6 (14:16) yes, fear of change,

P 3 (14:18) fear of going elsewhere

I (14.20) so people are staying for their fear of going elsewhere?

P3 (14.22) not all but I think some would be, yes

P6 (14.24) especially some, that say they will never go back to the ward, even though there are issues in ITU, they are a lot more protected than being on a general ward

P1 (14:39) I have never walked on a ward since qualifying

P6 (14:42) so for you that would be massive, oh my god

P1 (14:44) I fear them sending me to a ward, I've worked, like I've been sent to general critical care and SSCU and that's as far, as I will go, oh my god (laugh)

P5 (14:54) you know you choose when you go into Critical Care, it's I think personally from my own, and I went there knowing I wanted to care for people you know at a very very advanced level, and that patients are really sick that are in ITU so you are looking after the whole patient and getting really stuck in and being able to learn and being on a ward it's a little bit more kind of, I don't know kind of, and I think people go to and I think people stay in ITU for that reason, because you like the buzz of it if you like, the

P6 (15.31) and your all kind of

P3 (15:33) together

P4 (15:34) it's able to do your job as a nurse properly

Yes, yes

P2 (15:38) its quality, you are delivering quality aren't you

P6 (1543) instead of juggling patients on a ward, juggling twenty-eight patients, that you can dabble just a little bit

P5 (15:47) and the more experienced you become you do have that sort of autonomy to be able to make decisions, and your listened to more and sort of have more of an input with doctors and I think you feel valued in working in critical care. I think you get quite an element of respect, don't you?

Yes, yes

P2 (16:07) aww it's that aww you work in intensive care – (laugh)

I (16:14) so that's why you stay

P2 (16:17) a lot of our staff, well 50% of our staff have been there fifteen years plus and because they haven't got degrees, they are not willing to make the leap, and they won't change jobs because they can't, they haven't got degrees and not seeing that they can apply for other jobs and promotions

P1 (16:34) I don't know how it is on the ward, but we are very good and flexible in working hours on a ward where you have naturally got less nurses, so I don't know if they can kind of accommodate the shift patterns as well, whereas I work every Thursday a long day and 1 other long day and because we have so many other staff that's irrelevant really

P6 (16:59) so we are the opposite, we haven't got we are only a little unit so there is no flexible working what so ever its, you're doing the same as everyone else and that's that

I: so, can I pick up a point where you said the lack of degrees prevent movement – is it that you feel that all jobs now advertised as degree level

P2 (17:20) that's why a lot of people have stayed, and they are also they have gone right the way through, they started when they qualified, and they have gone all through, they have family and a nice comfortable life with no ambition

P3 (17:32) They are also.

P2 (17:33) they don't want to mentor students and all that comes in, they are just happy what they are doing, there is no one challenging them

P3 (17:39) we had someone who have been on our unit for about twenty years, I think, they are ready to go and they have done critical care and they went to do respiratory specialist nurse and she was told she hadn't got enough respiratory, umm experience because she's just been on ITU for twenty years (laugh) so that I think we sometimes see your too experienced in other aspects to go elsewhere sometimes as well, isn't it?

I (18:13) so are you saying that potentially these that have long years in service would have gone but can't go?

P3 (18:18) yes, possibly, yes because of certain posts that they are interested in aren't, they supposedly not qualified for because they have been in critical care for so long and they have not experienced the wards and things and community

P2 (18:44) conversely one of our girls, went for an interview she is really highly qualified, masters in critical care and she was told she is too qualified for the job, she wouldn't stay so they weren't going to interview her

I: (19:00) so why do some thrive? Do you seem some that thrive?

P2 (19:06) Yes and you see the new ones coming in and somebody said a quote that she said the other day '' I didn't realise how much I didn't know till I got here and now I know because she had worked in Liver, she had come and it 'makes sense now'' ''it fits in, I've got all the pieces of the jigsaw and it's now making sense'' that's what she said

I: (19:23) so is she thriving?

P2 (19:24) yes

I (19:26): in what way do you see she's thriving?

P2: (19:28) because she's enthusiastic and she wants to teach what she's already learnt and she's taking it forward, she's doing reading and teaching around, in the schools as well, that could just be her, could be her personality, she came very very unsure and she's blossomed like a flower, its lovely to see

P3: (19:47) its confidence as well isn't it cos there's enough of you to build each other's confidence up .. up sometimes and on our unit if you've done something good you will be told, you've done, did well, did well today, and I don't think I can't comment as such, but I can't imagine that happens as much on the wards

I: (20:10) and who does that come from?

P3: (20:13) from your colleagues, everyone really

P4 (20:13) colleagues, sisters

P3: (20:14) anyone really, the sisters, the people that are more experienced

P4 (20:19) I think going on confidence and that first year of being in critical care is like the first, if you can do that one year after that then you will thrive and its keeping the staff in that first year

P3: (20:33) yes, mm

P4 (20:34) enthusiastic, interested and in that first year, you were so worried about making a mistake, thinking of so much to learn and that's where other things like the lack of training and support. Mmm I think we are sort of losing staff and they are not staying on to then thrive because they are not being looked after and nurtured enough in the first year

P3: (20:57) mm

P5 (21:00) I think that some people that are coming don't really know what they are coming to and they are the ones that tend to go because they just think – oh I will try ITU

P3: (21:04) mm yes

P5 (21:05) and they don't actually know, sometimes that the case, isn't it that sometimes people come, I think that sometimes they think they can be easier option

P3: (21:13) and sometimes they are quite brazen, they come in, marching in and think they know everything and then you give them just even a HDU patient and they are like oh, but then they don't speak up and then they start to crumble then

P5 (21:28) perhaps the ones that you find those that actually say you know this is not for me

P4 (21:30) they have probable come into it thinking it's better and I need some experience, acute experience be safer than the ward, maybe that's

P3: (21:40) or they were at a level on the ward and they thought they knew what they were doing there and so when they come to critical care and it's completely different. They have thought they were going to be at a better start at a higher standard and they are actually not, and they are not willing to speak up because we get quite a lot who say they know what they are doing but when you actually look you don't actually know what you are doing. But they are not speaking up erm, so they don't get supported because they are not voicing out as well.

I (22:15) so going back to the point you mentioned about that they are not staying because they are not nurtured – how are some nurtured, how do we nurture?

P4 (22:25) I think by providing proper supernumerary time, proper training programs,

P3: (22:32) have one designated mentor/ preceptor or a couple

P4 (22:34) I think we've learnt

P3: (22:35) we have learnt recently what needs doing

P4 (22:37) there's been, we had a lot of new starters

P3: (22:42) all in one go

P4 (22:44) which we haven't had in a long time and then some of those have left

P3: (22:50) newly qualified went they

P4 (22:51) and the second sort of group of people to start I think we have been a lot better with, learning from the first group, from the feedback, which was the sort of lack of support

P3 (23:01) echoed the lack of support

P4 (23:04) lack of support, lack of supernumerary time

P3 (23:05) but it wasn't for not wanting to, it was because of staffing levels and the more experienced being sent to go to the wards and sent to different units and things the new starters were being left, they weren't being looked after and all the experience had students mm so they weren't able to have

P4 (23:25) or the other way in their first year they were being sent to the ward or across site to work and obviously, that was making them worried because they are going out of their comfort zone again, and we had to do that because of skill mix. Otherwise if you started sending the senior staff over then if we have an emergency that needs dialysis or something like that then we wouldn't have the staff to do it ourselves. So ummm unfortunately some of the junior staff are being asked to go to the wards

or going across site to work or something because of the way the skill mix is so that makes them anxious sometimes, just some people not all of them, some of them take it in their stride.

P3 (24:12) they were being, because there wasn't a proper programme to say where they were going with their training on the unit, when they had been here say six months, you would expect them to be able to do something but then they hadn't even seen it ever before, and you are like what! So, I think other staff members expect certain things of them because they have been here a certain amount of time and they are not able to do it, it drops their confidence again because not everyone words things, properly do they? (laugh) and nicely, they can, umm not shout but they are

P5 (24:15) A bit aggressive

P3 (24:47) Yes, you should be doing this by now or something like that

P5 (24:53) rather than showing them

P3: (23:54) mm yes

P4 (25:00) and I think in ITU as well you have got to be able to go home and pick up a book and read about it, there has got to be a lot of directed study as well. I don't think it's

P3: (25:09) but you're exhausted as well

P4: (25:11) you're exhausted from work and then you know you've got to have a life outside of work as well so it, it's quite a mm hard job isn't it

P3: (25:20) and some days, if you're not being told what to look at then you're not going to look at it, because you could be looking at completely the wrong information couldn't you. If there no guidance I think that's where we lost big time, was with the guidance

P4: (25:38) mm

P2 (25:40) so how long is your supernumerary period?

P3: (25:42) it's four weeks

P2 (25:46) that's not long

P3: (25:46) but if your, but if you look like you are doing well and we are short of staff then it could be three weeks, it could be two weeks (laugh) couldn't it?

P2 (25:55) that's not long

P4: (25:55) see

P2 (25:57) we increased to six to nine weeks, still depending on how they do but we reassess after that time and decide if they need longer

P3: (26:02) we should do longer

P1 (26:08) it's a long while now and I can't remember but it's a good couple of months before they can actually give medications, any type they have drug competency books and until they have got it signed off in the competency book you can't give it

P2 (26:220 IV's - so people are being deskilled before they start

P1 (26:24) I think it's good for newly qualified though because as supernumerary, three weeks

P2 (26:28) we don't take newly qualified, we have six months minimum, before we take anybody

P1 (26:33) yes

P6 (26.35) I've even said to my manager we've had someone that did their four, well they did three and half weeks then two shifts and I said I don't think he's ready to be in the numbers and she said I haven't got a choice, he's got to be in the numbers. He's not really ready now

P3 (26:47) and they sink even more then don't they

P6 (26.50) it's up to the nurse in charge to look after those, those members of staff but then if you are busy and you can't be working with them all day

P3 (26:58) and I don't think they can be listen sometimes, we've had people who have been on temporary posts and then they have been given permanent posts but when you work with them you think, they are not, they haven't got it at the moment they, they don't seem to be, some people seem to be too confident, but they actually know what they are doing

P 4 (27:18) but there are a few issues there

P3 (27:18) and err management don't ask for any feedback of how the temporary staff are going and then they get a permanent post because they have interviewed well

P4 (27:31 they interview well, particularly on value based interview questions

P3 (27:32) but it shouldn't be on all that, but it should be on how they are working – shouldn't it

P2 (27:34) we always are involved in the discussions

P3 (27:37) we are not and then that brings morale down even more because you think we've got a permanent post now of someone who doesn't care, who's not a team worker and

P4 (27:47) I think the recruitment as well, I umm

P3 (27:49) is not, our manager either

P4 (27:50) it's not, sometimes, I think it has been on this but previously umm it was, they were interviewed by the Trust basically and they put three places where they would like to work, and they were allocated where, whereas I did, I worked in x in critical care for a little while and at the interview I was asked ITU questions at the interview. Or related to like what would you do if someone's blood pressure was low? So, I should be able to know even if I was a ward nurse well to know to start doing observations you could answer something, so it would show a certain level of knowledge and skill and things whereas the interview questions at the moment are values based so it is all to do with the Trust

P6 (28:41) and how you are as a person

P4 (28:42) how you are as a person and how you cope with things

P2 (28:46) is that just for newly qualified?

P3 (28:48) no that's everyone

P2 (28:50) everyone doesn't get, you're not interviewed by your unit

P3 (28:51) no not at anymore

P4 (28:52) well this last batch have, but before that

P2 (28:59) all the band 6 levels now, all get involved in our recruitment

P3 (29:01) ours used to when I was interviewed it was the manager and it would be one of the sisters or charge nurses would be interviewing so it was, and it was even the matron, that was on the first interview when I first did it

P2 (29:18) we were even told, you know you are done on a points process don't you but if you feel that they don't fit into to the team then you don't have to take them

P3 (29:22) yeh and that's where they are going back to now, I think for a few years it was like that and then for a few years it was all put into the Trust and our management didn't have a choice of who was coming and when they arrived, we have had really poor staff haven't we and they have been the ones who the majority have left, you would have someone from the community hospital who has not had any hospital experience for years suddenly being put on ITU who wasn't really wary of blood sugar levels and things like that, were they. Let things that we would see as basic would be nothing to them at all, so

P4 (30:03) I suppose that's where you come in and if you've got six months' worth of experience you sort of expect

P2 (30:06) we don't accept anybody

P4 (30:09) you know where, other trusts, our trusts will have newly qualified

P2 (30:15) the only newly qualified we do take are those that have been a health care for five years before they did their training. So, they already knew what was going on

P3 (30:23) and that's because you are looking at an individual aren't you, you're looking at their individual background and that should be involved where you have worked previously and is this going to, are you going to have some background knowledge to build upon rather than starting from fresh.

P5 (30:43) just in regard to what levels of nurses are that are coming into the unit are we looking at their education and training prior to – what a lot of us are saying is that newly qualified don't know this and this might not be just an individual thing it's just that's not being, the seeds aren't being sown at a very early stage. Often you find that what, you even have students, they might be in their very final year that have come to us for an elective placement and you might even be signing these students off to say they are confident in this, this and this but actually their basic nursing skills I don't feel are always there because it's not a priority in their training it's much more degree level, where they might be able to sort of you know present fabulous assignments about different things but the relation to them in their clinical practice isn't always great – isn't always there

I (31:42) can I throw it out there that it hasn't changed it remains 50% practice and 50% education- what would you say?

P3 (31:49) it depends where your placement are as well, definitely,

P2 (31:52) definitely

P3 (31:53) for myself I was a diploma I was but at a big city hospital, erm but where I was it was, there was probably about six different universities because it was a big city. Erm and you would have loads

of students but sometimes, I had one placement two weeks on a falls assessment unit (laugh) for two whole weeks, no for ten weeks that was, a ten week placement on there and I was just like, taking blood pressure, weighing them and that was it, but we pushed to go elsewhere but you don't always have that opportunity so that was in my second year so when you get to the third year and they expect you, got an expectancy of you as a third year student and if you've had really poor placements for those first two years you're not going to be up to everything apart from having your books and knowledge and things like that, what you've had at Uni rather than placements

P1 (32:54) I came to critical care newly qualified, the most acute placement I had had was SSCU but the majority of my training I did at community hospitals, I did the diploma for the first year but I did step up to the degree for the second and third year but I don't think it made a difference in terms of placements and my sign off placement was a community hospice erm but I'm still in critical care four years later, even though my background was not acute and our interview process was you all get sent to generic interviews at Keele – just a generic interview, of all the hospitals you just put your top three choices

P3 (33:28) Mm

P1 (33:31) and I just got sent to critical care

P3 (33:38) but then some people might not have coped with that might they? As an individual

P1 (33:40) I struggled

P3 (33:42) and you said that you've dropped your hours whereas on our trust you haven't got, we are just twelve and half hours shifts , that is it on our unit, that's all isn't it. So, if that was the case you would have gone, wouldn't you? Mm

P1 (33:56) I don't know, it helped, short shifts helped a lot, I think I would have probably would have moved if I would have had to stay on long shifts. But I think sometimes it is just individuals, its personality

P3 (34;06) yes definitely

P1 (34:09) whether you stay in critical care or not

P4 (34:11) and I think when I've been interviewed for my ITU job I was quite pleased that I got the job for ITU and I was proud

P3 (34:20) I'm proud

P1 (34:22) I cried, I didn't want to go

P4 (34:24) if I had been interviewed for like, for erm a number of jobs and I didn't know where I was going and I didn't know the manager that I was going to be working for it would be a bit hollow experience, I don't know

P3 (34: 44) You are pound though, I was newly qualified as well and I was shocked, I was so proud to even get the interview, because I was wow I didn't think I would be suitable as such but I just thought I would go because I wanted High dependency experience and getting the job I was shocked but I was nurtured, I was looked after, I only had four weeks supernumerary but I was, I felt supported but working seven years the first year they changed all breaks systems, loads of things changed very quickly when I was there it's not like at all anything like when it was when I first started so I feel, I

appreciate starting when I did because I was looked after and that's when we've looked back haven't we at the ones that haven't been looked after because we haven't, we wanted to but we haven't had the ability to help

P4 (35:35) the unit hasn't allowed it

P3 (35: 36) we haven't been because we have been pulled here there and everywhere, and pressures are being put on us more and more mmm

P4 (35:44) yes, definitely, the units changed

P3 (35: 46) and the Trusts changed what they expect of you, erm, I don't think you get looked after as much do you, like we did seven years ago

I (36:05) Ok, again you might bring something up, you have touched on it, was you heading towards along personal resilience, is it more of an individual thing, that you stay on?

P3 (36:18) possibly, yes

P2 (36:19) I think it's more of a team thing, or we like to think of ourselves as a family

P3 (36: 21) yes

P2 (36:21) because we all go out together, got our little band we've all created. If an admission comes through the door and everyone piles into the bed space and gets on with it and everybody knows because we have been there for so long what's expected and who does what and it just gets done

P1 (36:37) I think it can be clicky though, for a new starter

P3 (36: 39) yes

P1 (36:39) I know I really struggled just to get a roll when I started. It was hard work, erm and our senior teams are very good but I think we have, we would have agency staff, we have done for years and we have such a high turnover that it can be difficult for new starters to erm, and generally we are erm, I would like to think now that I am kind to new starters and try and help them and support them but I think even if you've got a nice team it can still be difficult to join that, as a new person I, when I started I didn't know anyone, I had never been to critical care and it was difficult to kind of fit in to me what kind of felt like all these clicky people, and I found, I found it difficult from that point of view

P3 (37:30) mmm

P4 (37:30) I suppose as well because of the number of staff you have got cos I worked in another critical care it was thirty beds there was a lot more staff, so I was meeting new staff all the time in my supernumerary period so I never, whereas in my current erm unit it's an eight

P3 (37:48) there's familiar faces all the time

P4 (37:50) yes so you know you get same people more, so I suppose it was harder maybe

P1 (37:56) and working long days you see less people don't you

P3 (37:57) I, yes

P1 (37:57) I do two long days a week now and I will not see people for months, just because we have worked opposite shifts

P3 (38:01) I, yes

P1 (38:04) opposite shifts so you are not always seeing the same people

I: (38:10) so belonging, sense of belonging? Is that important

P3 (38:15) yes as you say like belonging to a family

P4 (38:17) definitely

P3 (38:20) because we are like a family aren't we, you feel the same in your unit as well

P4 (38:21) yes

P6 (38:26) But as people leave you feel oh my little family, the family isn't the same anymore

P3 (38:29) yes, morale goes because we have had people retire as well haven't we, like a lot of people have been there for so long and they are strong characters and suddenly they have gone or those people with long term sickness and they are big characters as well and when they go or they have gone because they are not being developed, haven't had the opportunity to develop on our unit, erm it upsets everyone else doesn't it, you feel like you have lost your brother or something(nervous laugh)

P2 (30:01) we've been to each other weddings and christenings and funerals unfortunately

P3 (39:02) yes, and nights out, and even people when you haven't really worked with them seeing because we have got someone recently who I can remember although P4 might not remember (sorry) but they got diagnosed with terminal cancer and we all come together and put a collection for flowers and things like that, you might not know them but we all think ohhh, they were on our unit, and they were a member of staff on our unit so we all care

P2 (39:35) we've had that similar thing and you've had charity events with them and still do

P3 (39:30) and they might not have had

P2 (39:41) they will do it

P3 (39:41) yes

I: (39:44) so why is that important? do you think that affects the thriving and striving

P6 (39:49) it's kind of gives you a sense of safety almost

P3 (39:52) yes probably

P6 (39:52) something's going wrong you kind of think I can rely on these people to get come through, to pull through this whereas this more disjointed you might think I don't know what's going to happen here

P3 (40:02) yes

P1 (40:03) We know if we have good a good team on or a poor skill mix

P3 (40:07) mmm

P2 (40:09) it's amazing what a difference one person makes doesn't it

Yes, mm

P3 (40:16) and your confidence goes … on critical care doesn't it so if you are on a low people, your team will pick you up won't they but if your team doesn't pick you up then that's when you will keep going low then you don't want to be there anymore do you

P4 (40:28) there a great sense of teamwork and that's why people like it because you can rely on the team because often you are very close to them and I think as well you're going through really emotional, ITU is a really emotional area as well, you are dealing with a lot of, you know, upsetting things and I think as a team you sort of go through all of that together, don't you?

P3 (40:48) and your supported basically aren't you, so if you're having a bad shift your friend next door

P4 (40:52) yes

P3 (40:55) not even your friend your colleague say, will notice and pick you up, and think your struggling there let me help you and it's a, from what I've heard you don't get that on the wards, they will be this is my bay and I don't care what's going on in that bay, this is my bay. That's it

P4 (41:15) that's what it used to be like

P3 (41:16) and that's what a lot of the outreach team say that the nurses feel that, they will go up and say 'they're a patient bay 1 do you know I've been told to look at them, can you tell me and they are like I don't know, they are not in my bay'. so, they are not interested whereas we are not like that

General group laugh – query something said by P2

P2 (41;37) how does agency, because we don't have agency staff, how does that change the dynamic, like transient staff, we have quite a few Spanish nurses at band 5 but they only stay for a couple of years and they go again

P1 (41:49) yes we've have had, we have just got a very high turnover of staff erm, agency and bank nurses tend to be one of the team because they have been coming for years and they come back regularly so a lot of our agency and bank is as good as having one of your own, err experienced staff. Erm because it tends to be people who are senior elsewhere, a lot of ours are senior elsewhere and here for agency. Erm, its new starters think it's difficult to give them the support they need and we just have a poor skill mix and you all struggle, but we did once have a bank nurse and she had not worked in critical care for years so every job that needed doing she literally she just couldn't do it, you may as well have not had her there without being horrible because she just couldn't even do her basics she was coming to you and you were having to look after her patient as well as your own patients. So, you've got that side when you do have poor bank staff, generally

P3 (42:51) but they shouldn't be allowed on the unit because we had that

P1 (42:53) I don't think they will come back again

P3 (42:54) they are not allowed now, on our bank system we had one staff kept on coming and they were just from the ward and they were making they were petrified weren't they to the point where they were making errors and we all reported back to the manager and she was like that's it, right if they are bank they have to be ITU so basically, we cover our bank by our staff, err

P1 (43:22) our staff do as well

P3 (43:24) and there will be some people who have left or and then they just come back and do bank shifts with us. But then our agency we do get sometimes they will come back, they will be the same

ones. But we try and treat them as much as we would our, as one of our team as well because they seem to work better don't they. If you're going to have a drink then they have a drink, yes you just include them in everything don't you. It is scary as an agency nurse, I've been an agency nurse and it is scary, being on your, on a different department, different paperwork, everything like that. I don't know

I (44:03) anything else on belonging? Being part of a team? Family?

P2 (44:10) it's part of a bigger team as well, as we've got nine consultants, but they are very good consultants and the doors are always open. If they see someone is upset any of the consultants will take you off and have a chat with you, and support you or the physios

P6 (44:27) I think because you spend more time at work if you work full time you actually than you do at home so you see these people a lot more, so I think that's why you all become so close

P3 (44:36) yes

P6 (44:37) it's not reliant on them but emotionally a bit of a crutch aren't they, sometimes

P1 (44:42) because you're a lot together with them

Yes, yes

P3 (44:43) because you go through things on shifts that's difficult, because that can be highly emotional but even things when you go through something personally – they are not just your colleagues they are your friends, aren't they so, people can pick up that's something's not right today. What's the matter, and take you away, because we are all human, aren't we and life happens outside of work. But I don't know but you do it is support isn't it and I think that probably keeps you from going elsewhere because once you have got comfortable and you feel belonging to a family and the team then you don't know what going to be like if you go elsewhere. Is it going to be the same? Are they going to be as welcoming are they going to be?

P2 (45:25) Look after you

P3 (45:26) yes - because I would be frightened now, to leave properly, I enjoy agency

P4 (45:32) the thing is where would you go?

P3 (45:33) yes

P4 (45:36) the thing is where would you go anyway? Because you like that acute care

P3 (45:40) Yes,

P4 (45:41) you were saying that you erm

P3 (45:46) the quality of care

P4 (45:46) you care for the whole person and you can do everything for that person, well and you work in that fantastic team so where would you go to do anything else, what else is out there? the only thing you're really looking at would be specialist nurse jobs really, to go up in the erm career pathway, then would you get that, I don't think you would

P3 (46:12) yeh and I would be frightened now to leave properly and that's a fact that when we have a really poorly patient and you don't think that they are going to make it and they do, it's that proud

of what, that you were able to assist in that, (pause) care of that patient and potentially for them to survive and then come in to see you again in six months' time walking into the unit and say thank you, erm, you don't, I think that's a lovely thing

P4 (46:39) yes

P3 (46:41) as well isn't it, on our unit

P2 (46;43) and they do come back time after time, sometimes bring us Easter baskets every year

P3 (46:44) Christmas and you see them, and you think wow look at you, like and you remember how poorly they were and you didn't think that they would survive twenty-four hours and then they are having a lovely little lovely life outside of that and going on holidays and things and I think that's nice isn't it, when you have that

I (47:02) ok so you have sort of brushed on a couple of times career pathway and where do you go? So, if we look at that and identity then. Where do you see yourselves? Do you see what I mean? If you're saying, it's scary to move elsewhere

P6 (47:21) I think ITU nurses always want to go up, they don't want to, often go back, not saying a wards down if you know what I mean they don't want to go back to ward level. they either go specialist or sister or manager or something. Well I think they do, it's not often they go the other way

P3 (47:35) yes, I think mine would always. I wouldn't want to be management, but I definitely want to be a sister erm, on the unit and I would want to do that for at least ten to fifteen years more really and then I think I would like to go into hospice care really. I wouldn't want to go into the wards

I: (47:56) so do you all see career development within critical care?

P1 48:00 Not locally

P3/P4 (48:00) no, no

P3 (48:03) I think you have got to wait for someone to retire on our unit

P4 (48:05) and it, and it you know it's funded for the critical care course for example you can't go up the career ladder without the critical care course so there only a limited number of spaces for that, per year. And then you have to work really hard to get on to, for us anyway, you know there an interview process, you have to be seen to be doing stuff on the unit and acting up as well. So, it's you have to work hard at your career progression

Mm, mm

P2 (48:43) it's not automatic once you have done your critical care course

P3 (48:45) you have to wait till someone retires or something

P1 (48:53) a lot of our experienced nurses move to be nurse specialists at a band 6 level because they were waiting just so long or the very experienced but you have to have the critical care course and you've got to have your mentorship and the difficulties getting funding for those, so even though they will put you in charge when there is no staff but they are they equally reluctant to fund you to actually get your band 6

P3 (49:15) you don't always get looked after, there's an expectancy of, because I think we were as soon as we started this course we were put on the high dependency, like right you are in charge now. I had literally done one day

Laugh, from multiple group members

P3 (49:28) one day at uni, like what are you doing? There are like well you are on it now so, we haven't got anyone else to take charge on that unit, so you will have to do it. And I'm like – ok (laugh)

P4 (49:37 I think as well with that it's because they make it hard to get on the course because then you have to have an interview sort of mini presentation such, isn't it like discussion so I suppose they

P6 (49:52) almost trust you

P4 (49:53) almost trust you from that, but at the same time it's just like oh I've only done a day

P3 (49:57) but you feel used sometimes don't you and when you don't you might not get something back out of it, sort of thing, you're doing all of the hard work and then suddenly they might not be that development placement for you to go into. So, because we have lost someone who's really experienced haven't they, and they just couldn't wait any longer for a charge nurse post and they were a massive asset to the unit. And that loss to all of our morale that would have been amazing for them to have become one of our charge nurses so now erm another hospital has gained

P4 (50:23) in fact we have lost a few experienced staff

P3 (50:36) our friend

P3 (50:41) but I think that's down to development isn't it

P4 (50:42) yes

P3 (50:44) not having that role, place for them to have, to step into

Yes, yes

P6 (50:54) I don't know because I have only been there three years, but I don't know previously there was a lot more band 6's and less 5's whereas now I think it's gone more 5's less 6's. I don't know is that what it used to be like?

P3 (51:05) there's always more 5's than 6's on ours

P1 (51:12) we've now had junior band 5's and senior band 5's and that how I think we have got around it locally – laugh

P3 (51:19) that's what we've got, we've got that. You have to meet criteria, but you don't get anything more for it

P1 (51:26) no, no you get nothing more for it, no criteria that's kind of known about (laugh)

P3 (51:29) you are just the sisters back up, that sort of thing that's how it is seen, you just get moved

P4 (51;33) yes

P3 (51:33) on the off duty, from there to there

P1 (51:39) and its more difficult to get swaps

Laugh generally in room

I: (51:43) so do you see that there is a career, do you have career plans?

P3 (51:50) I have one but it's difficult to know that you are actually going to succeed that with if there's going to be a place/ role or not

P4 (51:59) I don't know, I think ultimately, we. Well, me I am on the course and you want to be a 6 eventually, charge nurse, sister whatever, I don't know what after that though. because also if you go anywhere else unless it's a specialist nurse job you wouldn't necessarily get a 6

P3 (52:18) Mm

P4 (52:20) anywhere because you haven't got that experience in that area. So sometimes they are stuck

P5 (52:25) the training isn't just about wanting to move up it's about consolidating your learning, and just for your own development within your field. It doesn't always have to be

P6 (52:34) we often say we haven't done it to become a 6

P5 (52:38) yeh, my, I don't want that, I've done it because I've been in Intensive care for many many years and I don't want to do it to be a band 6 I want to to do it just to consolidate my learning

P3 (52:49) do a better job as well isn't it

P5 (52:50) and I think sometimes that perhaps why this also happens when people do courses then the expectation is that I've done it and I want to be at this level now and that's changing as well isn't it. Which is good to want to move through but then

P3 (53:06) yes, I think also just because you've done the course I think you need more experience, erm, before you become a sister in charge

P5 (53:15) by having the course doesn't make you ready for the next role

P3 (53:18) no, I agree there

P5 (53:19) being a better nurse or being a better practitioner because you have a course

P3 (53:24) yes, because I think actual physical experience beats somethings sometimes because you're living and working it, seeing it all the time, but the course helps back up that knowledge and understand it isn't it

P5 (53:35) it's still being flexible and updating knowledge

P3 (53:42) it's making you understand why that is happening but it doesn't teach you the experience cos you see all the experienced nurses on the unit and the sisters and things, something will have happened and they will be like ooh did you see that sign come up and you're like ooh yes I did – well like that will always happen when that situation occurs. But you don't always see that in a book, But they have lived it and seen it

P4 (54:04) Mm,

P3 (54:05) hundreds of times and they know that's the sign to look for

P5 (54:09) this course in itself isn't actually teaching you how to be a band 6 it's not what the course is doing, and I think that's what people got the course

P3 (54:15) I can be, yes

P5 (54:17) band 6 isn't about the nursing role yes, its

P3 (54:20) its coordinating isn't it

P5 (54:22) but yes, it's about

P6 (54:24) coordinating and managing beds

P5 (54:26) and personality managing, managing all of them, those things it's not about what we are learning about so that's why I don't

P2 (54:35) opens up more doors doesn't it

P5 (54:35) so at my interview why did you want to do the course, I never once said because I want to be a band 6. I didn't say that

P3 (54:43) Mm, mm

P5 (54:44) because this is for me, it's for my development, for my nursing, yes, it's to make me better but also for me to inform the new junior members that are coming to be able to support them better. It isn't about

P6 (54:54) Better teaching

P5 (54:55) maybe that what it's about where it's going wrong as well people think oh yes, I'm I can do this now because I've got a course

P3 (55:03) and also I think it's other teams expectations of you, like you are on the course so suddenly they are like you're going to be a charge nurse, sister and you're like ohh like hang on I'm like let me just finish the course first (laugh) and people expect you that you're going to be a sister and charge nurse, that is what you want but as you say it's to develop your knowledge and skills as well to. To if you want to be a sister or charge nurse, to go for it but that's not how you be a sister who's just on the course

P2 (55:34) who would want to be on the, I haven't got the energy if you look at what the band 7's have to put up with on the shift, I think I don't want to do that. I would rather do my job properly, good quality care, feel like I have done a good job and go home

P6 (55:46) Yes, yes

P6 (55:47) that's how it works

P3 (55:49) and a lot of them are worrying that, you see the sisters mainly spending most of the time trying to cover the shifts

Mm, mm

P3 (55:56) they are not actually looking after the really poorly patients, they are not overseeing, they are trying to cover the shifts because there's sickness (laugh)

P4 (56:03) but I think because people wait so long to get on the course and they have been qualified

P3 (56:08) they are ready

P4 (56:09) so long I think that's why people get impatient and they think I've got the course now, you know just the flip side of the coin because they have been qualified for so long and they have been waiting and waiting and waiting to get on the course and then they have done the course and they are still waiting for that. Because they particularly do want it, so erm

P2 (56:30) that not the same here

P3 (56:32) Its opportunities isn't it as well

P2 (56:34) do you not do six months then they get straight onto to the course?

P1 (56:35) Oh no

P2 (56:36) because the girls when I did it had done a year and they were straight onto the course because they couldn't do balloon pumps until they have done the course

P1 (56:40) no, ours is that you can't do swan studies until you have done the course and where that has come from because it is still in-house training so I am not sure either where that has come from. No I had been qualified two years before I had been asking about the course and it went on funding because I think they like you to have a couple of years' experience because they don't want to fund those that they think are potentially going to leave, you need to show that you are committed to critical care to get on the course

P3 (57:09) Mm

P3 (57:12) We have to sign a contract to say

Mm,

P2 (57:13) did you?

P3 (57:13) to say if we left you have to pay the trust back

P5 (57:18) Pay, and you have to stay on the unit for two years following the course, you don't just do the course and go elsewhere

P1 (57:22) I was told once I had got funding you can theoretically move but obviously for your competency books you need to be on critical care, so you are kind of tied for that bit. But we had to sign to say that we would pay back funding but not that we would work in critical care for so long

P6 (57:36) it just says in the Trust

P3 (57:38) Yes, ours says the Trust

P6 (57:42) for two years

Mm, mm

P6 (57:47) which I suppose for them because they want to retain their staff that have got the course I do understand that, because they have had people do it and leave and then say, oh ok

P3 (57:53) which makes sense

P5 (57: 58) but your spending money, and they are just going

P3 (57:59) it's a lot of money as well, it's not cheap

P2 (58:03) our staff find it much harder to get on the mentorship course considering how many people we mentor or teach in from all different midwives right the way through to theatre technicians, medical students, student nurses new starters. You are teaching the whole remit aren't you. And you really can't get on the course, we have got too many mentors

P1 (58:22) Ive been given students and new starters but I couldn't get funding to do my mentorship

P6 (58:26) we have to have the mentorship to get onto the course

P1 (58:30) and I've still got to do the course

P3 (58:340 it used to be a criteria but I think some people have slipped through it

P4 (58:39) they don't like it, the odd few have gone through but most of the time we have to have the mentorship. You have to have done workbook 1

P3 (58:43) you have to be second on,

P4 (58:47) there like a criteria before you can get, before you can apply and then we have got the interview

P3 (58:55) so there are obstacles, you can't I think, we have had a new starter come in and they are like well I would like to start the course. But you have to kind of educate them and you have to do the module 1 first which is in house training then you have got to do this and then you have got to do that and then also you have to interview for it so just prepare it could be about three or four years if you are lucky. Its seven years for me, well six years really and some people even longer, isn't it, so you have to. It's kind of wait your turn isn't it as well, your kind of told

P6 (59:29) for many years you are on the back burner, because other people have been waiting

P3 (59:33) because there's only two per unit isn't there, so which then puts

Mm

P3 (59:40) for us

I: (59:45) How do critical care nurses' self-identity feelings and ideas and attitudes relate to their social environment?

erm, erm

I (60:06) so how much do you think your identity, ideas and thoughts relate to the area that you work?

P4 (1:00:15) I think a quite a lot really because I

P3 (1:00:17) because your caring nature isn't it

P4 (1:00:18) yes and on a personal level erm I like, I wouldn't say I'm OCD but I quite like things done properly

P3 (1:00:27) laugh, I developed that

Group laughs

P4 (1:00:30) I quite like the environment of critical care because I can get mm I know what needs doing and I can get it done, really well and then I can go to the doctor get my prescription quickly because we have got doctors there. Erm, you know you can, you have all, it's that thing where you can care for the whole person again, mm

P5 (1:00: 54) Control

P4 (1:00:55) it is yes

P5 (1:00:57) control

I(1:00:57: control of what?

P5 (1:01:04) of being in charge of your own, you're one to one

P4 (1:01:06) your own space

P5 (1:01:07) with a level 3 patient, you've just got that one patient, it's your patient and you can with experience

P3 (1:01:15) yes

P5 (1:01:15) with experience which you have got you can manage yourself. Sometimes over that twelve hour shift you can see an improvement in your patient, from when you have come on, that's really satisfying, not that it's only down to you but you get that because you its consistency, you're there and you're with your

Mm, mm

P3 (1:01:34) and you're continuously observing, the slightest of changes and achievement isn't it

P2 (1:01:44) I think you achieve at work far, what you would like to achieve at home but you can't, for me. Because I like to be in control and I like to see that I am doing a good job but it's not always possible at home but I know when I come to work I can control my own environment and I can achieve that by the end of the shift whereas

P3 (1:02:02) yes

P4 (1:02:06) and you have to be quite conscientious don't you in ITU, be quite precise, neat and thorough and methodical that's a really good point, even at home I will like sort of make lists and I will think I have got to sort that out and it's exactly the same at work, I will do the same

P6 (1:02:16) Methodical

P5 (1:02:21) It's very much a set way of working, isn't it?

P3 (1:02:25) yes

P5 (1:02:25) I'm not saying it's all I'm not going to

P3 (1:02:28) tick boxes isn't it as well, yes

P5 (1:02:29) in terms you know where you are going and where you are coming from, I know everybody works slightly differently

P3 (1:02:38) but we all go from the same hymn sheet

P5 (1:02:40) You've got your chart haven't you, everything is there to see and you know where you are

P3 (1:02:45) and there prompts there

P4 (1:02:46) everything about your patient

P3 (1:02:48) and there always a prompt there so even if you got so really busy that chart will be there's prompt on there to remind you- ohh, haven't checked NG tape, there's reminders there like you say with a list, there's a tick box for you to know that you have done everything. Ohh it feels good doesn't it when you have done it

P5 (1:03:04) yes it does, gold standard

P3 (1:03:07) yes

P2 (1:03:08) do you think there a difference between part time and full time, as part time I work shifts similar to yourself I will have one at the beginning of the week and one at the end of the week and you know you are going to go in and get a totally different patient so you got to have a set method of working through the information to make sure you don't miss anything whereas I don't know if full time gets the same patient for four days in a row

P3 (1:03:32) you can do, but also, we like because when I have one I handed over to you yesterday morning didn't I and like you could be working there tomorrow and I could be there the next night, so you are being handed over about that patient and I don't know your being up to date with it aren't you as well. Its continuity of care isn't it and so if say on three nights I could have the same patient three nights in a row, might not but sometimes you will, and you've got that continued care every night haven't you. erm

P5 (1:04:05) or even not having the same patient it's just that

P3 (1:04:07) and the relatives that

P5 (1:04:10) that care

P3 (1:04:10) yes

P5 (1:04:11) that care for the level 3 patient needs, you know where your, you can through a methodical way, can't you, through your ABCDE, all very because it's all there, and that's why as a critical care nurse

mmm

P5 (1:04:24) you can then go to other environments because you have that sort of got that ABC, yes well that comes in where ever you go and there's so many, that's lost isn't it on the ward even though that should still be the case

Mm, mm

P4 (1:04:36) seems chaotic

P5 (1:04:37) the patient environment, safety of the environment but this is where it's all falling down

P3 (1:04:37) But – yes

P5 (1:04:42) people don't learn that way anymore

P3 (1:04:43) a lot of people

P6 (1:04:45) not the time to do that and not that we haven't got the time

P3 (1:04:48) but we look into things deeply don't we whereas I can't say from experience but from what people have told me from before on the wards you do as you do but then when an ITU nurse goes you looking for problems, you're looking for issues more rather than dealing with what you have got. Whereas we are like cos you are thorough in everything else in the unit

P4 (1:05:13) well when I worked on a ward I was a basically as a ward nurse you were a coordinator management role and I didn't know a HCA would do my observations and I would, you are detached from your patient whereas in critical care you are 100% with that patient, you know all their blood levels you know erm everything that's going on you know all their family and it's that erm it's that standard that you can achieve

P2 (1:05:44) the only thing that I sometimes think is that the level two patients mess with your head a bit because you've got that very strict way of dealing with everything and they go I'm not getting up now, I will get up later

Mm

P5 (1:05:54) they can talk to you – thinking not actually don't

P2 (1:05:56) thinking move

P5 (1:05:54) very frustrated

P3 (1:05:59) Your control has gone then and they

P2 (1:06:01) can't move in the bed

P3 (1:06:05) and they move in the bed and we like them to stay still

Laugh generally around the room

P3 (1:06:07) You've made my bed look messy

P4 (1:06:15) I think there is definitely a link between personality and ITU there has got to be

Yes, mm

P2 (1:06:20 the same sense of humour

P3 (1:06:22) because you get, yeah because we have to deal with a lot of difficult situations don't we

P6 (1:06:27 we are completely OCD

P3 (1:06:27) mm

I: (1:06:40) there probably about three minutes remaining for you to talk about this concept of nurturing and why you are staying and not leaving, belonging and also these personality traits are quite interesting

P3 (1:06:50) I just love my job really

P4 (1:06:50) I do, yes just love my job

P3 (1:06:53) I just love to go home knowing I've been able to do the best that I can, mm and that when I hand over that other nurse is going to be doing the best that they can

P4 (1:07:01) it's a rewarding job isn't it

P3 (1:07:05) yes

P4(1:07:06) and you can do everything for one

P2 (1:07:08) and nobody knows everything because I always go to shifts and find something new that I didn't know before

P6 (1:07:51) there is always something to learn isn't there

Mm, mm

P6 (1:07:52) I could never walk in that place and say that I know it all and I don't think anyone ever could

P3 (1:07:56) Exactly, everyday even people that have been there twenty thirty years, there's always something different

P5 (1:08:05) it's very much a privileged role I always think

P3 (1:08:06) yes

P5 (1:08:06) for me, you can be at the end of someone's journey through hospital or they might of come to you in the first place, start off

P4 (1:08:12) definitely

P5 (1:08:14) and you see them move out and go out through the door but that's not always the case

P3 (1:08:17) and you become attached don't you sometimes like we've got someone who's there for eighty days now and become really cheeky and you get a bit of banter and they see the next staff come on and they get another little bit of joy of different staff, you build them up as well don't you, They build you up as well because you can see how well they are doing in those little baby steps, they are improving

P6 (1:08:42) we had a patient, and I don't know if you are meant to but we still go and see him now, 250 days he's in another hospital but he was here and now he's at another hospital and we still go and see him because you have built that bond, not just with the patient but with the family, you know all that those days of sitting, the families sitting around when they are sedated that who you talk to isn't it, you build these bonds it's quite nice really

Mm,

I: (1:09:19) any last comments before I turn this off. Thank you very much.

Appendix 6: Feasibility Study Analysis Formulating Meanings

Critical Care Nurses Thriving and Striving through Workplace Adversity

Colaizzi's Strategy Step 3: Formulating Meanings

Focus Group 1

Significant Statement	Formulated Meaning
P3 (2.48) not enough teaching, because of the staffing levels and pressures from the hospital,	Organisation pressures affect the amount of teaching which makes life difficult
P3 (2.48) not enough teaching able for new starters so it frightens them more	Staff realise that not enough education frightens new starters
P5 (3:02) the lack of sort of people in the professional development roles, there aren't actual people within these roles in an ongoing basis	Recognition that there aren't enough educators in roles on a continual basis
P6 (3:10) that aren't away from clinical, not separate role	Educators have multiple roles, not specific to education
P3 & P6 (3:18) no, no	These nurses do not have educators as specific identified roles within the area
P2 (3:19) we've got three people pretending to do one person's job but they just do off duty	This CC has shared educator role, and focus on organisation activities
P3 (3:38) because the staffing levels are shorter, and units are too busy and also the hospital takes staff from the critical care unit to staff wards which are short if we are up to dependency	Staffing levels, and dependency of patient delivery of education, as staff are moved to the ward when there is a lower patient dependency
P5 (3.56) and so you find that in the quieter periods you find that when you have got the opportunity to maybe work through competencies, competency books or actually work alongside somebody …. P5 *(4:06) … you're actually then moved to work within another area within the trust.*	When there are opportunities to teach and work through competencies, staff are moved to the ward areas
P6 (4:04) you're taken	Agreeing that they are moved to other areas
P5 (4.11) I think it's very much seen as they don't like to see ICU having very few patients and staff been	Nurses feel that CC is under review and lower dependency linked to having nothing to do, others consider this as negative, stigma attached

there doing nothing, I think that there is quite a stigma	
P6 (4.18) they already think we do nothing, so then to have no patients and also be doing nothing,	Lack of insight of CCN activities when CC has reduced occupancy
P5 (4.25) and that an Intensive Care, critical nurse you should be able to work anywhere, because you're an ITU nurse, there's that sort of preconceived idea that you know everything and often be put in situations where you know.	CCN's believe that they are perceived to be able to work in all environments, that CCN knowledge is wide and that they can work in any situation
P5 (4.25) It's not good for your own morale as well	This preconceived opinion affects CCN morale
P5 (4:47) if you're sent to A&E confidence can be knocked we are not A&E nurses but it's ok for them to say I can't go to ICU if they are not busy because I'm not an ITU nurse, it's very much that an ICU nurse can go here there and everywhere, you can go to AMU, everywhere don't we	CCN complain that confidence is 'knocked' when being sent to emergency and assessment areas, Acknowledge that A&E nurses refuse to work in CC, in similar position, when dependency low
P6 (5:0) yes	Others agree
P3 (5:9) clinical sites, matrons *P6 (5:16) anyone, anyone really. Even our management sometimes, anyone*	Identification that managers both within and external to CC decides that CCN's can work anywhere
P5 (5:20) our managers have very little power, they want you to be doing your competencies doing that extra work, supporting …. And they are not able to stop it really	CCN opinion that local managers would prefer CCN's to remain in CC to complete competencies and have limited power to avoid this
P2(5:35) when you go to, well we have a standard operating procedure and wherever we go we go as a pair of hands we don't go to an end or we don't go to take a bay, we go	CCN describes their role in the ward environment, 'pair of hands' rather than to lead a specific area, supported by a Standard Operating Procedure
P5 (5.42) but when you get there and it's like oh you're in that bay up there	Experience different for these CCN's, expected to lead 'bays' and this is undesirable
P2 (5:48) well we go well the policy says no, just in case we have to be called back, so you have no protection at all then	This CCN highlights how important the SOP is to support the work that they should be providing – ensuring that they can return to CC if required
P3 (5:52) speaking up for yourself	Encouraging other CCN to voice opinion about this
P6 (5:55) yes stick up for yourself, I do. I don't take an end I will just wash or do obs or something	Encouraging others be firmer on have clarity on what they will do, tasks such as personal care and vital signs monitoring

P1 (6:00) we are sent as a nurse and expected to do a ward round, like erm, the medication, do all the drugs, and things which obviously you don't do in ITU, you don't do drugs	CC nurse perception of expectations that they should perform leadership roles in the ward environment such as ward rounds and medication rounds, and how they feel these are different to the CC roles
P2 (6:10) its discharges and referrals, social work team, we don't do those sort of things	CCN do not perform discharges and referrals to social work, they are different to their typical care
P2 (6:23) I think that's because they have come off the area, they have come off the wards because they don't want to be on the wards. They come, and they realise oh that they will be sent to the wards and they could, so the junior staff come in and they are always the first to be sent back out because they have just come off the wards	New starters to CC didn't expect to have to return to ward areas when dependency is low, they have chosen to leave the wards but due to their recent experience they are more current in practice so are the first to be sent
P4 (6:33) we have actually lost a few staff because of that, well one in, yeh	This is a reason for attrition
P3 (6:38) well a lot, we have lost near about 20 in the last year, haven't we?	Large numbers of staff have left CC in the previous twelve months
P4 (6:44) it's because of the stress and strain of not being, not knowing where you are going to be working on that day whether you'll be in another Trust, across site or whether you will be on a different ward or it's just the not knowing where you will be working	Attrition of staff is related to the stress and strain on working in multiple environments and not on CC
P6 (6:58) it puts people's' anxieties up, anxiety through the roof	Working on wards increases anxiety
P2 (7:04) from the education point of view we have gone from eight hours to 12 ½ hours and we have now lost the 2 ½ hours or the hour and half in the middle to do any teaching so we have half an hour crossover and that's it	Change in shift patterns has reduces opportunity for teaching as reduced overlap of staff
P5 (7:17) that's interesting with the change in shift pattern I think it's when you've had your earlies and lates coming on there was always that overlap because there was more staff on so that time was there to say right the people that have been on the early after handover, even if you've just got twenty minutes for an each individual at different times to do a short presentation on, that's how it used to be many years ago didn't it,	Previous shift pattern increased the time that more staff were on the unit, this allowed for at least minutes for teaching Identified teaching time during previous shift patterns
P6 (7:32) yes	Others agreeing

P5 (7:36) you went a did a little bit of don't know, transducing a CVP line something quite straightforward, condensed down and you learnt from it didn't you, and you learnt, there just isn't that time to do that now and it is because of the change of the shifts definitely	Identifying the types of simple short teaching sessions that happened during the overlap in the previous shift patterns The reduction in these prevents this
P2 (7:50) and the golden time that you can't give to the students anymore and that protected time they are not getting because you haven't got time, off away	Reduction in protected time to give to students – 'golden time for teaching lost'
P1 (8:09 when I started I started on long days, erm so we do 7.30 till 21.00 and I found it very stressful and the only reason I stayed was because I swopped and did short shifts. Because you have that overlap and from an education point of view but also from a support point of view, if I was on an early I knew I only had to work till 13.00 and someone else would come on and if I was on a late shift, the earlies didn't go home till 15.30 so I had that overlap to just get people to just help with turns and anything you've got that time and I'm back on long days now due to childcare and I've been qualified four years and now I don't mind doing long days at all but I found a lot of our new starters erm start on the long days and do drop down to the short shifts because we have got that flexibility on our unit and that has kind of helped us out and if not I think a lot would have left due to them being stressful	CCN identified the stress of long shifts as a new starter, and benefits of changing to shorter shifts and that they would have left without this option. The overlap period ensured that there was help to assist with care, however once they were more experienced they returned to the long shifts for personal reasons, to assist with child care. Identifies this as a common pattern for new starters and the flexibility locally can support this
P5 (9:07) I think that is a big thing, the shift, the length of time the shifts everybody is exhausted really and if you've got a very busy unit particularly busy mmm and you get to sort of four o'clock in the afternoon you might may not have even have had a break you might have been to the toilet once or you haven't had a break and you actually get to that point that you think gosh am I doing my absolute best. You know sometimes, yes but it all comes down to cost though at the end of the day that's why that's happened isn't it, the shifts have been changed because it's all cost related at the end of the day. And that comes back to the education and the teaching all that's going back because there isn't the money there to give time and I'm sure that across all Trusts	CCN's identify that long shifts are exhausting, and offer little opportunity for comfort breaks or meal breaks and relate this to whether that are functioning at their best. There is an understanding that the change to the shift patterns is similar across all CC units, and that they were changed as a cost saving and that there isn't time to support education and teaching
P3 (9:54) and the ideas of dependency, some people you would like get an ITU patient and you treat them as a one to one but actually someone will come in,	Acknowledging a lack of adherence by local managers to dependency scoring tools when assistance is required in other work areas

matron, or someone and say no they are a half but they are not because they are taking one nurse to look after but because there's a lot going on and I think that's stops it as well because it then takes people another member of staff to the ward or something because they say that patient is that dependency but it's not actually because the CMD form and things like that might say that but it isn't actually that isn't it	
P5 (10:31) and having a dependency, you have a dependency of six, but we always go over that dependency	Supporting the commentary that dependency tools are not adhered to when related to the workforce numbers
P3 (10:38) mm	Others agreed to this
P3 (10.46) and that takes the charge nurse, coordinator to have to have a patient then as well at times, then they are not able to support the new starters and newly qualified and things like that so it's putting it down to their, more experienced staff nurses to that pick up on that. But then also you be got a really poorly patient yourself and it's, added stress and you're given a student to look after and you're just being pulled from here, there, its pressures isn't it	The negative affect of not adhering to dependency tools means that the supernumerary staff are included within the numbers and this affects the supervision of new starters and new registrants. The responsibility is then on the other more experienced staff to identify any needs, which causes stress as they are caring for the acute patients. This is in addition to having additional roles such as student nurses, this adds to the pressure being experienced.
P4 (11.21) I think those pressures are increased because of the criteria for ITU, for a patient to come into to ITU is changing all the time, and sometimes because they will say they need to come here for closer monitoring because the ward can't, come to that level of support and so they will come to us and actually they probably don't need to, don't need to come, don't need an ITU bed, they need an intermediate care area or something like that. So that's sometimes where the pressure comes from and the dependency goes over	CCN's acknowledge that the admission criteria for patients is dynamic and some admissions relate to the lack of education and supervision on the wards, or the lack of an appropriate intermediate area of care. This inconsistency can lead to an increased dependency of patients on the CC unit and causes pressure to the CC workforce.
P5 (11:56) ten years ago some of the patients that now that we are getting to ITU wouldn't even have been entertained to even have come through the doors	Awareness of the changes to admissions criteria over the last decade
P2 (12:02) we find that change depends on which consultant, we have nine consultants and it depends on whose week it is, there you go I have soft admission	Admissions depend on the gate keeper, which differs from week to week

P5 (12:11) which have been due to place which we didn't always have so some of these patients are sort of not coming through but there are so many that come through, and we think actually why are we admitting them I'm not saying don't treat the patients obviously but you have to be sensible on how far a 96-year-old who's got a generally good quality of life is coming through to the unit to be ventilated, sedated, possibly renally supported. Is that what we have to question – is that in the interest of the patient or are we just doing it because the consultant, the consultant level won't actually say	CCN describe a time when admissions criteria were stricter and consultant decision making was firmer. They clarify that patients should receive appropriate care but is CC the 'right place'?
P6 (12.470 won't make a decision	Reduction in decision making by gate keepers
P4 (12:49) I think it comes down to the wards as well because I don't know what it's like at X but at x mm for example epidural training things like that	Relate these decisions on admissions to the lack of knowledge on aspects of nursing management such as epidural training
P2 (12:58) mm. yes,	Agreeing with statements
P4 (13:00) if they have got an epidural mm often they need blood pressure support anyway, but there was a time where they were coming to us because of that	Reasons for admissions, inability of ward nurses to care for some pain management systems
P2 (13.11) we are the only unit that, there is no training throughout the rest of our Trust for epidurals. So, we get everyone	This CC admits all patients with this particular management as policy, as there is no specific training for this for ward staff
P6 (13:17) really, crikey	Surprise by CCN's who are not used to this admission policy
P2 (13.19) and they put arterial lines in to make them level 2	CC admission definition relate to level 2 and level 3 care, so these addition care management processes are undertaken to ensure the patient fulfils the admission criteria
P5 (13:22) so you get paid, so you get some funding for them	By adhering to the levels of care ensures funding for the admission so management is being commenced to ensure funding for these patients
P2 (13:26) sometimes	CCN agree that this practice happens
P5 (13;27) Mm, sometimes. Otherwise you don't get paid	CCN agree that this practice happens
P2 (13:28) no otherwise you don't get paid	CCN clarifying why this happens, to ensure financial payment for patient admission

P4 (13:33) so if the wards were better, well equipped and had more training and education and time. And we've got a four-bedded bay that's mmm monitored in the whole of the Trust, so they are probably more if there were more beds like that would save on Critical Care admissions, it would release some of the pressure	CCN's advice on what is required to enable the wards to have these types of patients to reduce CC admissions
P2 (14.15) ours is because people are comfortable	CCN suggest why nurses stay in CC, they are comfortable
P6 (14:16) yes, fear of change,	Nurses fear change
P 3 (14:18) fear of going elsewhere	Fear working elsewhere
P3 (14.22) not all but I think some would be, yes	Some fear the change to go and work elsewhere
P6 (14.24) especially some, that say they will never go back to the ward, even though there are issues in ITU, they are a lot more protected than being on a general ward	CCN's work in a protected environment in comparison to the ward nurses and would therefore not return to that work area
P1 (14:39) I have never walked on a ward since qualifying	Some have never worked in a ward area since registration
P6 (14:42) so for you that would be massive, oh my god	Recognition that it would be difficult to work in an environment that you have never been exposed to since registration
P1 (14:44) I fear them sending me to a ward, I've worked, like I've been sent to general critical care and SSCU and that's as far, as I will go, oh my god (laugh)	Recognise the fear of being sent to wards when experience has been limited to Specialist acute environments caring for level 2 & 3 patients
P5 (14:54) you know you choose when you go into Critical Care, it's I think personally from my own, and I went there knowing I wanted to care for people you know at a very very advanced level, and that patients are really sick that are in ITU so you are looking after the whole patient and getting really stuck in and being able to learn and being on a ward it's a little bit more kind of, I don't know kind of, and I think people go to and I think people stay in ITU for that reason, because you like the buzz of it if you like, the	Realisation that when you choose CC as a work environment that you will be caring for the acutest patients in a holistic way that will also develop your knowledge and understanding which is different to the ward environment. CCN's like the 'buzz' that you get from this type of care
P4 (15:34) it's able to do your job as a nurse properly Yes, yes	They like feeling that they can do their job properly,

P2 (15:38) its quality, you are delivering quality aren't you *P6 (1543) instead of juggling patients on a ward, juggling twenty-eight patients, that you can dabble just a little bit*	A positive reason to stay is the assurance that you can deliver quality care The numbers of patients in wards prevent this, you have to prioritise, with all patients receiving some care but not all care
P5 (15:47) and the more experienced you become you do have that sort of autonomy to be able to make decisions, and your listened to more and sort of have more of an input with doctors and I think you feel valued in working in critical care. I think you get quite an element of respect, don't you? *Yes, yes*	Many agree that as you become more experienced in CC you become a more autonomous practitioner, valued and respected within the MDT
P2 (16:07) aww it's that aww you work in intensive care – (laugh)	Personal feeling of reward, intrinsic reward sensation of working within that environment
P2 (16:17) a lot of our staff, well 50% of our staff have been there fifteen years plus and because they haven't got degrees, they are not willing to make the leap, and they won't change jobs because they can't, they haven't got degrees and not seeing that they can apply for other jobs and promotions	Half of the CC staff are seasoned practitioners without degrees, preventing them leaving as it is thought that a degree is required for promotion and jobs in other environments
P1 (16:34) I don't know how it is on the ward but we are very good and flexible in working hours on a ward where you have naturally got less nurses, so I don't know if they can kind of accommodate the shift patterns as well, whereas I work every Thursday a long day and 1 other long day and because we have so many other staff that's irrelevant really	CCN's stay due to extrinsic factors such as flexibility in working hours which wouldn't be accommodated in the ward due to the reduced number in the workforce Examples of a very specific shift pattern that is accommodated was given as an example
P6 (16:59) so we are the opposite, we haven't got we are only a little unit so there is no flexible working what so ever its, you're doing the same as everyone else and that's that	A contrasting opinion is offered by those working in a smaller unit, where the working hours are inflexible
P2 (17:20) that's why a lot of people have stayed, and they are also they have gone right the way through, they started when they qualified, and they have gone all through, they have family and a nice comfortable life with no ambition	Seasoned staff came to CC when registered and remained throughout their career- staying as their personal lives develop have families, feeling comfortable. Seen as having no ambition
P2 (17:33) they don't want to mentor students and all that comes in, they are just happy what they are doing, there is no one challenging them	Some staff do not want to mentor students, happy to 'do what they do' and no one questions or challenges this – lack of personal drive

P3 (17:39) we had someone who have been on our unit for about twenty years, I think, they are ready to go and they have done critical care and they went to do respiratory specialist nurse and she was told she hadn't got enough respiratory, umm experience because she's just been on ITU for twenty years (laugh) so that I think we sometimes see your too experienced in other aspects to go elsewhere sometimes as well, isn't it?	Difficulties in finding employment elsewhere, seen as too specialised, niche area
P3 (18:18) yes, possibly, yes because of certain posts that they are interested in aren't, they supposedly not qualified for because they have been in critical care for so long and they have not experienced the wards and things and community	View that seasoned nurses with increased length of service supposedly find it difficult to find posts in secondary care due to lack of ward experience
P2 (18:44) conversely one of our girls, went for an interview she is really highly qualified, masters in critical care and she was told she is too qualified for the job, she wouldn't stay so they weren't going to interview her	Contrasting opinion of CCN's aren't shortlisted for posts due to being too qualified for roles elsewhere, the concern that they won't stay – finding it difficult to move on
P2 (19:06) Yes and you see the new ones coming in and somebody said a quote that she said the other day '' I didn't realise how much I didn't know till I got here and now I know because she had worked in Liver, she had come and it 'makes sense now'' ''it fits in, I've got all the pieces of the jigsaw and its now making sense'' that's what she said	Those that thrive, recognise the learning that takes place in CC, *''it fits in, I've got all the pieces of the jigsaw and its now making sense''.* Education is important
P2 (19:24) yes	Acknowledgement that they are thriving
P2: (19:28) because she's enthusiastic and she wants to teach what she's already learnt and she's taking it forward, she's doing reading and teaching around, in the schools as well, that could just be her, could be her personality, she came very very unsure and she's blossomed like a flower, its lovely to see	Someone who is seen to be thriving is 'enthusiastic', 'wants to teach', sharing their knowledge, part of their personality, When someone is doing well 'they blossom, and its lovely to see', their development is obvious
P3: (19:47) its confidence as well isn't it cos there's enough of you to build each other's confidence up .. up sometimes and on our unit if you've done something good you will be told, you've done, did well, did well today, and I don't think I can't comment as such, but I can't imagine that happens as much on the wards	Confidence is a factor that helps nurses to thrive, positive reward, feedback all improved confidence and this is considered to not be some evident on the wards
P3: (20:13) from your colleagues, everyone really	The feedback is from all of the team
P4 (20:13) colleagues, sisters	Peers and seniors give feedback

P3: (20:14) anyone really, the sisters, the people that are more experienced *P4 (20:19) I think going on confidence and that first year of being in critical care is like the first, if you can do that one year after that then you will thrive and its keeping the staff in that first year*	Feedback comes from the senior team, sisters and even those that are more experienced Maintaining confidence during the first year is the key, from then you can thrive, but the difficulty is the first year
P3: (20:33) yes, mm	Agreeing that the first year is difficult
P4 (20:34) enthusiastic, interested and in that first year, you were so worried about making a mistake, thinking of so much to learn and that's where other things like the lack of training and support. Mm, I think we are sort of losing staff and they are not staying on to then thrive because they are not being looked after and nurtured enough in the first year	During the first year you need the following enthusiasm, fear of making clinical errors is high, and there is so much to learn, which can be affected by the lack of support and training Need to be nurtured to thrive and last the first year
P3: (20:57) mm	Agreeing that this is important
P5 (21:00) I think that some people that are coming don't really know what they are coming to and they are the ones that tend to go because they just think – oh I will try ITU	If new starters have a lack of awareness of CC they tend to leave
P3: (21:04) mm yes	Agree with this point
P5 (21:05) and they don't actually know, sometimes that the case, isn't it that sometimes people come, I think that sometimes they think they can be easier option	Some new starters have a limited awareness and believe think CC is an easy option, they tend to leave
P3: (21:13) and sometimes they are quite brazen, they come in, marching in and think they know everything and then you give them just even a HDU patient and they are like oh, but then they don't speak up and then they start to crumble then	Nurses that commence CC need to appreciate the role of the CCN, there is evidence that those that have little understanding of the role and do not speak up for support 'crumble'
P5 (21:28) perhaps the ones that you find those that actually say you know this is not for me	New starters attitude – some identify early on that CC is not for them
P4 (21:30) they have probable come into it thinking its better and I need some experience, acute experience be safer than the ward, maybe that's	Reasons for coming to work within critical are, feel that they would be safer as a ward nurse with this experience – not in their career plan to stay
P3: (21:40) or they were at a level on the ward and they thought they knew what they were doing there and so when they come to critical care and it's completely different. They have thought they were going to be at a better start at a higher standard and they are actually not, and they are not willing to speak up because we get quite a lot who say they	Some new starters gain ward experience first with the aim to help them adjust, but realise it's so different. Variance between how new starters think they are performing and how the experiences staff feel on

know what they are doing but when you actually look you don't actually know what you are doing. But they are not speaking up erm so they don't get supported because they are not voicing out as well.	their performance, especially those that do not ask for support. The lack of speaking up means that they may not be supported.
P4 (22:25) I think by providing proper supernumerary time, proper training programs,	New starters need appropriate training, with supernumerary time
P3: (22:32) have one designated mentor/ preceptor or a couple	Consideration needs to be given to the number of mentees that experienced staff mentor
P4 (22:34) I think we've learnt	Reflection on prior experiences of new starters
P3: (22:35) we have learnt recently what needs doing	Recent experience
P4 (22:37) there's been, we had a lot of new starters	Influx of new starters
P4 (22:44) which we haven't had in a long time and then some of those have left	Not had new starters for a long time
P3: (22:50) newly qualified went they	Newly registrants who then left
P4 (22:51) and the second sort of group of people to start I think we have been a lot better with, learning from the first group, from the feedback, which was the sort of lack of support	Reflected feedback of those recent new starters informed behaviour for new starters, increased the support
P3 (23:01) echoed the lack of support	Agreed about this support
P4 (23:04) lack of support, lack of supernumerary time	Reasons for attrition, due to being unsupported and lack of supernumerary status
P3 (23:05) but it wasn't for not wanting to, it was because of staffing levels and the more experienced being sent to go to the wards and sent to different units and things the new starters were being left, they weren't being looked after and all the experience had student's mm, so they weren't able to have	The lack of support wasn't intentional, it was affected by the staffing levels, supporting the wards and experiences staff mentoring student nurses
P4 (23:25) or the other way in their first year they were being sent to the ward or across site to work and obviously, that was making them worried because they are going out of their comfort zone again, and we had to do that because of skill mix. Otherwise if you started sending the senior staff over then if we have an emergency that needs dialysis or something like that then we wouldn't	Other reasons for attrition included being sent to the ward, and working across sites, which increased stress levels during a period of settling in. The selection to send these new starters was influenced by the skill mix.

have the staff to do it ourselves. So urmmm, unfortunately some of the junior staff are being asked to go to the wards or going across site to work or something because of the way the skill mix is so that makes them anxious sometimes, just some people not all of them, some of them take it in their stride.	This affected some of the staff not all of them, some were able to cope
P3 (24:12) they were being, because there wasn't a proper programme to say where they were going with their training on the unit, when they had been here say six months, you would expect them to be able to do something but then they hadn't even seen it ever before, and you are like what! So, I think other staff members expect certain things of them because they have been here a certain amount of time and they are not able to do it, it drops their confidence again because not everyone words things, properly do they? (laugh) and nicely, they can, umm not shout but they are	There was a lack of a structured education programme, and their achievement at a six-month period was not what all staff expected. This reaction and feedback to the new starters affected their confidence due to how it was presented
P5 (24:15) A bit aggressive	Feedback was not given in a constructive manner
P3 (24:47) Yes, you should be doing this by now or something like that	Examples of the participants feel this should have been given
P5 (24:53) rather than showing them	Feedback could have been more constructive and provided in a learning manner
P4 (25:00) and I think in ITU as well you have got to be able to go home and pick up a book and read about it, there has got to be a lot of directed study as well. I don't think it's	There is expectations that there has to be some self-directed learning outside of the clinical workplace
P3: (25:09) but you're exhausted as well	Factors that affect self-directed learning
P4: (25:11) you're exhausted from work and then you know you've got to have a life outside of work as well so it, it's quite a mm hard job isn't it	Influencing factors for self-directed study
P3: (25:20) and some days, if you're not being told what to look at then you're not going to look at it, because you could be looking at completely the wrong information couldn't you. If there no guidance I think that's where we lost big time, was with the guidance	Direction is required for this guided study to ensure the relevance of this additional work
P2 (25:40) so how long is your supernumerary period?	CCN's reviewing inconsistency between he supernumerary periods across units
P3: (25:42) it's four weeks	

P2 (25:46) that's not long	Length of time at a DGH where they had recently had significant numbers of new starters leave – four weeks In comparison another DGH – commenting that the period is too short
P3: (25:46) but if your, but if you look like you are doing well, and we are short of staff then it could be three weeks, it could be two weeks (laugh) couldn't it?	Also admitting that this is flexible depending on the availability of staff and the capability of the new starter
P2 (25:55) that's not long	Identified as too short by other participants
P2 (25:57) we increased to six to nine weeks, still depending on how they do but we reassess after that time and decide if they need longer	In comparison to this unit who have an induction or supernumerary period of 6-9 weeks (three times as ling) and still assess whether this is appropriate for the individual
P3: (26:02) we should do longer	Recognition that it should be longer
P1 (26:08) it's a long while now and I can't remember but it's a good couple of months before they can actually give medications, any type they have drug competency books and until they have got it signed off in the competency book you can't give it	This participant couldn't identify what the protocol was in their unit, but highlighted that the responsibility of medication administration was withdrawn until they have been reassessed
P2 (26:22) IV's - so people are being deskilled before they start	CCN identified this as deskilling new starters
P1 (26:24) I think it's good for newly qualified though because as supernumerary, three weeks	Supporting this concept, to enable new starters to concentrate on other aspects during their supernumerary period
P2 (26:28) we don't take newly qualified, we have six months minimum, before we take anybody	CCN works in a unit where newly qualified nurses aren't recruited, must have a minimum of six months post registration experience which may support the comment of deskilling if unable to administer intravenous medication
P6 (26.35) I've even said to my manager we've had someone that did their four, well they did three and half weeks then two shifts and I said I don't think he's ready to be in the numbers and she said I haven't got a choice, he's got to be in the numbers. He's not really ready now	CCN's feedback on competence following supernumerary status was not heeded, staffing numbers were the influencing factor
P3 (26:47) and they sink even more then don't they	The potential response if new starters are not assessed on an individual basis – they do not cope

P6 (26.50) it's up to the nurse in charge to look after those, those members of staff but then if you are busy and you can't be working with them all day	The responsibility is with the nurse in charge to support those new additions in the numbers, but the limitations of this is recognised, affected by dependency, acuteness, they cannot be supervised all the time
P3 (26:58) and I don't think they can be listen sometimes, we've had people who have been on temporary posts and then they have been given permanent posts but when you work with them you think, they are not, they haven't got it at the moment they, they don't seem to be, some people seem to be too confident, but they actually know what they are doing	Nurses that have their temporary contracts fulfilled to permanent aren't always ready, they appear too confident and appear to know what they are doing
P4 (27:18) but there are a few issues there	Raising issues on temporary contracts
P3 (27:18) and err management don't ask for any feedback of how the temporary staff are going and then they get a permanent post because they have interviewed well	Management do not seek feedback from existing staff on those on temporary contracts before supporting the post into a permanent position – based on interview technique alone
P4 (27:31) they interview well, particularly on value based interview questions	Interview technique based on values rather than including feedback on performance
P3 (27:32) but it shouldn't be on all that, but it should be on how they are working – shouldn't it	Suggestions for feedback to be included in interview process
P2 (27:34) we always are involved in the discussions	In contrast to this unit where staff opinion on feedback is valued
P3 (27:37) we are not and then that brings morale down even more because you think we've got a permanent post now of someone who doesn't care, who's not a team worker and	The effect of feedback not being valued – this reduces morale as they recognise they will be working with the member of staff
P3 (27:49) is not, our manager either	The interview is not by a local manager, so the feedback isn't valued
P4 (27:50) it's not, sometimes, I think it has been on this but previously umm it was, they were interviewed by the Trust basically and they put three places where they would like to work and they were allocated where, whereas I did, I worked in x in critical care for a little while and at the interview I was asked ITU questions at the interview. Or related to like what would you do if someone's blood pressure was low? So, I should be able to know even if I was a ward nurse well to know to start doing observations you could answer something, so it	Organisation based interviews not specific to CC, participant had also been exposed to organisation wide interview however on this occasion clinically related questions were asked depending on where they had identified that their preference for work was. But the current method of organisation wide interviews is based on Trust values and not clinically related.

would show a certain level of knowledge and skill and things whereas the interview questions at the moment are values based so it is all to do with the Trust	
P6 (28:41) and how you are as a person	Personal attributes were not considered at interview
P4 (28:42) how you are as a person and how you cope with things	Coping ability was not considered at interview
P2 (28:46) is that just for newly qualified?	Participants clarifying was this for all recruits?
P3 (28:48) no that's everyone	This method of interviewing is used for all recruitment
P2 (28:50) everyone doesn't get, you're not interviewed by your unit	There is no local recruitment at unit level
P3 (28:51) no not at anymore	No local recruitment
P4 (28:52) well this last batch have, but before that	Until now after the previous group that have mainly left
P2 (28:59) all the band 6 levels now, all get involved in our recruitment	CCN's are involved in the recruitment at this unit
P3 (29:01) ours used to when I was interviewed it was the manager and it would be one of the sisters or charge nurses would be interviewing so it was, and it was even the matron, that was on the first interview when I first did it	Senior staff used to interview prior to the organisational interviews, this was the experience by this participant
P2 (29:18) we were even told, you know you are done on a points process don't you but if you feel that they don't fit into to the team then you don't have to take them	This participant is involved in interviewing and team attributes are valued, and considered in process
P3 (29:22) yeh and that's where they are going back to now, I think for a few years it was like that and then for a few years it was all put into the Trust and our management didn't have a choice of who was coming and when they arrived, we have had really poor staff haven't we and they have been the ones who the majority have left, you would have someone from the community hospital who has not had any hospital experience for years suddenly being put on ITU who wasn't really wary of blood sugar levels and things like that, were they. Let things that we would see as basic would be nothing to them at all, so	When organisational interviewing undertaken, attrition increases, community based practitioners with no hospital based experience were allocated to critical care, they had a lack of knowledge and understanding

P4 (30:03) I suppose that's where you come in and if you've got six months' worth of experience you sort of expect	Expectations of those that have been registered for six months
P2 (30:06) we don't accept anybody	Recruitment criteria
P4 (30:09) you know where, other trusts, our trusts will have newly qualified	Newly qualified interviewed and recruited and on some units
P2 (30:15) the only newly qualified we do take are those that have been a health care for five years before they did their training. So, they already knew what was going on	Value of recruiting those with experience including as a HCA in critical care
P3 (30:23) and that's because you are looking at an individual aren't you, you're looking at their individual background and that should be involved where you have worked previously and is this going to, are you going to have some background knowledge to build upon rather than starting from fresh.	Value of assessing the individual during recruitment, experience valuable
P5 (30:43) just in regard to what levels of nurses are that are coming into the unit are we looking at their education and training prior to – what a lot of us are saying is that newly qualified don't know this and this might not be just an individual thing it's just that's not being, the seeds aren't being sown at a very early stage. Often you find that what, you even have students, they might be in their very final year that have come to us for an elective placement and you might even be signing these students off to say they are confident in this, this and this but actually their basic nursing skills I don't feel are always there because it's not a priority in their training it's much more degree level, where they might be able to sort of you know present fabulous assignments about different things but the relation to them in their clinical practice isn't always great – isn't always there	The point shouldn't be as to whether recruit newly qualified, more that it should focus on experience, has the newly qualified been exposed to CC? During the elective placement for a student nurse, you can identify if they have the skills, previous experience and exposure. Fundamental skills are not always evident, degree level nursing may mean they can write a good assignment, but do they have the appropriate skills? These are not always evident
P3 (31:49) it depends where your placement are as well, definitely,	The placement experience affects a student's nurses ability
P2 (31:52) definitely	Agreeing with this comment
P3 (31:53) for myself I was a diploma I was but at a big city hospital, erm but where I was it was, there was probably about six different universities because it was a big city. Erm and you would have loads of students but sometimes, I had one	The placement circuit depends on numbers of students and where you are allocated, this participant listed a number of placements that offered little exposure to a variety of experiences,

placement two weeks on a falls assessment unit (laugh) for two whole weeks, no for ten weeks that was, a ten week placement on there and I was just like, taking blood pressure, weighing them and that was it, but we pushed to go elsewhere but you don't always have that opportunity so that was in my second year so when you get to the third year and they expect you, got an expectancy of you as a third year student and if you've had really poor placements for those first two years your not going to be up to everything apart from having your books and knowledge and things like that, what you've had at Uni rather than placements	falls assessment clinics, so you had to rely on the theory aspect of the programme.
P1 (32:54) I came to critical care newly qualified, the most acute placement I had had was SSCU but the majority of my training I did at community hospitals, I did the diploma for the first year but I did step up to the degree for the second and third year but I don't think it made a difference in terms of placements and my sign off placement was a community hospice erm but I'm still in critical care four years later, even though my background was not acute and our interview process was you all get sent to generic interviews at Keele – just a generic interview, of all the hospitals you just put your top three choices	This CCN had Acute experience during her student nurse training but the majority was non acute and she remains in CC after four years after a attending a generic interview
P1 (33:31) and I just got sent to critical care	CCN was allocated to CC
P3 (33:38) but then some people might not have coped with that might they? As an individual	But is this right? Can everyone cope with this?
P1 (33:40) I struggled	A CCN who was allocated to CC indicated that they struggled at first
P3 (33:42) and you said that you've dropped your hours whereas on our trust you haven't got, we are just twelve and half hours shifts , that is it on our unit, that's all isn't it. So, if that was the case you would have gone, wouldn't you? Mm	Others highlight that she had also admitted to reducing hours to cope with the placement to CC, and that couldn't be offered in their unit
P1 (33:56) I don't know, it helped, short shifts helped a lot, I think I would have probably would have moved if I would have had to stay on long shifts. But I think sometimes it is just individuals, its personality	P1 admitted that if they had not agreed to her request of short shifts she would have left CC
P3 (34;06) yes definitely	Personality has some effect on this
P1 (34:09) whether you stay in critical care or not	Personality affects whether you stay or leave

P4 (34:11) and I think when I've been interviewed for my ITU job I was quite pleased that I got the job for ITU and I was proud	CC nurse describes feeling proud when recruited to CC
P3 (34:20) I'm proud	Others agree to this feeling
P1 (34:22) I cried, I didn't want to go	Personal effect of recruitment when it wasn't personal choice, this participant wasn't happy with the decision, they cried
P4 (34:24) if I had been interviewed for like, for erm a number of jobs and I didn't know where I was going, and I didn't know the manager that I was going to be working for it would be a bit hollow experience, I don't know	Nurse wanted to be interviewed by the team that they were applying for, needed substance to the interview
P3 (34:44) You are proud though, I was newly qualified as well and I was shocked, I was so proud to even get the interview, because I was wow I didn't think I would be suitable as such but I just thought I would go because I wanted High dependency experience and getting the job I was shocked but I was nurtured, I was looked after, I only had four weeks supernumerary but I was, I felt supported but working seven years the first year they changed all breaks systems, loads of things changed very quickly when I was there it's not like at all anything like when it was when I first started so I feel, I appreciate starting when I did because I was looked after and that's when we've looked back haven't we at the ones that haven't been looked after because we haven't, we wanted to but we haven't had the ability to help	Pride in being selected, for the interview and then the post. Felt supported with examples of feeling nurtured, exposed to four weeks supernumerary and was 'looked after'. This nurse recognises the changes with the organisation, appreciates starting when they did, and recognises how differently the new starters are looked after now. Highlights that this is not due to the lack of wanting to but the inability to do so.
P4 (35:35) the unit hasn't allowed it	Organisation hasn't supported this nurturing / support
P3 (35: 36) we haven't been because we have been pulled here there and everywhere, and pressures are being put on us more and more mmm	Increased demands have put pressures on these experienced staff and continue to do so
P4 (35:44) yes, definitely, the units changed	Local units have changed – pressures have prevented the nurturing
P3 (35: 46) and the Trusts changed what they expect of you, erm, I don't think you get looked after as much do you, like we did seven years ago	Organisations have changed, they don't value the nurturing and support as they did
P3 (36:18) possibly, yes	Resilience helps you cope – yes agreed

P2 (36:19) I think it's more of a team thing, or we like to think of ourselves as a family	Nurses value the team, the family
P3 (36: 21) yes	Nurses agree that CC is like a family
P2 (36:21) because we all go out together, got our little band we've all created. If an admission comes through the door and everyone piles into the bed space and gets on with it and everybody knows because we have been there for so long what's expected and who does what and it just gets done	How they see their CC family, helping each other, just getting on with supporting each other
P1 (36:37) I think it can be clicky though, for a new starter	Nurse identifies the notion of CC as a 'clicky' environment for new starters
P3 (36: 39) yes	Others agree with this
P1 (36:39) I know I really struggled just to get a roll when I started. It was hard work, erm and our senior teams are very good but I think we have, we would have agency staff, we have done for years and we have such a high turnover that it can be difficult for new starters to erm, and generally we are erm, I would like to think now that I am kind to new starters and try and help them and support them but I think even if you've got a nice team it can still be difficult to join that, as a new person I, when I started I didn't know anyone, I had never been to critical care and it was difficult to kind of fit in to me what kind of felt like all these clicky people, and I found, I found it difficult from that point of view	The notion of joining that click for new starters, how difficult this can be, with high turnover of staff and agency staff. This nurse hopes that they are kind and recognises this behaviour, they experienced how difficult it was to be a member of the team and how it can be difficult to fit in
P4 (37:30) I suppose as well because of the number of staff you have got cos I worked in another critical care it was thirty beds there was a lot more staff, so I was meeting new staff all the time in my supernumerary period so I never, whereas in my current erm unit it's an eight	Recognition that the size of the unit and therefore the number of staff has a part to play in 'fitting in'. Continually meeting new staff during their supernumerary time when support and nurturing is valued in comparison to their local unit which is much smaller
P3 (37:48) there's familiar faces all the time	Familiarity, seeing the same people helps with the adjustment
P4 (37:50) yes so you know you get same people more, so I suppose it was harder maybe	This is harder in the larger units
P1 (37:56) and working long days you see less people don't you	Recognition that working long shifts increases the length of time to meet all the staff
P1 (37:57) I do two long days a week now and I will not see people for months, just because we have worked opposite shifts	CCN nurses raises the point that when working part-time you frequently do not see staff for months

P1 (38:04) opposite shifts so you are not always seeing the same people	Nurses identify that the shift patterns and not seeing the same people makes it difficult to fit in
P3 (38:15) yes as you say like belonging to a family	It is important to feel like you belong, like being in a family
P4 (38:17) definitely	Others agree that you ned to feel like you belong
P3 (38:20) because we are like a family aren't we, you feel the same in your unit as well	Participants clarify that other CCN in other units feel the same about belonging and it feeling like your family
P4 (38:21) yes	Others agree
P6 (38:26) But as people leave you feel oh my little family, the family isn't the same anymore	It is recognised that attrition has some effect on the family, the family changes
P3 (38:29) yes, morale goes because we have had people retire as well haven't we, like a lot of people have been there for so long and they are strong characters and suddenly they have gone or those people with long term sickness and they are big characters as well and when they go or they have gone because they are not being developed, haven't had the opportunity to develop on our unit, erm it upsets everyone else doesn't it, you feel like you have lost your brother or something(nervous laugh)	The seasoned practitioners are strong characters within the family, when they leave, the whole family is affected, it's like losing a sibling
P2 (30:01) we've been to each other weddings and christenings and funerals unfortunately	There is a closeness attending each other's special occasions, such as wedding, christenings and funerals, like family members
P3 (39:02) yes, and nights out, and even people when you haven't really worked with them seeing because we have got someone recently who I can remember although P4 might not remember (sorry) but they got diagnosed with terminal cancer and we all come together and put a collection for flowers and things like that, you might not know them but we all think ohhh, they were on our unit, and they were a member of staff on our unit so we all care	Nurses kindly regard ex family members even if they didn't know them, sense of feeling when they know they are severely unwell
P2 (39:35) we've had that similar thing and you've had charity events with them and still do	Nurses share experiences of how they have supported ex- CCN's in times of difficulties, organising fund raising etc
P6 (39:49) it's kind of gives you a sense of safety almost	The family makes the nurses feel safe

P3 (39:52) yes probably	Others agree to this comment regarding safety and the family
P6 (39:52) something's going wrong you kind of think I can rely on these people to get come through, to pull through this whereas this more disjointed you might think I don't know what's going to happen here	Compared to how you can rely on your family, in times of difficulty, even when you are unsure of the outcome
P1 (40:03) We know if we have good a good team on or a poor skill mix	Nurses indicate that they can identify if they have a good team or a poor skill mix on the shift
P2 (40:09) it's amazing what a difference one person makes doesn't it *Yes, mm*	Nurse describes the difference one person can make to a team, others agree
P3 (40:16) and your confidence goes … on critical care doesn't it so if you are on a low people, your team will pick you up won't they but if your team doesn't pick you up then that's when you will keep going low then you don't want to be there anymore do you	How experiences on CC can affect you confidence and nurses identify how your team, 'picks you up' and if this doesn't happen then this affects your sense of being on the unit and reason to leave
P4 (40:28) there a great sense of teamwork and that's why people like it because you can rely on the team because often you are very close to them and I think as well you're going through really emotional, ITU is a really emotional area as well, you are dealing with a lot of, you know, upsetting things and I think as a team you sort of go through all of that together, don't you?	Nurses recognise the importance of sharing the emotional experiences of working within CC, not having to go through it alone, the team can be relied upon to support the emotional labour
P3 (40:48) and your supported basically aren't you, so if you're having a bad shift your friend next door	Recognition that the nurse working in close proximity will support you, be aware of what youa re going through
P4 (40:52) yes	Agreeing with this commentary
P3 (40:55) not even your friend your colleague say, will notice and pick you up, and think your struggling there let me help you and its a, from what I've heard you don't get that on the wards, they will be this is my bay and I don't care what's going on in that bay, this is my bay. That's it	This is compared to relationships on the ward, who are not aware of what is happening in the next bay of the ward. Even colleagues, rather than close friends help when they see you struggle, not left alone to cope
P4 (41:15) that's what it used to be like	Agreeing with the example of the ward behaviour
P3 (41:16) and that's what a lot of the outreach team say that the nurses feel that, they will go up and say 'they're a patient bay 1 do you know I've been told to look at them, can you tell me and they	CC Outreach teams are exposed to this behaviour when they attend the wards, nurses limited knowledge of the environment outside of their limited area, and lack of interest to assist

are like I don't know, they are not in my bay'. so, they are not interested whereas we are not like that General group laugh – query something said by P2	
P2 (41;37) how does agency, because we don't have agency staff, how does that change the dynamic, like transient staff, we have quite a few Spanish nurses at band 5 but they only stay for a couple of years and they go again	Agency staff or overseas nurses are part of the team as they are not transient, they stay long periods of time
P1 (41:49) yes, we've have had, we have just got a very high turnover of staff erm, agency and bank nurses tend to be one of the team because they have been coming for years and they come back regularly so a lot of our agency and bank is as good as having one of your own, err experienced staff. Erm because it tends to be people who are senior elsewhere, a lot of ours are senior elsewhere and here for agency. Erm, its new starters think it's difficult to give them the support they need and we just have a poor skill mix and you all struggle, but we did once have a bank nurse and she had not worked in critical care for years so every job that needed doing she literally she just couldn't do it, you may as well have not had her there without being horrible because she just couldn't even do her basics she was coming to you and you were having to look after her patient as well as your own patients. So, you've got that side when you do have poor bank staff, generally	The regular requirement for agency staff mean that they are one of the family, they are experienced and have been with the team for a number of years. The support that is lacking is with the new starters. A nurse identifies one experience with an agency nurse that affected how they are now recruited, she had no prior experience and couldn't cope, nurses were having to undertake all her work as she didn't understand the CC basics. They were having to do their own and her job
P3 (42:51) but they shouldn't be allowed on the unit because we had that	The nurses found this unacceptable
P1 (42:53) I don't think they will come back again	The agency nurse wouldn't want to come back again, they didn't have a positive experience
P3 (42:54) they are not allowed now, on our bank system we had one staff kept on coming and they were just from the ward and they were making they were petrified weren't they to the point where they were making errors and we all reported back to the manager and she was like that's it, right if they are bank they have to be ITU so basically, we cover our bank by our staff, err	Nurses raised safety concerns of having agency staff with no CC experience, they feared making errors, so now they are required to have CC experience, or the shifts are covered by the team
P1 (43:22) our staff do as well	Nurses from other units agree that this happens within their units
P3 (43:24) and there will be some people who have left or and then they just come back and do bank shifts with us. But then our agency we do get	Ex- CC nurses also form part of the agency group, but it is recognised that it remains scary, with different protocols and documentation. They need

sometimes they will come back, they will be the same ones. But we try and treat them as much as we would our, as one of our team as well because they seem to work better don't they. If you're going to have a drink then they have a drink, yes you just include them in everything don't you. It is scary as an agency nurse, I've been an agency nurse and it is scary, being on your, on a different department, different paperwork, everything like that. I don't know	to be treated like one of the team, recognising to include them during comfort breaks etc.
P2 (44:10) it's part of a bigger team as well, as we've got nine consultants, but they are very good consultants and the doors are always open. If they see someone is upset any of the consultants will take you off and have a chat with you, and support you or the physios	There is the wider family as well, the Consultants who have an open-door policy. They notice if the nurses are upset, they are part of the support mechanism, as are the physiotherapists.
P6 (44:27) I think because you spend more time at work if you work full time you actually than you do at home, so you see these people a lot more, so I think that's why you all become so close	The nurses recognise that you spend more time with this family than you do your actual family, this is the reason for the closeness.
P3 (44:36) yes	Others agree to this
P6 (44:37) it's not reliant on them but emotionally a bit of a crutch aren't they, sometimes	The family are your emotional support
P1 (44:42) because you're a lot together with them Yes, yes	This is due to the lengthy time spent together through the same experiences
P3 (44:43) because you go through things on shifts that's difficult, because that can be highly emotional but even things when you go through something personally – they are not just your colleagues they are your friends, aren't they so, people can pick up that's something's not right today. What's the matter, and take you away, because we are all human, aren't we and life happens outside of work. But I don't know but you do it is support isn't it and I think that probably keeps you from going elsewhere because once you have got comfortable and you feel belonging to a family and the team then you don't know what going to be like if you go elsewhere. Is it going to be the same? Are they going to be as welcoming are they going to be?	Highly emotional area, sharing of personal tragedy, they become your friends, the team will notice when something is not right. Recognition that there is a life outside of the work environment, personal life and that each other need support. It is this that prevents you leaving CC, you are comfortable and belong to a family and you are unsure if you will have that elsewhere. Unsure that other places are welcoming
P2 (45:25) Look after you *P3 (45:26) yes - because I would be frightened now, to leave properly, I enjoy agency*	Unsure that other work environments will look after you This is their safety net, it would be scary to move elsewhere, although nurse work agency elsewhere

P4 (45:32) the thing is where would you go?	Lack of awareness of where you could move to
P4 (45:36) the thing is where would you go anyway? Because you like that acute care	Lack of appreciation of where to go when you like to work within acute care environments
P3 (45:46) the quality of care	Lack of appreciation where you could provide this quality of care?
P4 (45:46) you care for the whole person and you can do everything for that person, well and you work in that fantastic team so where would you go to do anything else, what else is out there? the only thing you're really looking at would be specialist nurse jobs really, to go up in the erm career pathway, then would you get that, I don't think you would	Nurses describe their role, caring holistically, within a fantastic team, commenting on where would you find this elsewhere? Recognising that in the career pathway the move would be towards a specialist role, but adding that they didn't think they would make this move
P3 (46:12) yeh and I would be frightened now to leave properly and that's a fact that when we have a really poorly patient and you don't think that they are going to make it and they do, it's that proud that you were able to assist in that, (pause) care of that patient and potentially for them to survive and then come in to see you again in six months' time walking into the unit and say thank you, erm, you don't, I think that's a lovely thing	This would be a fearful change, and would it be worth it when they are proud of what they do, the impact of helping someone to survive and seeing them return to the unit to give thanks, is a powerful factor to support nurses staying in CC
P3 (46:41) as well isn't it, on our unit	The nurses agree that it's a powerful memory having patients return to the unit following such an experience
P2 (46:43) and they do come back time after time, sometimes bring us Easter baskets every year	Sharing experience of patients returning to give thanks
P3 (46:44) Christmas and you see them, and you think wow look at you, like and you remember how poorly they were and you didn't think that they would survive twenty-four hours and then they are having a lovely little lovely life outside of that and going on holidays and things and I think that's nice isn't it, when you have that	Such an intrinsic and extrinsic motivation seeing families continue with their life after such an experience
P6 (47:21) I think ITU nurses always want to go up, they don't want to, often go back, not saying a ward down if you know what I mean they don't want to go back to ward level. they either go specialist or sister or manager or something. Well I think they do, it's not often they go the other way	Nurses describe the career pathway as leading to specialist or managerial roles rather than transferring to wards, this is rare.
P3 (47:35) yes, I think mine would always. I wouldn't want to be management, but I definitely want to be a sister erm, on the unit and I would want to do that	Long term career pathways listed as being a sister in palliative care, but this was seen in the distant future

for at least ten to fifteen years more really and then I think I would like to go into hospice care really. I wouldn't want to go into the wards	
P1 48:00 Not locally	Cannot visualise a local career pathway
P3 (48:03) I think you have got to wait for someone to retire on our unit	Longevity of staff means there is limited movement in the senior hierarchy, often waiting for someone to retire
P4 (48:05) and it, and it you know it's funded for the critical care course for example you cant go up the career ladder without the critical care course so there only a limited number of spaces for that, per year. And then you have to work really hard to get on to, for us anyway, you know there an interview process, you have to be seen to be doing stuff on the unit and acting up as well. So, it's you have to work hard at your career progression	Career progression commences with CC HE modules, but funding and capacity restricts this. The process to be considered includes interviews, 'acting up in a senior position' and additional roles and responsibilities, so to progress requires commitment
Mm, mm	General agreement that this is the case
P2 (48:43) it's not automatic once you have done your critical care course	Professional reward is not linked to academic achievement
P3 (48:45) you have to wait till someone retires or something	Still a requirement to wait for a position to become vacant
P1 (48:53) a lot of our experienced nurses move to be nurse specialists at a band 6 level because they were waiting just so long or the very experienced but you have to have the critical care course and you've got to have your mentorship and the difficulties getting funding for those, so even though they will put you in charge when there is no staff but they are they equally reluctant to fund you to actually get your band 6	Recognition that some staff move out of CC to Specialist band 6 posts due to lack of career progression within CC. Funding for education modules that are required for senior positions remains difficult, another reason for nurses to leave CC. However, it is recognised that you are expected to perform this role without having the professional band on occasions due to skill mix and reduction in staffing numbers.
P3 (49:15) you don't always get looked after, there's an expectancy of, because I think we were as soon as we started this course we were put on the high dependency, like right you are in charge now. I had literally done one day	CC module bring new expectations for the nurse, these can be immediate like being expected to be in charge
P3 (49:28) one day at uni, like what are you doing? There are like well you are on it now so, we haven't got anyone else to take charge on that unit, so you will have to do it. And I'm like – ok (laugh)	The unit expects immediate reward, in times of need
P4 (49:37 I think as well with that it's because they make it hard to get on the course because then you	It's as if they have checked that you are capable, all the hops that you have jumped through to get on the course

have to have an interview sort of mini presentation such, isn't it like discussion so I suppose they	
P6 (49:52) almost trust you	New trust in you
P4 (49:53) almost trust you from that, but at the same time it's just like oh I've only done a day	The trust and responsibility are immediate, but maybe too soon for the CC nurse
P3 (49:57) but you feel used sometimes don't you and when you don't you might not get something back out of it, sort of thing, you're doing all of the hard work and then suddenly they might not be that development placement for you to go into. So, because we have lost someone who's really experienced haven't they, and they just couldn't wait any longer for a charge nurse post and they were a massive asset to the unit. And that loss to all of our morale that would have been amazing for them to have become one of our charge nurses so now erm another hospital has gained	Nurses feel that they are doing all the hard work, and yet there isn't a reward following the development. Experienced staff leave due to this waiting game, which affects morale as they see that that individual would have been a valuable assess yet other units have gained their experience.
P4 (50:23) in fact we have lost a few experienced staff	This is not a new phenomenon
P3 (50:41) but I think that's down to development isn't it	Lack of development and opportunity is the cause of experienced staff leaving
P3 (50:44) not having that role, place for them to have, to step into *Yes, yes*	Lack of opportunities in CC General agreement of this
P6 (50:54) I don't know because I have only been there three years, but I don't know previously there was a lot more band 6's and less 5's whereas now I think it's gone more 5's less 6's. I don't know is that what it used to be like?	This nurse perceives that there used to be more senior positions in comparison to previous years
P3 (51:05) there's always more 5's than 6's on ours	Nurse disagrees stating that there were always more junior staff nurses
P1 (51:12) we've now had junior band 5's and senior band 5's and that how I think we have got round it locally – laugh	New role descriptors allow junior staff to now be classed as more senior but remain in the same professional band.
P3 (51:19) that's what we've got, we've got that. You have to meet criteria, but you don't get anything more for it	Increased responsibility but no reward for these new roles
P1 (51:26) no, no you get nothing more for it, no criteria that's kind of known about (laugh)	Agreeing, with this commentary

P3 (51:29) you are just the sisters back up, that sort of thing that's how it is seen, you just get moved	The role descriptor clarifies that you are the support mechanism for the sister
P3 (51:33) on the off duty, from there to there	This is identified locally but not rewarded professionally
P1 (51:39) and its more difficult to get swaps	There are disadvantages for this role, off duty becomes more restrictive and difficult to change
P3 (51:50) I have one but it's difficult to know that you are actually going to succeed that with if there's going to be a place/ role or not	Nurse identifies that they have a career plan, but they are unsure if they can succeed, if these roles will be available
P4 (51:59) I don't know, I think ultimately, we. Well, me I am on the course and you want to be a 6 eventually, charge nurse, sister whatever, I don't know what after that though. Because also if you go anywhere else unless it's a specialist nurse job you wouldn't necessarily get a 6	Immediate career plan is to become a sister/ charge nurse but unsure of the longer-term plan. Aware that if they choice to move out of CC they may not achieve the professional band that they have as a sister on the unit.
P4 (52:20) anywhere because you haven't got that experience in that area. So sometimes they are stuck	Lack of experience in other specialities reduces the avenues for the career progression
P5 (52:25) the training isn't just about wanting to move up it's about consolidating your learning, and just for your own development within your field. It doesn't always have to be	CC education can also be for intrinsic reward not only for professional advancement
P6 (52:34) we often say we haven't done it to become a 6	Commences cc education for personal development rather than career progression
P5 (52:38) yeh, my, I don't want that, I've done it because I've been in Intensive care for many many years and I don't want to do it to be a band 6 I want to do it just to consolidate my learning	This CC nurse with many years' experience is undertaking learning is for personal development
P3 (52:49) do a better job as well isn't it	Education is to improve performance
P5 (52:50) and I think sometimes that perhaps why this also happens when people do courses then the expectation is that I've done it and I want to be at this level now and that's changing as well isn't it. Which is good to want to move through but then	This is the reason why CC nurse are expected to behave differently as it is seen that this is what they want from the course, which is good for some but that is not everyone's plan
P3 (53:06) yes, I think also just because you've done the course I think you need more experience, erm, before you become a sister in charge	Following the theory experience is required prior to professional development
P5 (53:15) by having the course doesn't make you ready for the next role	The theory alone does not prepare for career progression

P3 (53:18) no, I agree there	Agreement with this
P5 (53:19) being a better nurse or being a better practitioner because you have a course	The reward is that following this you are a better CC nurse
P3 (53:24) yes, because I think actual physical experience beats somethings sometimes because you're living and working it, seeing it all the time, but the course helps back up that knowledge and understand it isn't it	Experience is essential, and the theory helps you understand that experience
P5 (53:35) it's still being flexible and updating knowledge	Following the education, you still need to keep up to date
P3 (53:42) it's making you understand why that is happening, but it doesn't teach you the experience cos you see all the experienced nurses on the unit and the sisters and things, something will have happened, and they will be like ooh did you see that sign come up and you're like ooh yes I did – well like that will always happen when that situation occurs. But you don't always see that in a book, but they have lived it and seen it	CC nurse value the benefit of experience, this can be seen in the experienced nurses in various situations, they have lived it and seen it before, teaching can't provide this
P3 (54:05) hundreds of times and they know that's the sign to look for	Experienced practitioners know the signs to look for, these are the benefits of experience over knowledge
P5 (54:09) this course in itself isn't actually teaching you how to be a band 6 it's not what the course is doing and I think that's what people got the course	The CC course doesn't teach you how to be a band 6, there is a difference between what the course provides and what a professional role is
P5 (54:17) band 6 isn't about the nursing role yes, its	Differentiation between the course and professional roles
P3 (54:20) its coordinating isn't it	The role is about coordinating practice and manging beds
P6 (54:24) coordinating and managing beds	The role is about coordinating practice and manging beds
P5 (54:26) and personality managing, managing all of them, those things it's not about what we are learning about so that's why I don't	Management versus theory of critical care
P2 (54:35) opens up more doors doesn't it	The course opens these avenues for you – for the professional development
P5 (54:35) so at my interview why did you want to do the course, I never once said because I want to be a band 6. I didn't say that	CC nurse identifies why they wanted to undertake the CC course, it wasn't about gaining a more senior role

P3 (54:43) Mm, mm	Others agree
P5 (54:44) because this is for me, it's for my development, for my nursing, yes, it's to make me better but also for me to inform the new junior members that are coming to be able to support them better. It isn't about	The course is about personal development, to improve my care, to enable me to inform and teach others, support them better
P6 (54:54) Better teaching	Personal reasons for completing the CC course
P5 (54:55) maybe that what it's about where it's going wrong as well people think oh yes I'm I can do this now because I've got a course	Suggesting that there is a misinterpretation about the CC course and the relationship to a senior role
P3 (55:03) and also I think it's other teams expectations of you, like you are on the course so suddenly they are like you're going to be a charge nurse, sister and you're like oh like hang on I'm like let me just finish the course first (laugh) and people expect you that you're going to be a sister and charge nurse, that is what you want but as you say it's to develop your knowledge and skills as well to. To if you want to be a sister or charge nurse, to go for it but that's not how you be a sister who's just on the course	CC nurse identifies that there appears to be a difference between some CCN's reasons for completing the CC course and organisations reasons for you completing the course. There is an expectation that undertaking the course means that you want to go for promotion, rather than personal development. Being on the course alone is not enough for you to be promoted
P2 (55:34) who would want to be on the, I haven't got the energy if you look at what the band 7's have to put up with on the shift, I think I don't want to do that. I would rather do my job properly, good quality care, feel like I have done a good job and go home	Nurses opinion of a band 7 role and realisation that it is not their goal, personal achievement, quality care, knowing they have done a good job is their aim
P6 (55:46) Yes, yes	Other nurses agree with this intrinsic reward
P3 (55:49) and a lot of them are worrying that, you see the sisters mainly spending most of the time trying to cover the shifts	Nurses perception of the sisters' role, which concentrates on managing the rotas
P3 (55:56) they are not actually looking after the really poorly patients, they are not overseeing, they are trying to cover the shifts because there's sickness (laugh)	Senior roles have limited contact with the patients and limited time to support practitioners because they are having to 'cover shifts'
P4 (56:03) but I think because people wait so long to get on the course and they have been qualified	Awareness that it takes a long time to get a place on the CC course
P3 (56:08) they are ready	By the time they have a place they have the experience – they are ready for the professional development and senior role

P4 (56:09) so long I think that's why people get impatient and they think I've got the course now, you know just the flip side of the coin because they have been qualified for so long and they have been waiting and waiting and waiting to get on the course and then they have done the course and they are still waiting for that. Because they particularly do want it, so erm	CC nurses are ready for both sides of the coin, professional development and the course because they have waited so long to secure a place on the course. But that doesn't mean they are linked
P2 (56:30) that not the same here	In contrast, this CC nurse offers a different experience
P3 (56:32) Its opportunities isn't it as well	CC education offers opportunities for career development
P2 (56:34) do you not do six months then they get straight onto to the course?	CC nurse offers differing opinion that locally they can secure a place on the course within 6 months
P1 (56:35) Oh no	This differs to this practice area
P2 (56:36) because the girls when I did it had done a year and they were straight onto the course because they couldn't do balloon pumps until they have done the course	Nurse experience of why individuals get a place on the course, to enable them to expand their roles
P1 (56:40) no, ours is that you can't do swan studies until you have done the course and where that has come from because it is still in-house training, so I am not sure either where that has come from. No I had been qualified two years before I had been asking about the course and it went on funding because I think they like you to have a couple of years' experience because they don't want to fund those that they think are potentially going to leave, you need to show that you are committed to critical care to get on the course	The CC course enables nurses to expand their roles, but the places remain limited and often nurses wait two years for a place due to the limited funding. Minimum of two years' experience is required prior to securing a place on the course, showing commitment to the work environment.
P3 (57:12) We have to sign a contract to say *Mm,* *P3 (57:13) to say if we left you have to pay the trust back*	Contracts have to be signed to say that the nurses won't leave the organisation if they secure a place, otherwise they will have to repay the cost of the course.
P5 (57:18) Pay, and you have to stay on the unit for two years following the course, you don't just do the course and go elsewhere	Similarly, these nurses agree to remain on the unit for two years post completion of the course.
P1 (57:22) I was told once I had got funding you can theoretically move but obviously for your competency books you need to be on critical care, so you are kind of tied for that bit. But we had to sign	And these would have to pay back the course cots if they leave the organisation, but they are not contracted to stay on the unit, but they are aware that they wouldn't be able to complete the course

to say that we would pay back funding but not that we would work in critical care for so long	as they couldn't achieve the competency documents if they left the unit.
P6 (57:36) it just says in the Trust *P3 (57:38) Yes, ours says the Trust* *P6 (57:42) for two years* *Mm, mm*	Nurses compare their agreements with organisation for funding the course, relating to where they must work and for how long
P6 (57:47) which I suppose for them because they want to retain their staff that have got the course I do understand that, because they have had people do it and leave and then say, oh ok	Nurses agree to this commitment in principle
P3 (57:53) which makes sense	Agreement appears sensible
P5 (57: 58) but your spending money, and they are just going	Staff shouldn't just leave if they have been supported to complete the course
P3 (57:59) it's a lot of money as well, it's not cheap	Awareness of the funding costs of the course
P2 (58:03) our staff find it much harder to get on the mentorship course considering how many people we mentor or teach in from all different midwives right the way through to theatre technicians, medical students, student nurses new starters. You are teaching the whole remit aren't you. And you really can't get on the course, we have got too many mentors	Nurses highlight difficulties in securing places on other academic course, especially those that relate to mentoring. There is limited support for this due to the professional requirements and local arrangements regarding the amount of mentoring that takes place in clinical practice
P1 (58:22) I've been given students and new starters, but I couldn't get funding to do my mentorship	CC nurse raises awareness of the significance of mentoring and the difficulty to secure educational support in the form of funding
P6 (58:26) we have to have the mentorship to get onto the course	These CC nurses have to complete the mentorship module as a pre-requisite for the CC course
P1 (58:30) and I've still got to do the course	Unlike this nurse who still need to complete any mentorship training
P3 (58:34) it used to be a criteria but I think some people have slipped through it	The educational plan for the nurses is not always adhered to
P4 (58:39) they don't like it, the odd few have gone through but most of the time we have to have the mentorship. You have to have done workbook 1	Inconsistent criteria to secure places on the CC course, with this nurse highlighting that the competencies need to be completed prior to commencing the module

P4 (58:47) there like a criteria before you can get, before you can apply and then we have got the interview	Nurses on this unit have a criteria to fulfil before attending the interview for the CC course
P3 (58:55) so there are obstacles, you can't I think, we have had a new starter come in and they are like well I would like to start the course. But you have to kind of educate them and you have to do the module 1 first which is in house training then you have got to do this and then you have got to do that and then also you have to interview for it so just prepare it could be about three or four years if you are lucky. Its seven years for me, well six years really and some people even longer, isn't it, so you have to. It's kind of wait your turn isn't it as well, your kind of told	Obstacles are highlighted as barriers to secure a place on the course, the new starters have a limited understanding of this plan. They need to understand that they need to complete local education programmes first, then attend an interview, which might take four to five years. For this practitioner it took seven years to secure a place on the CC model, so you can see why they are professionally ready for development by the time they secure a place. 'wait your turn policy'.
P6 (59:29) for many years you are on the back burner, because other people have been waiting	Waiting your turn for a pace as others more experienced have already been waiting
P3 (59:33) because there's only two per unit isn't there, so which then puts	The limited number of funded places is the cause of this
P4 (1:00:15) I think a quite a lot really because I	Agreement that identity relates to the area of work
P3 (1:00:17) because your caring nature isn't it	CC nurse attributes include caring nature
P4 (1:00:18) yes and on a personal level erm I like, I wouldn't say I'm OCD but I quite like things done properly	Personal attributes of organisation skills, OCD really, things have to be completed properly
P3 (1:00:27) laugh, I developed that *Group laugh*	Others agree that they have developed this OCD type nature since commencing in CC
P4 (1:00:30) I quite like the environment of critical care because I can get mm I know what needs doing and I can get it done, really well and then I can go to the doctor get my prescription quickly because we have got doctors there. Erm, you know you can, you have all, its that thing where you can care for the whole person again, mm	Suits this CC personality because they can plan and deliver care, prompt responses from members of the MDT, care for the patient holistically
P5 (1:00: 54) Control	This behaviour is identified as control
P4 (1:00:55) it is yes	Agreement that it is control
P5 (1:01:04) of being in charge of your own, you're one to one	Being in control and acting autonomously
P4 (1:01:06) your own space	Control of your own space

P5 (1:01:07) with a level 3 patient, you've just got that one patient, it's your patient and you can with experience	Caring for one acute patient
P5 (1:01:15) with experience which you have got you can manage yourself. Sometimes over that twelve hour shift you can see an improvement in your patient, from when you have come on, that's really satisfying, not that it's only down to you but you get that because you its consistency, you're there and you're with your	Personal satisfaction gained from seeing improvement over the long shift, recognition that it's a team approach but you're the consistent factor in that patients care
P3 (1:01:34) and you're continuously observing, the slightest of changes and achievement isn't it	Attributes of a CC nurse include the ability to monitor and notice the slightest of changes, this is a personal achievement
P2 (1:01:44) I think you achieve at work far, what you would like to achieve at home but you can't, for me. Because I like to be in control and I like to see that I am doing a good job but it's not always possible at home but I know when I come to work I can control my own environment and I can achieve that by the end of the shift whereas	This CC nurse achieves at work what they can't at home, having the control in the workplace, this is a personal achievement
P4 (1:02:06) and you have to be quite conscientious don't you in ITU, be quite precise, neat and thorough and methodical that's a really good point, even at home I will like sort of make lists and I will think I have got to sort that out and it's exactly the same at work, I will do the same	CC nurse attributes include conscientiousness, methodical and neat, a list maker, demonstrating that these common personality traits across the group
P6 (1:02:16) Methodical	Personality traits of being methodical
P5 (1:02:21) It's very much a set way of working, isn't it?	CC has a set way of working which they all like
P3 (1:02:25) yes	Agree to this behaviour
P3 (1:02:28) tick boxes isn't it as well, yes	Organisational methods, tick box behaviour
P5 (1:02:29) in terms you know where you are going and where you are coming from, I know everybody works slightly differently	CC nurse like structure to their day, even though some work slightly different
P3 (1:02:38) but we all go from the same hymn sheet	But they have many common attributes
P5 (1:02:40) You've got your chart haven't you, everything is there to see, and you know where you are	Organisational tools include the CC charts

P3 (1:02:45) and there prompts there	These charts provide the prompts
P4 (1:02:46) everything about your patient	They contain the information about your patient
P3 (1:02:48) and there always a prompt there so even if you got so really busy that chart will be there's prompt on there to remind you- ohh, haven't checked NG tape, there's reminders there like you say with a list, there's a tick box for you to know that you have done everything. Oww it feels good doesn't it when you have done it	These prompts are used to organise the CC nurse when they are busy providing structure, and reminders for care management, this provides personal satisfaction
P5 (1:03:04) yes it does, gold standard	Aiming for a gold standard
P3 (1:03:07) yes	Agree with this aim
P2 (1:03:08) do you think there a difference between part time and full time, as part time I work shifts similar to yourself I will have one at the beginning of the week and one at the end of the week and you know you are going to go in and get a totally different patient so you got to have a set method of working through the information to make sure you don't miss anything whereas I don't know if full time gets the same patient for four days in a row	Nurse question the difference in continuity of care for part-time and full-time workers. For the part time workers, they need a set method of working as they lack the continuity that nurse who are their more frequently might have. This ensures organisation of care is complete
P3 (1:03:32) you can do, but also, we like because when I have one I handed over to you yesterday morning didn't I and like you could be working there tomorrow and I could be there the next night so you are being handed over about that patient and I don't know your being up to date with it aren't you as well. Its continuity of care isn't it and so if say on three nights I could have the same patient three nights in a row, might not but sometimes you will and you've got that continued care every night haven't you. erm	Full time staff have more continuity in their care
P5 (1:04:05) or even not having the same patient it's just that	This doesn't necessarily mean with the same patient,
P3 (1:04:07) and the relatives that	It could relate to the relatives
P5 (1:04:10) that care	Agree to this
P3 (1:04:10) yes	Agreeing
P5 (1:04:11) that care for the level 3 patient needs, you know where your, you can through a methodical way, can't you, through your ABCDE, all very	Nurses work in a methodological manner using structured assessment tools, this is specific to a CC nurse

because it's all there, and that's why as a critical care nurse	
P5 (1:04:24) you can then go to other environments because you have that sort of got that ABC, yes well that comes in where ever you go and there's so many, that's lost isn't it on the ward even though that should still be the case	These are attributes that you can use when working elsewhere, skills that are useful on the wards
P4 (1:04:36) seems chaotic	The wards are not organised appear chaotic
P5 (1:04:37) the patient environment, safety of the environment but this is where it's all falling down	The lack of organised approach impacts on patient safety
P5 (1:04:42) people don't learn that way anymore	Suggestion that nurses don't learn this structure
P6 (1:04:45) not the time to do that and not that we haven't got the time	The time factor influences the structure on the ward
P3 (1:04:48) but we look into things deeply don't we whereas I can't say from experience but from what people have told me from before on the wards you do as you do but then when an ITU nurse goes you looking for problems, you're looking for issues more rather than dealing with what you have got. Whereas we are like cos you are thorough in everything else in the unit	Attributes of a CCN looking more in depth, looking for problems. Problem solvers rather than just manging what you have been tasked with Thorough working practices
P4 (1:05:13) well when I worked on a ward I was a basically as a ward nurse you were a coordinator management role and I didn't know a HCA would do my observations and I would, you are detached from your patient whereas in critical care you are 100% with that patient, you know all their blood levels you know erm everything that's going on you know all their family and it's that erm it's that standard that you can achieve	A ward nurse is a coordinator of care, more detached in comparison to a CCN who understands their patient in detail, including the family. Standards to achieve
P2 (1:05:44) the only thing that I sometimes think is that the level two patients mess with your head a bit because you've got that very strict way of dealing with everything and they go I'm not getting up now, I will get up later	A level 2 patient can disrupt this method of care,
P5 (1:05:54) they can talk to you – thinking not actually don't	Conflict with CCN management – patient's wishes versus CCN methodical organisational skills
P5 (1:05:54) very frustrated	Causes frustration for the CCN
P3 (1:05:59) Your control has gone then and they	CCN loses control

P3 (1:06:05) and they move in the bed and we like them to stay still	Lack of control with these patients
P3 (1:06:07) You've made my bed look messy	Lack of control
P4 (1:06:15) I think there is definitely a link between personality and ITU there has got to be	Distinct personalities work within CC
P2 (1:06:20 the same sense of humour	Attributes of a CCN include the sense of humour
P3 (1:06:22) because you get, yeah because we have to deal with a lot of difficult situations don't we	The emotive environment affects the sense of humour, shared sense of humour
P6 (1:06:27 we are completely OCD	Personal attributes or OCD behaviour
P3 (1:06:50) I just love my job really	Nurses talk about 'loving their job'
P4 (1:06:50) I do, yes just love my job	Agreeing with this 'love of the job'
P3 (1:06:53) I just love to go home knowing I've been able to do the best that I can, mm and that when I hand over that other nurse is going to be doing the best that they can	Personal satisfaction of working within CC, knowing we are doing the best we can
P4 (1:07:01) it's a rewarding job isn't it	Highlighting it as a rewarding job
P3 (1:07:05) yes	Agreeing with this
P4(1:07:06) and you can do everything for one	One patient has complete care
P2 (1:07:08) and nobody knows everything because I always go to shifts and find something new that I didn't know before	Realisation that they will never know everything – there is always something to learn
P6 (1:07:51) there is always something to learn isn't there	New learning all the time – this is positive element of the job
P6 (1:07:52) I could never walk in that place and say that I know it all and I don't think anyone ever could	Realise that they won't know everything, and this is OK, always something to learn
P3 (1:07:56) Exactly, everyday even people that have been there twenty thirty years, there's always something different	Always something new after 20/30 years
P5 (1:08:05) it's very much a privileged role I always think	CCN nursing is a privileged role
P3 (1:08:06) yes	Agreeing that this is a privileged role

P5 (1:08:06) for me, you can be at the end of someone's journey through hospital or they might of come to you in the first place, start off	There is always variety in the workplace whether you are at the beginning or end of someone's journey
P5 (1:08:14) and you see them move out and go out through the door but that's not always the case	Understanding that the outcome is not always a positive one
P3 (1:08:17) and you become attached don't you sometimes like we've got someone who's there for eighty days now and become really cheeky and you get a bit of banter and they see the next staff come on and they get another little bit of joy of different staff, you build them up as well don't you, They build you up as well because you can see how well they are doing in those little baby steps, they are improving	Share that this experience causes attachment to patients, especially the long-term patients, this is positive for both parties. Positive seeing them improve little by little
P6 (1:08:42) we had a patient, and I don't know if you are meant to but we still go and see him now, 250 days he's in another hospital but he was here and now he's at another hospital and we still go and see him because you have built that bond, not just with the patient but with the family, you know all that those days of sitting, the families sitting around when they are sedated that who you talk to isnt it, you build these bonds its quite nice really	Bond between the CCN and the patient especially the long-term patients, this continues after they have left the environment

Focus Group 2 Significant Statement	 Formulated Meaning
P8 (2:56) The challenging, you kind of like erm come across like cultural, erm managerial, erm institutional, kind of like affected the way … (pause) the way you work or the way expect differently from like, from like when you are from uni, studying. Like you see these clicks or things like that, pockets of	**The challenges for the nurses are cultural, managerial and institutional, these affect the way of working.** **Challenges for the CCN include the pockets of clicks**
P9 (3:35) We speak a lot about diverse, don't we but I've never heard of adversity … (pause) can you give us a definition?	**Lack of understanding of the term, definition of adversity, rather than diverse requested**
P10 (3:47) I think we create the adversity, the stressful	**Working with an adverse climate is stressful, and the adverse situations are created**
P9 (3:58) Okay, I mean like when trying to go to a fourteen-hour shift, you always see some barriers there whether it be management or the team you're working with. I'm sure that part of the adversity	**During the shift the management or the team cause the barriers to work**
P7 (4:29) I think the institutional challenges at the minute is the … (pause) the fact that we have to more with less, we have to look after more people, sicker people with less nurses, less resources. Everything has got to be perfect, but everything has got to be quick, and that's a big institutional challenge at the minute	**The institutional challenge for the nurses is caring for more acute patients with less nurses and resources** **The pressure for perfection within the timescale is an institutional challenge**
P9 (4.56) Nationally as well everyone is saying publicly how the NHS is failing, erm, each trust is known locally, erm, is said to, certain trusts owe millions and millions in the back of your mind. We have messages from our err directorate, they tell us how we are doing financially how we are doing and that has an implication and err cut backs doesn't it throughout certain units	**The global evidence of adversity relates to the public opinion of the 'failing NHS', the financial debt.** **The local institution informs the nurses of the crisis and its implications to each unit.**
P8 (5:34) Managerial wise really, for us this is a direct influence how well we work and the quality of care we can provide. *Erm you were err talking earlier about dignifying the death and everything like that, but the other day I had the patient for their last office and a minute after I finished the last office my next patient was ready for, for to get admitted, you know err and err, there was no support like you were saying this morning well you should be with someone counselling us and telling us how we feel, there is*	**Adversity has a direct influence on the quality of care that CCN's provide** **Situations which require the nurse to immediately move on to caring for the next patient after performing end of life care management, having no time to debrief, or reflect demonstrates the lack of support from our management.**

not even time, my patient was just washed, I had to go and finished straight after washing and I had to go to admit another patient. Because that's how it is at the moment at the time and I was kind of more experienced, I was POD leader and had to go and take it. Erm lacking of managers and sometimes you get treated like numbers. Erm lack of support sometimes individual lack of recognition … (pause) it's non-existent	**This team leader feels that individual recognition for the care given is 'non-existent'**
P9 (6:49) Especially in the type of environment that we work in, there are some really horrendous days, erm say for instance you are doing a withdrawal on someone, err they expect you, like P2 has just said to completely forget about that, and that's it now, next task that's what it seems to be like that at times doesn't it	**The nature of CC presents emotional and acute challenges, but there is an expectation that you can immediately move on from one challenge to another and forget about what has just happened.**
P8 (7:09) Mm, mm, one it one out *P9 (7.14) Think of the numbers*	**The pressure of patient numbers, consistent flow of patients** **The patient numbers add to the pressure and stress levels**
P10 (7:32) I think in the cardio thoracic side, it's because we are following the especially the thoracic ones to the ward, then sometimes it's just this thing. Your two patients you're trying to do it at one time because they are hurrying because the cardiac ones are about to come out and no-one going to look after them and trying, you're trying to do as much as you can for the ward, because the ward sometimes, the ward staff doesn't have time to do it. You're trying to help the ward then you become stressed because … (pause) it's difficult to do things in one job just to accommodate the others. That's, that's the thing that's more standing in cardio thoracic. It's quite quick pace in there	**The flow of elective patients effects the care given. This nurse identifies the pressure of time on discharging patients in preparation for the next, whilst ensuring that you prepare the patient for the ward and reduce the workload for the ward nurses. In attempt to reduce other nurses' workload you become stressed, the pace of work is so quick.**
P7 (8:57) I think it is whether you can, whether you can put up with that, the fact that you are going to be challenged every day and you might not be supported in the way that you want to be, whether you can, you can accept the good with the bad because not every day is a bad day some days are really easy days and whether that's acceptable to you or not	**Nurses relate the ability to remain in CC with the ability to face challenges every day, when you may not be supported.** **Reference to facing the 'good with the bad' and whether the nurses finds this acceptable.**
P8 (9:29) The thing that plays a part in that is that a lot of our nurses are kind of part time, like you do 22 ½ hours a week and like 21.30 till 37 ½ sometimes I will do bank as well. It's like my second home and	**For this nurse longevity can be referenced to part time and full time working hours, although long days means that you are at work long hours, they do ensure that you have time to recover before**

some of most of our nurses do like two long days or two nights and they go home, they have four, five days to recover. A lot of things really, sometimes	**the next shift or allow for additional bank shift working.**
) I think, I think so because you do have more days off to, to, to kind of like, you know recover in a way, if that's the right word for it. Erm and sometimes it depends on the personality it really it depends on what you can take and what you can't take, not particularly like if you struggle you are weak, like sometimes, like I see nurses in my workplace not mentioning names or anything they come, they think their job is just write the numbers down and make sure the alarms doesn't go they don't touch ventilators, they don't touch anything and they are very happy in critical care, they can give, I always ask you're not actually weaning that patient you know you're just looking after the patient and for some, for some people, like them there's no problem, they come they make sure that patient is you know okay ish but don't contribute to the weaning and don't contribute in other things,	**There is consideration that aprt-time staff can stay longer, because they have longer to recover.** **Personality is identified as a factor relating to longevity in practice, can you 'take it'.** **This nurse differentiates between those nurses that monitor and record and there are those that actively progress the patient in their management of care; some offer little contribution to patient progression. These nurses do their job and go home, offer little contribution to other things.**
P9 (11:03) There are some educational barriers	**Education is identified as a barrier to remining in CC.**
P8 (11:07) I think what I am saying is it is easier thinking a patient, a patient trying to wean trying to do things always thinking	**Referring to those that offer little advancement to a patient care**
P9 (11.16) It's not always the theory behind it	**A lack of theoretical understanding**
P8 (11:17) I approached the nurse the other day and she asked me about the ventilator things like that and I said that's a big tidal volume, oh that's the tidal volume and the pressure support down and she said I don't touch things like that. I mean that for me that's you know, so why are you in critical care? She's very happy in critical care because you know they, like I keep my head down but don't do nothing, make sure I don't do the bad things and sometimes that's fits I don't know, I'm not sure, some times like it happens, err in teams , like lots of clickys and some people are gathered together and they stay together, but I don't know, I don't know why	**Nurses are different in their approach, with some maintaining care and others progressing care, this nurse cant understand why those who have no interest in progressing care remain in CC.** **CC has lots of small 'clickys', people gathering together, this nurse suggests they 'keep their head down' and stay out of the clicks.**
P9 (11:57) And from a very personal point of view as I said earlier I, this is the second Trust that I have worked in a critical care environment erm ... (pause) the first trust that I worked at, I only worked there for six months, I used to cry on the way to work and	**Nurse compares a previous experience of working in CC to this current experience; a very different experience. The prior experience made them apprehensive, 'crying on the way to work', staff**

I used to sit at handover and I used to feel so apprehensive, even taking a level one patient. I remember a particular situation and my patient was in pain, I asked the sister in charge, who was very unapproachable, if she would come and check me some CD's out so I could give the patient some analgesia and she said 'what's it for?' and I explained and she said 'no' and walked away, and went to the next nurse who was her friend and said 'can I help you with your wash' and I was probably deemed unprofessional but then I went, one side of the unit, and the other side of the unit and I asked the nurse at the next bedspace, they were, and they came and they said 'are you ok?' and I said 'no I would like to give my patient some analgesia, and they said and sister overheard that. So I'm proud, I'm proud of myself for giving good care and I felt like I let that patient down, erm so I got very upset and I decided to leave whereas the Trust that I am, I have never … upsetting days and we have some horrible situations, but I love the team that I work with and I pride myself coming to work and I have never had a bad day in terms of teamwork, so I am happy to stay at the hospital that I am at now. Because I love my team and I feel err very comfortable and as part of the members of the team, I can say if I am unhappy with the situation. Whereas at the other Trust, there is a particular nurse as well, who is a male nurse, he asked for an exit interview, saying exactly what I was saying, there is nothing, they didn't do anything in particular but there is a way of making you feel, erm I don't know if that was bullying, I'm not too sure. So, I only lasted six months there, they said they were sad to see me go they said that they thought I had potential, but from that point of view I wanted to give up nursing. I realised, whereas now I am on the critical care course, I feel I am progressing well unit the unit. So, I think a lot of it is to do with the support you receive	**were unapproachable, and this affected the care that could be delivered.** **As a 'proud nurse', she felt that she was 'letting patients down'.** **CC can be emotive, and have difficult days but in the new unit, 'I love the team', she is comfortable within this team and can voice her opinion about situations.** **Examples were raised where staff leave CC and management do not consider the reasons why.** **Bullying was cited as a reason by this CCN to leave the other unit.** **Previous experiences made this CCN consider leaving the profession, but instead they moved to another CC unit. They now feel like they are progressing personally and professionally.** **Support and feedback are essential to feel like you are progressing and want to stay.**
P8 (14:23) We're in the pod, in the pod, one of the girls was basically bullied out, she left and I knew why, knew why she left because, but I was like stay here. But there is a bunch of nurses that decided that she doesn't fit, and they weren't particularly nice to her, she had no support, one of the managers spoke to her and I was saying to her, have a night out with them, if you miss a night out they might of kind of	**Bullying is cited as a reason for staff leaving, This nurse believes 'if you don't fit', this affects the support you receive.** **Staff encourage others to 'fit in' this includes engaging with social activities**

think you kind of like don't like them, that was my advice, and I got four stamps and then she left, and I, you know, they was kind of bullying that was, like little pockets I say, clickies, if they think you don't fit and you not strong enough, they will destroy you	**Suggesting that if you don't fit in with the 'click' and you are not 'strong enough, they will destroy you', suggesting you need to be resilient if you don't join the 'click'.**
P8 (15.16) No	**This staff member was new to CC**
P8 (15:17) No, well what I was saying, sometimes things are a bit different ….. kind of like if they don't like it or they say something to you or, they make your life a bit less easy I will say, and some people can't take it and they go	**When asked to clarify, this CC nurse feels that it might not be bullying, but you need to be resilient as 'life isn't easy in CC' and some nurses can't take it and leave.**
P9 (15:37) In terms of longevity as well, I came from a DGH hospital to a tertiary centre and I was very intimidated, I know I had done six months in that environment but going from the type of patients that I nursed there to the type of patients that I nurse now, and I had already had the six months, nurses when they newly qualify … (pause) they are keen to start with, they are keen as students, a lot nurses who are students and then suddenly now they are the qualified nurse, they no longer, even though we give them support they're no longer that, it's their patient now and there's been particularly a few nurses that have qualified September that are already on about leaving there, they are not sure that it is what they want to do and I think that no matter how much support that you try and give it's automatic, and I worked on a ward when I qualified. And it's an automatic 'Oh my god can you imagine being a nurse' and we all say to them, just try and I know you feel horrible now but try and ride it out, things do get better, the more you learn, the more you are exposed, but some people cannot deal with that, can they? They can't deal with the stresses and they have left	**The sudden concept of autonomy when newly qualified can affect a nurse when coming to CC. As a student nurse they were confident, but even when supported some nurses find it difficult to cope.** **Working within a large tertiary centre was highlighted as very different for this nurse than a smaller unit, commencing in a smaller unit with less support they could still recognise how these newly qualified nurses were feeling.** **This nurse highlights the advantage of gaining experience on a ward prior to coming to CC, and encouraging newly registrants to persevere and that 'things do get better'.** **As knowledge develops and with increased exposure, stressors are reduced but some nurses find this initial impact too difficult to cope with and leave CC.**
P7 (16:51) I think it's difficult as well, because when *you are pod leader, you really want to support your team, you know you've got a junior staff nurse in the corner, she's, they've been qualified minimal amount of time now, petrified and someone's shoved them in a side room for you, you want to get in there, you can't, you can't go and support that person because you've got your own patient, with someone sick.*	**Nurses recognise the difficulties in trying to support more junior staff, with minimal experience, recognising their fears but battling with the ability to provide support for them** **Highlighting that caring for their own patient means that they sometimes watch someone struggle because of the acuity of their own patient.**

The band 7 will be on the phone when is that bed going to be ready I've got the bed manager breathing down my neck so I'm going to breathe down your kind of situation! And that I think is the biggest, one of the biggest challenges we face. Because we all want to help each other, we all want to support each other but you are in a situation where you just can't.	**The difficulties in patient allocation are highlighted, allocating new starters in sider rooms affects the support you can give.** **These nurses detail the organisation pressures that they are challenged with, the most challenging being bed pressures**
Some days you're lucky, you're lucky if you just manage to have a two second conversation with that newly qualified staff nurse and it will be along the lines of 'are you all right?', and you keep going because you just haven't got the time to spend with them, and that's very, very different situation from when I started in ITU. Because when I started in ITU, people had time, there was floating nurses, I had buckets of support, absolute buckets and then the new ones now I feel sorry for because they don't get what I did	**There is recognition that they want to support each other but on occasion situations mean they know they can't.** **A brief encounter checking that the new starter 'is alright' is very different to the experience that this nurse experienced when they were new to CC**
P7 (18:15) I think it is the new, more the starters that leave and the higher turnover	**Nurse indicates that it is not the experienced staff that leave, the turnover relates to the new starters**
P9 (18:19) …… and I don't know if it's the fact where you work but people that have been there for years and you have people that have been there for like minutes, there doesn't seem to be many middle of the range. I've been there eighteen months and I feel like I'm very much middle of the range but there's lots of people who are on about leaving, I spoke to a new starter the other day, she's been qualified six months and she said, 'I'm just going to give myself one year and in terms of nursing one year in ITU seems good, appears good on paper'.	**Recognition that there are new starters and seasoned staff but limited middle range staff** **Mid-range staff are identified as being there approximately eighteen months, but staff aren't reaching this length of time.** **Staff can be heard saying they are going to leave, they have been there about six months, and can identify that they will continue for up to one year then make a decision to stay or leave. They realise that this will be considered a good experience when applying for other jobs.**
That was her theory, and I thought oh, so I tried to persuade her, I was like, hopefully that's like, why do you feel uncomfortable, let's see if we can look into that? And it's not as if the unit doesn't provide support in terms of, they have implemented erm practice development nurses and the Step one competencies, you've got the supervision period, but they are trying to implement where a pod leader can be supernumerary, but it's just not, with the actual demand of the unit, it's not achievable, is it really?	**Nurses encourage them to stay, supporting and giving fed forward on what they can do.** **The unit is recognised as having an education team, work related competency documents, and supervision periods to support new starters.** **But the lack of supernumerary area leads, and the demands of the unit support remains difficult.**

P10 (19:29) I think in my case, it's like before I was in ITU, I was in a unit where I stayed twelve years, and I think for me it's just the structure is why I stayed there for a while, I don't mean to leave but I found like, I would spend six months there and during the management of change I became … and I got disappointed so that's why I left the unit and went to ITU. And now I think it's more of a job satisfaction, … there a space where they are and experienced cardio thoracic just won't stop the new ones doing the same, it's the new ones who are leaving and the old ones are leaving behind, I think it's, I think it's most of the time the new ones and the old, old ones leaving them behind, I find because most of the time we are really short staffed and you cannot really guide the new ones properly you yourself as the senior ones as well as having your patient because you ended up having the most sick patient because you are more experienced, so you don't have time anymore to support the new ones. It shouldn't be, you should always be there with them	**The organisation structure affects job satisfaction, this improves longevity in the workplace. This nurse came to CC with many years' experience following organisation change they are now rewarded with job satisfaction, the changes inflicted upon them in the previous workplace made them unhappy, they became disappointed.** **These organisational changes are now evident in CC and new starters are leaving.** **They are faced with the challenges of staff shortages, which reduces the support and guidance for new starters, being the most experienced they have the most acute patient. They acknowledge that this behaviour isn't right, staff need support.**
P9 (21:41) I think sometimes it's hard to feel like you have your own identity, erm when we talk about is numbers, they will say 'we have go so many nurses on tonight, or dependency this or dependency so .. but on the flip side of that, when you come onto the unit and you want .. against the patient's, you're the allocated nurse or when you introduce yourself to the patient's, that's when you've got your own identity. But in terms of erm, we have allocated. or if they are short they will send off a ward or they will send it doesn't matter if there has been any continuity of care. Say for instance I could be in one pod on one shift and work the very next day and be sent somewhere else, whereas, for me, I think it would make more sense to look after that patient, especially for the patient with continuity of having the same the same nurse. Erm sometimes you do just feel like you are a number and you're very replaceable	**Identity is difficult to relate to when organisationally CC relates to staffing numbers and occupancy.** **Organisation does not recognise identity when wards require staffing, CC patients and their continuity is not recognised.** **Nurses feel like they are a number when there I s no consideration for patient allocation.** **Lack of appreciation for the self.**
P8 (22.49) Education that's a big thing now like now like we're poor in education, we are very poor at education, until recently when some called education programme which that disappeared as well, for the PDN's, erm, and that, basically they used to do like a weekly education programme for nurses to attend, we don't dream to leave the unit, our patient for an hour, two hours, to have a bit of	**Weekly programmes of education are difficult to attend due to time and patient acuity. It is no longer seen as possible to spend an hour or two away from the patients**

training here and there. It's just not possible. For doctors it is but not for us. Especially now, we are always full packed, err, there's no chance of that, there's definitely, we have a lack of education for nurses, not just in critical care but in an area like critical care there should be more of an effort put into education, they're always talking about cost, cost, cost and not time off … not just manual handling and things like that, like spend a day or half a day on, taking care of your patient rather than going there, so	**This differs for the medical staff whoso education has protected time** **Nurses are reminded of the cost of external education** **Education should be more than mandatory training such as manual handling**
P7 (23:50) It annoys me because, like, doctor's education is protected isnt it?	**The value of medical versus nursing education, medical is protected**
P9 (23:55) And ours isn't, but I do think that if, we had someone that was struggling, and erm we could give them an hour of teaching	**Recognition that education time should be found for the nurse that appears to be struggling**
P8 (24:05) At the bedside	**Bedside teaching should be available**
P7 (24:06) At the bedside	**Agreeing with this**
P8 (24:08) Yeh,	**Agreeing**
P7 (23:09) But away from the bedside as well, and we could go and do some teaching if they are unsure, then we can say, okay then, I will sit down for an hour and talk to you about blood gases. Because if you do understand, then you do feel more confident, I think that would help, make people feel a bit stronger, like they have more resilience because they have got some erm, they've got some knowledge to help support them, so they can support themselves but it's like (P2 Name) says it's not possible. Asking for an hour … (pause) for two nurses off the unit is, you may as well ask for twenty nurses off the unit, it's not going to happen	**In addition to formal teaching away from the patient, this would include such aspects as blood gases.** **The advantages of this type of teaching is that it promotes confidence and increases the nurses' ability to cope – more resilient** **This is currently difficult to deliver, two nurses away from the bedside for an hour is logistically too difficult**
P10 (25:00) And I think in ITU as well you have got to be able to go home and pick up a book and read about it, there has got to be a lot of directed study as well. I don't think it's people who need, like reassuring like you're a good nurse lets try and develop your skills even more. you only have the people who are on that radar	**Expectation that there is a personal requirement for learning, directed study** **Acknowledgment that certain nurses are on the 'radar' but there is limited time to reassure all staff**
P8 (25:46) It's the standard, trying to catch some come and give you, erm proper, proper uncalled-for lectures, erm, quite a few of them, many are unapproachable, er, from my point of view, and I	**Nurse negatively reflects on how difficult it is to ask for education, staff are unapproachable, and they wouldn't ask for support**

personally, I never, never, quite a few of them I've never had a problem with, but I never go to them because I know the outcome	
P8 (26:10) Oh yes, they will come to you and drag you down and (mumbling) and (mumbling). I haven't experienced many of good educational, education like that. You are kind of like a piece of trash, and err, I just, and I have experienced this recently, not long ago and I had to ... from that, guys I am having a really, really bad day, it was busy, had to kind of like calm down a bit, you just, err I don't find the approach very comfortable at all. At all	**Nurse identifies a recent negative experience with the education team relating to their approach when they had requested support**
P9 (26:47) I think there's a erm, we had a lecture the other day, and they said you are not an ITU nurse and we actually asked, what did she say, and they actually said you are not an ITU nurse until you have been on ITU for nearly seven years she asked the whole group, she been on ITU for seven years. You can't say that to people, so the rest of us haven't worked in ITU for, for many years, and I think that reflects, 'cause the DGH where I worked at everyone had been qualified and worked for and that there was their bread and butter ITU.	**Nurses felt devalued when they experience had been devalued due to their longevity in practice, their experience was identified as limited because it was less than seven years.**
I think the minimum amount of time they worked there was about fifteen years, whereas when I came to the tertiary centre, I think it's, it's a big centre where there are lots of different erm specialities and lots of different things, the skill mix is very dilute, and I think that adds to the strain and stresses as well, because you only have certain nurses from in the pods that are capable of looking after what is deemed as, well you've just said the portliest patients and they you get well not always, not, not burnout and you'll end up saying 'all right, okay I have a little poorly patient again', it's sometimes nice , so refreshing. The other day when I got allocated to a erm, weaning patient because I could actually give good quality care I could promote rehab. Whereas like a few nights before I didn't even have a break 'because I was that busy with a certain patient. But erm, I think it becomes quite predictable, doesn't it, what type of patient you are going to be nursing	**Smaller CC units are referred to as seasoned nurses with longevity in practice (approx. fifteen years) in comparison to the tertiary centres where the skill mix can be dilute.** **Consistently caring for the acute patients can lead to burnout, as experienced nurses we are not exposed to the longer-term patients, which can be 'refreshing'.** **An experienced nurse can positively affect a rehabilitation patient care management** **Nurses describe predictable behaviour relating to patient allocation, which can lead to relentless exposure to the acutest of patients**
P9 (28:41) And how you are as a person	**Nurse allocation depends nurse attributes**

P10 (28:23) You are going to be nursing, with the skill mix, it gets a bit relentless at times *P7 (28:40) I do, I really feel like I belong on that unit, like I couldn't, erm … (pause) Sometimes it annoys me, like nothing else in this world, annoys me like nothing else in this world, but I don't think I would ever go anywhere else or do anything else. Like, yeah, no I definitely belong on that unit.*	**The current skill mix means that there is a relentless allocation to the acutest patient** **Nurse describes a sense of belonging in CC, recognising that there are negative aspects to working there, but they wouldn't work in any other environment**
P9 (29:05) Erm I just ... (pause) every, every day is challenging, and I, I like that, I expect that, and kind of anxious to sort of meet that sort of challenge and to sort of succeed. But it's the little things, like, you know, if you manage to sit down with a new starter and do a page of preceptorship book, for me, that, that day is victory, because I have spent that time with that person. Or when you have patients come back and you can remember them being so sick, and they are coming back talking and they are going home with their family. To me, that, that makes me feel like I am definitely doing the right thing. And because we are such a supportive team and quite a close team, I think that helps for the sense of belonging that I feel sometimes, well all the time.	**Belonging is defined as understanding that CC is challenging, and they are anxious to achieve that and succeed.** **Sense of achievement is fulfilled if you can spend time with a new starter and review their competency documents, 'that's a victory'** **Sense of achievement is experiencing patients return to the unit after their discharge, this confirms positively their decision to stay.** **The sense of closeness and support from the teams makes the nurse feel that they belong**
P8 (30:03) My point, my point is that, not the structure of the system but like P1 (name given) says, it's like when you're learning about that patient, and that close to that patient families that they, teamwork sometimes. I think I belong to that, yeah, but the overall, no, like, I like the patients and the education side of it and the learning, like you see people come in and never get out, like some come back and visit us after. Erm, where do they go (mumbling) you see things like that and it makes your day, makes you think like, you know, it doesn't get any harder than that but err it doesn't get that much satisfaction, you don't get that much satisfaction if you're with someone else	**Nurses can belong to their direct team without belonging to the organisation.** **Nurses are close to the families** **A sense of achievement is felt when patients visit the unit, this is such a positive experience for the nurse, there is no greater satisfaction than that**
P8 (30:06) We don't accept anybody	**There is a criterion for recruitment**
P10 (30:09) You know where, other trusts, our trusts will have newly qualified	**This organisation accepts newly qualified nurses**
P8 (31:02) Yes, oh no not the team, the above it, the teams, the teams fine,	**This nurse clarifies that they belong to the team but not the higher structure, the management**
P8 (31:16) I think I mean management, yes, erm	**Definitely not the management**

P10 (31:24) I think when I started in ITU, I think I started for the wrong reason, I don't think I feel I belong there, but then I think when I got more experience on looking after the next patient, like some satisfaction of seeing them bringing them up to the ward and knowing that they were going home, I think I'm going to feel like I'm, it's what I've always wanted to do, I know … (pause) I am happier now than before. So, I feel er, like I do belong now, unlike before. Like when I first, the first one or two years when I started in ITU	**Recognition that as a nurse they commenced working within CC for the wrong reasons, they didn't feel like they belonged there.** **But following exposure and experience the personal satisfaction of caring for these acute patients, they realise that CC is where they belong, they are happier. They acknowledge that this belonging took one or two years.**
P9 (32:11) I came from a ward environment and I still do bank shifts on coronary care, erm … (pause) and the things that I have learnt in critical care are very transferable and I don't appreciate how much I've learnt in that environment until I actually do the ward shifts. Erm, a few months ago, I looked after a patient who was err, very poorly on the unit in coronary care, and er, fortunately it wasn't any of my teammates and I had to nurse him to the point where all the staff were like, oh my god, thank god you are here. The doctors were like, aww, what's going on, what's going, she's an ITU nurse, erm, but I could transfer my skills from working in ITU, and made me appreciate everything that I had learnt because I was transferring, we were taking gases off the patient, I was doing gases, I was interpreting the gases, you don't actually reflect on how much you do until you get in, in a different environment, until you have had ITU stripped away from you. And that's why I, my passion is cardiology but I'm not ready to go back to cardiology because I am enjoying how much I am learning and it's made me better nurse and how I practice, erm, in a different style now, there's a lot more theory about how to nurse patients so if thats sense of belonging, then yes, I do belong in critical care, erm but I enjoy doing both. And I think it's, it would be good for all critical care nurses to do a stint on the wards so that they can appreciate, maybe if they developed a rotation err and in the first couple of years when you're newly qualified, erm, and vice versa. Because I think sometimes the ward nurses especially, from the feedback I've had, when I have worked on different wards, they don't appreciate what ITU nurses do and vice versa.	**CC provides transferable skills which aren't always internally appreciated until they are exposed in another environment.** **The nurse provides examples of working in another acute environment when a patient deteriorated and how they used their skills to manage this situation. The performance was externally and internally rewarded internalising that their knowledge and skills had developed, this was personally satisfying.** **There was a lack of appreciation of how they had developed until an experience exposed them to manage a situation.** **Nurse identifies that CC is not their passion, but the experience and education is developing them as a nurse, and senses that this is belonging.** **They have a career plan to return to their area of passion but find both areas satisfying** **Exposure to other environment would enable CCN's to appreciate their development.** **Suggestion were made for new starters to rotate to the ward environment in their first couple of years post registration, this would bring positive reward to both the clinical wards and the nurses when they receive feedback on their development.**
P7 (34:25) I think it must do, mustn't it? *P8 (34:30) Yes it does*	**Belonging is a reason to remain in CC** **Agreeing with commentary**

P8 (35: 30) Capability is definitely one of the.. we have seen nurse, one, two nurses that started with me, and one was kind of my mentor, you know, on a ward, she lasted three weeks, she just said "I feel horrified, I cant, I cant deal with it''	**Nurses have left CC due to feeling horrified, not capable**
I had I never worked in critical care before, so not because she was crap on the ward because, it's just she wasn't capable of critical care environment, she just couldn't take it. It's obviously, if you are not capable of doing it then	**These nurses had both worked on wards with no previous exposure to CC, one left feeling incapable**
P9 (36:01) I think you have got to, as a critical care nurse you have got to be a very, err adaptable nurse, no disrespect to the ward nurses but sometimes they have very much a routine there on the wards, whereas in critical care as it is on the wards as patients can deteriorate, erm, but especially in critical care you can never, you can have a roundabout idea of what you are going to, how you are going to plan the day, doctors rounds and washes and stuff and all your patient care but it just takes one patient to deteriorate and this is where your teamwork comes into it. If one patient deteriorates if you don't work well as a team that one nurse, say for instance, I don't know, the patient was mine and all of a sudden, we went into the mud and I did, I left you with a patient the other day that was self-ventilating on room air, and you left me with the patient on quad strength norad and every inotrope going with a lot of intubation, with a lot of support. If you're okay, if you hadn't have been capable, if you were a new starter, and the person had allocated you that patient thinking they were self-ventilating on room air and all of a sudden, the day has spiralled out of control, it was overwhelming for us, wasn't it? How sick that patient ended up being, whereas if you had a new starter added in the mix, that's, well I would be really stressed out	**Capable is identified as being adaptable, ward nurses have more of a routine, in contrast to critical care where you have a plan but a change in acuity of one patient effects that plan.** **This is where the teamwork helps, examples are raised which highlight significant changes to patient's conditions, and how this patient 'spiralling out of control' would increase the stress levels of a new starter. But this couldn't have been predicted.**
P8 (37:34) It's difficult really, it's the ability to listen and to learn, and if you don't have that factor in critical care then	**CC nurse characteristics, they need to be able to listen and interpret information**
P7 (37:57) I do two long days a week now and I will not see people for months, just because it's critical and the other one is time management I think, it's like prioritising, you have to have pace as well	**Time management is an important characteristic of a CCN**

P8 (37:39) But you only learn your time management, with true expose don't you, if you are the only one used to looking after that well type patients, then when you get a poorly patient thrown into the mix, then your time management and all your prioritisation, you would be like oh my god what do I do? This is where the, they lack some support, you can see the nurses are busy with their own poorly patient, erm then as the junior nurse you then, and they are, some of them actually say they are sinking and they do are learning to the fact and then you go over and say what can we do. But it's just easier, I've done it myself, it's just easy to spiral out of control and all of a sudden you are just like, oh I don't even know what I am doing anymore and it's just, the doctors are asking you to do one things the physios are you to sit this patient out, there's a lot of environmental factors I think that affect it as well.	**These characteristics such as time management need to be exposed to various clinical situations, you need to be able to adapt and prioritise depending to what is happening within the whole CC setting** **As patients deteriorate nurses need to recognise that they are no longer managing that situation but they are still learning. Support is needed to help them readjust to the new situation.** **Need to understand their limitations** **Factors that influence patient management spiralling out of control include requests from members of the MDT team and they need to be able to prioritise these decisions.**
P7 (38:43) I think it's your ability to take constructive criticism and support from people, not just your band 6's or your band 7's, from the other band 5's. The new starters that I think do really well are the people that will go to other band 5's and say "in this situation, what would you do? I think I am going to do x, y and x, would you do that? Is that okay?'', rather than either ignore them or wait till a band 6 can get to you, which can be, however long it might be or do the worst thing in the world and say nothing and then it only gets picked up when things go spiralling out of control	**Nurses need to be able to take constructive criticism from a variety of professionals, seniors and peers.** **The nurses that ask for advice, and check their plan of care appear to do better, it prevents care spiralling out of control, they seek advice.**
P7 (39:29) Yes *P9 (39:29) Or reflective?*	**Those that are better at clinical decision making seem more capable** **And those that are reflective**
P7 (39:33) It's being better at clinical decision making, everyone is kind of, everyone is obviously busy but if you can have a rough idea in your head saying that kind of actually, "this isn't going actually as I would kind of like, okay who's, who have I got around me, I am going to go to them, that person there because she doesn't look very busy and I'm going to say to her, this is what I've got in front of me, I think I should do this, what do you think? ". Those people always do really, really well. The people that don't do well are the people who when the other nurses come and say ''oh, you know, this isn't quite right let me help you'' and then, those	**Clinical decision making is a key factor, identifying key individuals when situations are changing and verifying your plan with others for positive confirmation of the action.** **Those that work in this manner of positive verification of planning and respond positively to constructive feedback appear to do well**

people sometimes get quite defensive, those people don't do well.	
P8: (40:19) (incoherent) they find it kind of intimidating, don't they?	**Feedback can be intimidating**
P9: (40:14) Because we've got, I don't know what it's like on cardiothoracic but on the general side we've very much got a culture of, that we would happily challenge each other's practice and question each other, "why have you done that like that?" Not, in a bad way just, is that a better way of doing it, teach me, so I can be better and we, we certainly do that in our side, in our pod, somebody that can't, come, can't adapt to that culture wouldn't do very well, on the general side.	**CC has a questioning culture, not in a negative manner but as a developmental experience. Those that do not cope with this type of culture do not tend to cope well with CC**
P9 (40:44) I think as well, you might think I'm wrong for saying this but on the wards, its, I know I keep referring to it, because your management aren't so visible you kind of learn, you have to learn how to fend for yourself, don't you? You have your certain patients, you have to get through that day whereas in critical care, there is always someone, that you can ask, not that that is a bad thing, but it's , it's all like people have an automatic response, 'oh I don't know what to do with this", so instead of thinking for themselves, they will just go and ask, like another member of staff. There isn't that, I don't think people have quite developed that clinical decision making. Fair enough if they suspect something is wrong, so they will ask, but in terms of, and I have heard yourself, then you flip it back on them, on a mentor, what do you think you would do in that situation?, some people are very, very quick to just take instruction, and they are happy to be lead, that's probably a better way of saying it. There was a situation a little while ago where a band 6 asked a band 5 why they hadn't done observations on a patient for a few hours and they said "because you took my BP cuff off my patient's arm, you should tell me when I need to do my observation". Now as a critical care nurse that should be our bread and butter, but he was saying that it was the nurse in charge's fault for not prompting him to do the observations, and I think that sometimes because they are aware there always going to be a senior nurse or a senior band 5, senior band 6, and a band 7 on, they think oh well, I am not going to do it wrong because the band 6 will tell me if I am doing it wrong. Pause, that's how I see it.	**CC senior team are more visual in comparison to the wards.** **On the wards you work more independently, in CC they suggest there are supportive mechanisms in place as senior members are more available.** **Ward needs to make unsupported decisions.** **This nurse identifies that in contrast they feel that ward nurse has developed their decision-making skills. Mentors need to develop the skill of questioning rather than advising and nurses need to be less responsive to taking instruction and being lead** **Examples are shared relating to the lack of decision making and behaviour that requires instruction rather than active decision making. There is a reliance on the senior team.**

P9 (43:08) I think we promote power on our unit, don't we? the consultants, I can't do it but they like you to call them by their first name, it's very much, there's no, no such thing as a hierarchy, obviously they are consultants and you need to be aware of that, but they are very approachable, some more so than others, erm but they like you to be very much at the bedside, err, everyone like a multidisciplinary team, you can all, if you have got an issue then you can say, so I think they empower nurses	**CC empowers nurses.** **The hierarchy is less obvious and there is a common use of first names. The MDT are approachable and visible**
P7 (43:41) yeh, I think I would	**Agreement that this empowers nurses**
P8 (43:44) to a certain extent, not in everything	**Contrasting opinion in that this is not always the case**
P8 (44:45) erm, it's still very much really in a, kind of, we are not really, effectively in a position, we are not really the effective decision making, we are just, just, yeah, I don't think, most of the decisions are still in the hands of the clinicians	**CCN are not the decision makers, the medical team are**
P9 (44:02) yes, but I think you act as your patient's advocate, don't you? like I feel that	**This nurse questions this response, suggesting that CCN are the patients advocate**
P8 (44:13) no, but like as we are saying, the MDT and things, we are not really actively in the decision making	**Nurses opinion that nurses are not active in the decision making**
P8 (44:16) I think with our intensivist yes, but when there are other, say for instance when there are the neurosurgical team come round, there are about twenty of them that come round, they ask you very closed erm, closed questions, er,	**Clarification of the point suggests that CCN are more active in the decision-making process with the Intensivist team but not the patient's speciality team**
P9 (44:28) they don't tend to look at the patient, er, stay for about two seconds and then that's it straight onto the next patient. Whereas when I think of the intensivist they do, they will ask you in the morning if there are any concerns, so they do involve the nursing staff, they do try, and I know some more so than others. Mm I don't know you might disagree with that one.	**In support of the decision making of the nurse, this comment suggests that the speciality team do not make the grand plan, theya re there for a short period. It is the CC team that include the nurses in the decision making, giving opportunity to raise concerns. Although admittedly this is an individual approach, with some more effective than others.**
P8 (44:47) no, no, it's, erm it is like I say, some not, it depends who's in, we are not standardised, on the ward I think that's what the big problem is, the lack of much standardisation, you keep hearing, dont you, like, it depends who's in, depends who's in, which consultant is in, it's all like that	**The lack of a standard approach of including the CCN is highlighted as a concern, decisions are dependent on the consultant at the time.**

P9 (45:05) personalities as well, isn't it *P8 (45:05) Yes, exactly, who's approachable, who's not approachable, it's you know. Even human factors, it plays a part, you know, we are, we are, at the end of the day, if someone's not approachable we wouldn't go to them, be very friendly to them or. When I walk in I will try to, can't go after them, but its like you say, someone else is approachable we talk to them, like a equal, we express our opinions, and they listen, so, like you say, they is no such thing in the place, saying you need to, no standardisation, in place, they need to listen to the nurse, in that area, in that department, there's not such a thing*	**Agreeing that it is dependent on each personality** **Nurses raises the point of human factors and the importance of being approachable to ensure that a nurse will address them with a problem or support.** **Everyone is entitled to an equal opinion, there should be a place for this, but there is no standardisation in who listens to the nurse**
P10 (45:53) I think in cardiothoracic it's a little different, better with that, there's our post op care, post-op cardiac patients, it's like nurse-led, need to extubate, we take it out, it's not instruction from the consultant. There is a protocol, to follow so it's just, especially with the straightforward one, you can just	**This elective surgery CCN offers a comparison suggesting that elective surgery is nurse led, the nurse is more autonomous in their decision making**
P8 (46:11) I agree, yours it's just yours is more standardized than us, you do have the (incoherent)	**Others agree with this point on increased standardisation in elective surgical CC areas**
P10 (46:18) yes, although if the patient becomes a little bit more complicated after then it depends with the consultants, sometimes the registrar especially when you on at night, the registrar does not want to decide something just because this consultant has different views and things	**The nurse describes situation when this isn't the case, when the elective surgery becomes complicated then the medical team do not want to make a decision because of the lack of standardisation between the consultant team.**
P10 (46:35) doesn't want to do some things, occasions and procedures, sometimes it's a little bit difficult, because, (pause) you know you want something and you want the, you want your patient to be a little bit more, quicker to be extubated but you cannot do anything, because the consultant had a different point of view,	**Decision making remains dependant on Consultant opinion, it remains their overall decision and this is sometimes different to the CCN opinion**
P10 (47:01) although most of the time, it's, as I said its ok because we are nurse led in the cardiac unit, the cardiac patients	**This is not seen as a common issue**
P9 (47:16) I think, what's good for us as well, is we have the ACCP's, the advanced nurse practitioners. Now they were predominantly ITU nurses themselves, so they understand the pressures, dont they? So, if the doctor asks you to do something, if they are on the ward round, the ACCP's have that middle understanding that it's just not going to be	**Nurse recognise the value of having a team of Speciality nurses who understand their pressures, the ACCP's from a nursing background empathise with the nurses**

done instantaneously, it will get done when it's done. It's not as if critical care nurses ignore the jobs that need to be doing but we have our own agenda, that's probably not the right word, but we have got in our own mind our priorities and is just knowing when to do that and obviously it's just acknowledging the doctor, yes, we will do that but if you can just bear with me, I've just got to do this first. So, I think that is quite nice sometimes, because the ACCP's they will say just give them a few minutes, they understand, don't they? they can empathise with us, that's what I am saying.	
P7 (48:11) I think sometimes you can flip that on its head as well, if you can get a very junior doctor who comes to review the patient, and they genuinely, sometimes you can be in a position of power because they genuinely, really	**In contrast, the junior medical team request advice and support from experienced CCN's, they have a more powerful relationship with them**
P9 (48:22) don't have a clue	**Due to their lack of knowledge**
P7 (48:23) they really, really need your help and support	**The junior medical team are reliant on the CCN's support**
P7 (48:25) to be able to do what they need to do, to go through that patients notes, to be able to present at ward round. And I think as a band 6, very often people will, doctors will come up to you and say "what am I going to do with this?" and you are like, you need to go and speak to your senior doctor or your consultant. Erm but I think, pause, it's, I think, ITU nurses in general are in positions of power, just generally, we are, have, let's face it, complete power over some of our patients, completely ventilated, sedated patients, they are very vulnerable and the other side of that is, that we are very powerful in that relationship. And with the family as well, you know, I think everybody's had that situation where the family hangs on every, every word you say, every look you give them and in that sense, then I think there is power there, but I think that power has got to be used properly and not abused.	**CCN's are asked for advice from the junior medical team** **CCN offer advice and support to the junior medical team** **This is a position of power?** **CCN's are also in a position of power over their patients and families who are vulnerable.** **Families are in a vulnerable position and this powered needs to be used carefully**
P7 (49:55) I think your humour gets a bit darker, doesn't it?	**Characteristics of a CCN- humour is a little darker**
P7 (49:56)I think when I started in that unit I was (laugh) twenty-one and believe it or not guys I did not swear, when I first started on that unit (laugh)	**CCN offers that they didn't swear before commencing CC**

P9 (50:07) I think though the environment, the environment that we are in, some of the situations, like I've only worked in this unit for eighteen months and already, I keep saying it, oh my god, I'm going to remember these situations to the day I die, like for instance, I looked after a stillborn baby as well as nursing a patient, there not any other situation where I think how could II have done that? So, I think socially, I can't then go home and tell my partner all about this situation and why I am in, why I feel so sad, so I think that's why we do become really close, because we can empathise	**CCN is exposed to powerful life experiences, with lifelong memories due to the situations they are exposed to** **These situations are why CCN's become so close, sharing these emotive experiences, families couldn't understand these experiences.** **The team can empathise**
P9 (50:54) empathise with each other, so I might say to P1 (name given) I'm having a horrendous day or if you have got like a withdrawal, you can just, you don't even need to say it sometimes you just know and we are there for each other. So, I think, if you have got the right team and the right friends, like, then yeah if you got a good social network around you, as in the nursing staff, then yes it will make you last longer because I can't imagine being a junior nurse being put in that situation. Say, for instance, in a withdrawal or that stillborn situation and not having any humour or any support or any 'are you OK' afterwards, then going home and reflecting on it, because I know I would have cried in that situation, the senior nurse that was on with me did the same. We got each other through the shift, it was, then the next day reflecting on it, we keep reflecting on it, and I still reflect on it now. Whereas if you didn't have that, it could really eat you up I suppose.	**The team understand the situation that you are going through without the nurse having to voice their feelings. There is a common understanding that they are there to support you** **This team enables the nurse to remain in such an emotive environment, it's a social network** **The team guide the nurse through the difficult shift. Experiences are reflected on and reflected back upon, especially those events which are tragic, only those experiencing it with you understand**
P7 (51:46) I think some days, It does isolate you from, like, your family at home and your friends who maybe aren't nurses	**These events would not be understood by your friends and family, you are isolated from them**
P9 (51:55) you've just got to keep it normal haven't you?	**You keep normal for your family**
P7 (51:56) yeh, because you walk through the door, and then someone will talk to you about something that is maybe really bugging them, like the washing machine is broken or something and like I don't really care, the worst day in the world, I don't care about the washing machine or whatever. Err, and that's really difficult for our families or for our partners to grasp, I know when I first started, first moved in with my partner, he was like, genuinely, you are not to be spoken to when you come in from	**There is a sense of lack of perception and understanding from your family, the family events appear minor in comparison.** **Families genuinely understand that nurses need time to decompress when they get home**

work are you? And I was like, no love I'm not, let me go in the shower first. Because I just can't, personally I need that time to like, but I can imagine, like, if I wasn't allowed that time to decompress at home, that I could imagine it clearly being quite difficult	
P9 (52:47) and also, in seriousness though, my boyfriend said the other day because I have had a couple of weeks where the shifts have been horrendous, there has been lots of deaths recently, erm you shouldn't take it home with you, but you do take it home. That's just natural especially when you develop a relationship with relatives and the patient. So you don't disclose any information but they can sense mood, and erm he said "are you planning on staying in ITU for a long time?" because "he said it's going to affect your mental health", surely nurses get burnout, and for him what he deems as a bad day at work is completely different to what I deem a bad day at work. And I said "of course Im going to stay there because I love my job " and I love being a nurse, erm but I think sometimes, you think if you are not, I am not wanting to sound negative but if your, erm, you have a really rubbish day, then, like you said before, you had a withdrawal, and then all of a sudden you have an admission, that admission can turn into a withdrawal as well, it can have a knock on effect, if you are constantly faced with these barriers then you will get burnout you will just think, oh, it's not worth it, especially for the pay, you can get a job elsewhere, less responsibility	**The family of a CC nurse develop an awareness of the type of experience you have had that day** **A nurse can be exposed to frequent death, and they are aware they shouldn't take this home, but families sense their mood.** **Families question their longevity in the CC area, sensing their mood and suggesting that this may affect their long-term health** **The nurses 'love of the job' and 'being a nurse' ensures that you remain in CC but one negative experience after another does make you question is it 'worth it', you consider the barriers, the financial reward and burnout, you consider a job elsewhere with less responsibility, but you remain**
P9 (54:16) I don't feel that bad, not really, I know I don't	**They reflect on personal insight not burnout**
P8 (54:26) it depends, sometimes you go between, but I've never really felt it to the unit. erm (incoherent) put it that way, … try to not let things get me down and I've tried but like I said it does happen sometimes, when everything gets at you. I'm trying to think (incoherent)	**Resilience, in trying to not let the experience get them down**
P10 (54:56) I think I feel, because I am doing this course, I feel like more resilient because the more, I feel like the more knowledge you have got the better care you can give to your patient, erm I feel like it's more worth it, I think because you are more knowledgeable, I think! (laugh)erm, I felt like I am giving the patient better care. (Pause) And when I	**Education and the CC course increases resilience,** **the more understanding you have the quality of care increases which increases the job satisfaction and intrinsic reward**

have given the patient better care I feel more satisfied in my work. (Pause) Something I've wondered	**This increases satisfaction in the work environment**
P9 (55:41) I think I would probably sit in the middle, I think, there's days, it depends on the on the day, it depends on the shift, there situations where you are very vulnerable, in situations because you can reflect on it, you can compare it to your personal life, whereas like, you've just said being on a shift, erm, being on the course you've got your theory behind the knowledge, so sometimes when you're feeling vulnerable, say the patient starts to deteriorate, "oh god what are we going to do?" , no actually I know what I'm going to do, let's look at A-E, let's look at this, let's look at that, and you become more structured, so you kind of I don't know like a seesaw, I suppose	**This nurse feels unsure, some shifts increasing the vulnerability.** **But acknowledges that being on the course, enables reflection and increases the ability to cope in difficult situations, giving confidence that they can cope**
P7 (56:23) yes, yes, I kind of agree with P9 (name given)in, when I was a band 5, I kind of felt really resilient, I was like oh yes, this is alright, I love it here, blah blah blah, but, then I went into my band 6, and then I was a bit like, oh! oh now I don't know! and some days like, pause, some days I feel very very resilient and other days I don't but it's not, not really about me, why I don't feel, usually when I don't feel resilient is when I don't feel like I have done a very good job which is usually like when I have let either my patient or my staff down and I think it is quite closely linked to job satisfaction like we have said before, so when I feel like I've not had a particularly good day I've let somebody down, then I feel a lot less resilient	**Others agree, feeling resilient in some situations, but now reflecting of their position in amore senior role they question their practice at times.** **The difficult experiences no longer relate to their practice but situations relating to their management and supporting their team. This is linked to their current job satisfaction, the identify being less resilient when they 'feel that they have let others down'.**
P9 (57:18) I think ITU nurses start, obviously I've been in ITU for two years, but we like to be on control, and sometimes when you are not in control of the situation then that vulnerability just creeps in there doesn't it, because in our environment, if you've lost your cool, and with every kind of deteriorating patient, you have to be in control, you have to be collected, this is why the course is helping me because like I say you are getting the theory, whereas if you just flapped at everything, I think you would just, ITU wouldn't be for you it would just be a struggle for you, because thats a lot to take on, on the whole, I think we do	**CCN's like to be in control, and when you're not in control you are vulnerable** **A deteriorating patient situation requires control and calmness, education and increasing knowledge can support the nurse in providing that**
P7 (58:36) I think identity is difficult, though isn't it? Because an ITU part of what we are but it's not all that we are! For as much as we all enjoy our jobs	**The CCN identity is not all that they are, its just part of you, you have your professional identity**

and we all live working on critical care there's, it's just part of us and I think it's difficult, because you very much put your work hat on when you're at work even if you have got stuff going on at home, that gets shoved to one side. Pause, sometimes when I have got stuff going on that's personal that's been really helpful because it's been a way of sort of not thinking about that, thinking about this patient that's in front of me and just focusing on that for fourteen hours. But I think identity is difficult, difficult thing to think about, isn't it?	**when you are at work, and your personal identity gets left behind.** **At work, personal identity is put aside for the shift, you forget about it, focus on the experience at that time**
P9 (59:22) I think because we all wear a uniform, we are	**The uniform is our identity**
P7 (59:27) it's like dressing up isn't it?	**Become another person, 'dress up'**
P9 (59:27) obviously you get your professional identity don't you, your academic identity but until, like people say I'm just a band 5, I'm just a band 6, just a healthcare, until you are there with some ventilated sedated patients, when the family start to ask you about yourself, and then I think actually, I will say ooh, what's your favourite this or what your favourite that, how long have you worked here? And then you will start reflecting upon your own identity, I don't know that's just my experience, to be honest	**The close relationship with families expose our personal identity, they get to know the other identity, the personal one**
P8 (1:00:03) I don't think I can add anything to that really, that kind of all makes sense	**Nurses agree**
P9 (1:00:09) I think as well because we know each other's identities, don't we? and you know in terms of self-identity if you ask, well I don't know, if you asked me to sum myself up in three words I probably could, erm, but we know each other's characteristics and that's part of being a good team isn't it and you know, and be able to, I think I would like to say they would be able to pick up if I wasn't behaving right and I know definitely I would be able to pick up, well we would wouldn't we because we said to each other "are you ok today there something not quite right about you?", erm so it's knowing yourself, being self-aware isnt it. I think sometimes we feel like we have to have this big facade as critical care nurses we can deal with any situation, erm we are not allowed to show emotions. Pause, when you wave at me, saying what type of shift (laugh from P7 & P8)	**There is an appreciation of one another's identity,** **Personal characteristics could be identified and summed up and this is valuable so that we know everyone is coping** **Need to be self-aware, CCN do not have a façade to be able to deal with all situations, emotions may not be externally visible, but the team assurance demonstrate an understanding of the type of shift you are having**

P9 (1:01:29) it seems like we have said a lot of negative things, but there's a lot of positive, that's why we are staying	**Comment that negative concepts have been voiced, but recognition that nurses remain in CC because there are positive experiences**
P8 (1:01:33) it's about how we feel, I don't know, particularly	**Stay because of how they feel internally**
P9 (1:01:36) I feel like that when we talk about the NHS it's always negative, negative	**Reluctance that commentary about the NHS is generally negative**
P9 (1:01:38) always negative, negative, negative but when you've had a day when you've actually like I know it's so cheesy to say but you generally have saved someone's life, because you've been at one point, you've been doing everything under the sun, you're doing, even I dont know you've filtered, invigilao, like absolutely everything, every inotrope and you come away and think oh my god I've really helped save that person, or the doctor says "well done for today". You would be driving home and you're like 'yep' I would say that classes as nice	**The intrinsic reward of working in CC and making a difference to someone's life can't be understated. To leave work and have that feeling or to receive feedback on a job well done is positive**
P9 (1:02:08) I know it's dead cheesy	**Is it too simplistic to realise that you have achieved everything that you could have possibly achieved?**
P8 (1:02:10) I generally tell my family because I am from a foreign background and I can, say you don't know what you've got, the NHS, this is fantastic, come to other countries and you will see what the hell you have got here. I always say that to families and I genuinely mean it. I don't say it because they don't pay me for it, but I feel it and I, I think it's a brilliant, brilliant organisation and with all this faults in all its campaign whatever it is	**There is an underestimation of the value of the NHS, those that have experienced life without it value it more. This is not related to finances and that's its free but its brilliance**
P9 (1:02:39) it's easy to moan isn't it	**The realisation that it is so much easier to moan**
P9 (1:02:41) we moan about trivial stuff, then that's life isn't it? But when it really matters, you know	**Nurses can moan about trivial matters, but when it matters, there is a general understanding of the value of each other**
P9, P8,P7 (1:02:48) yes	**Nursing offers intrinsic reward, general agreement**
P7 (1:02:49) I think as much as we do, nurses do love a good moan, let's be honest	**Characteristically nurse love to moan**
P7 (1:02:55) But like, I think the reason that we are resilient, which we are, which we must be to actually keep coming to work every day, is because I actually we are proud about what we do and we believe in	**Nurses are resilient, and proud of what they achieve, believe in what they do and want to**

what we do, and yes there are things we might want to do better and we might want to work on and we might want to improve on but actually by enlarge we feel like we do a good job	**strive to do things better, which is why they stay in CC.**
P9 (1:03:20) it breaks your heart, I think we had a patient come back in, we had a lady who was post-partum haemorrhage, the one I was speaking to you about before, she was so sick, really really sick when she came in to the point where it was touch and go that she was going to survive, she walked up to the unit, she bought her little son in and her child had bought me a card full of pom-poms and in it it said 'thank you for saving my mommy's life'. How could you just not, it just completely made my day, honestly, to feel like you have made that much of an impact that they have travelled in from another county to come and see your unit to see where you helped them that could have been a completely different situation for that family, so I know we do moan but it's amazing and I am proud	**They realise they do a good job and strive to improve** **The positive reward of seeing an acutely ill patient return with their family cannot be expressed, its overwhelming, it's a motivating factor**
P8 (1:04:02) it's natural, it's amazing because we use a lot of emotion unlike the medical team, physiotherapy, no other emotion involved as well as like the professional, erm I think the only thing is it's a natural phenomenon	**What the CC nurse achieves is amazing and they are proud of their role**
P8 (1:04:19) it's almost like a fish bowl theory isn't it	**Nursing is so emotive in comparison to other members of the MDT, it's a natural phenomenon**
P10 (1:04:22) I think you usually feel better after moaning	**The group found the focus group experience a cathartic experience**
P7 (1:04:26) I think that helps, getting it out with people that know what you're talking about and understand	**positive effect of debriefing, realisation of the benefit of talking about the experiences with others that have the same experiences**
P8 (1:04:30) yes, that's it	**agreeing with the positive aspects of this type of communication (debrief)**
P7 (1:04:31) people that you can speak freely with, because obviously you can't go home and vent because it's not appropriate but then, catching P2 (name given) on the unit and you can go 'oh my god that, just tell you' , and then you just feel better and then you feel actually I can pick myself up and dust myself off and crack on again now	**a similar relationship takes place in the clinical environment – the sharing of experiences with co-workers, the positive benefit of sharing before exposing the self again to these experiences**

Appendix 7: Feasibility Study Analysis Clustering of Data

Critical Care Nurses (CCN's) Thriving and Striving through Workplace Adversity

Colaizzi's Strategy Step 4: Clustering of Themes (Focus group 1: Focus group 2)

Formulated Meaning	Theme Cluster	Emergent Theme
• Organisation pressures affect the amount of teaching which makes life difficult • Increased demands have put pressures on these experienced staff and continue to do so • **The pressure for perfection within the timescale is an institutional challenge**	Organisation pressures	Awareness of wider organisation affects
• Organisation hasn't supported this nurturing / support • Organisations have changed, they don't value the nurturing and support as they did	Lack of organisation support	
• **The challenges for the nurses are cultural, managerial and institutional, these affect the way of working.** • **The institutional challenge for the nurses is caring for more acute patients with less nurses and resources**	Organisational challenges	
• **The global evidence of adversity relates to the public opinion of the 'failing NHS', the financial debt.** • **Reluctance that commentary about the NHS is generally negative**	Evidence of wider organisation adversity	
• **The local institution informs the nurses of the crisis and its implications to each unit.** • **The organisation structure affects job satisfaction, this improves longevity in the workplace.** • **This nurse came to CC with many years' experience following organisation change they are now rewarded with job satisfaction, the changes inflicted upon them in the previous workplace made them unhappy, they became disappointed.**	Organisational structure and change	

• **These organisational changes are now evident in CC and new starters are leaving.** • **There is an underestimation of the value of the NHS, those that have experienced life without it value it more. This is not related to finances and that's its free but its brilliant**		
• Change in shift patterns has reduces opportunity for teaching as reduced overlap of staff • Previous shift pattern increased the time that more staff were on the unit, this allowed for at least minutes for teaching • Identified reduced teaching time during previous shift patterns • Others agreeing • Identifying the types of simple short teaching sessions that happened during the overlap in the previous shift patterns • The reduction in these prevents this	Influences of shift patterns – reducing teaching time	
• Reduction in protected time to give to students – 'golden time for teaching lost' • There is an understanding that the change to the shift patterns is similar across all CC units, and that they were changed as a cost saving and that there isn't time to support education and teaching	Loss of protected teaching time	
• CCN identified the stress of long shifts as a new starter, and benefits of changing to shorter shifts and that they would have left without this option. The overlap period ensured that there was help to assist with care, however once they were more experienced they returned to the long shifts for personal reasons, to assist with child care. Identifies this as a common pattern for new starters and the flexibility locally can support this • CCN's identify that long shifts are exhausting, and offer little opportunity for comfort breaks or meal breaks and relate this to whether that are functioning at their best.	Shift pattern – stress of long days	
• Supporting the commentary that dependency tools are not adhered to when related to the workforce numbers • Others agreed to this • Supporting the commentary that dependency tools are not adhered to when related to the workforce numbers • Others agreed to this • The negative affect of not adhering to dependency tools means that the supernumerary staff are	Dependency Tools- not adhered to	

included within the numbers and this affects the supervision of new starters and new registrants. • The negative affect of not adhering to dependency tools means that the supernumerary staff are included within the numbers and this affects the supervision of new starters and new registrants. • The responsibility is then on the other more experienced staff to identify any needs, which causes stress as they are caring for the acute patients. This is in addition to having additional roles such as student nurses, this adds to the pressure being experienced. • A nurse identifies one experience with an agency nurse that affected how they are now recruited, she had no prior experience and couldn't cope, nurses were having to undertake all her work as she didn't understand the CC basics. They were having to do their own and her job • The nurses found this unacceptable (that agency staff had no CC experience) • The agency nurse wouldn't want to come back again, they didn't have a positive experience • A nurse identifies one experience with an agency nurse that affected how they are now recruited, she had no prior experience and couldn't cope, nurses were having to undertake all her work as she didn't understand the CC basics. They were having to do their own and her job • Nurses raised safety concerns of having agency staff with no CC experience, they feared making errors, so now they are required to have CC experience, or the shifts are covered by the team • Nurses from other units agree that this happens within their units • Ex- CC nurses also form part of the agency group, but it is recognised that it remains scary, with different protocols and documentation. They need to be treated like one of the team, recognising to include them during comfort breaks etc. • The regular requirement for agency staff mean that they are one of the family, they are experienced and have been with the team for a number of years	Effect of non-adherence to dependency tools Loss of supernumerary lead Additional workload Agency Staff – recruitment Agency staff – lack of experience Agency staff – safety Agency staff as part of the team	

• CCN's acknowledge that the admission criteria for patients is dynamic and some admissions relate to the lack of education and supervision on the wards, or the lack of an appropriate intermediate area of care. This inconsistency can lead to an increased dependency of patients on the CC unit and causes pressure to the CC workforce. • Awareness of the changes to admissions criteria over the last decade • Admissions depend on the gate keeper, which differs from week to week • CCN describe a time when admissions criteria were stricter and consultant decision making was firmer. They clarify that patients should receive appropriate care but is CC the 'right place'? • Reduction in decision making by gate keepers • Relate these decisions on admissions to the lack of knowledge on aspects of nursing management such as epidural training • Agreeing with statements • Reasons for admissions, inability of ward nurses to care for some pain management systems • This CC admits all patients with this particular management as policy, as there is no specific training for this for ward staff • Surprise by CCN's who are not used to this admission policy CCN's advice on what is required to enable the wards to have these types of patients to reduce CC admissions • CC admission definition relate to level 2 and level 3 care, so these addition care management processes are undertaken to ensure the patient fulfils the admission criteria • By adhering to the levels of care ensures funding for the admission so management is being commenced to ensure funding for these patients • CCN agree that this practice happens • CCN clarifying why this happens, to ensure financial payment for patient admission	CC Admissions criteria Admissions Gatekeeper Change in type of admissions Effects of type of admissions on funding	
• CCN suggest that they see some staff as are comfortable • CCN's like the 'buzz' that you get from this type of care	Reasons why CCN's stay in CC? The 'buzz'	The Reasons Why Critical Care Nurse Stay in Critical Care

• Realisation that when you choose CC as a work environment that you will be caring for the acutest patients in a holistic way that will also develop your knowledge and understanding which is different to the ward environment. • Understanding that the outcome is not always a positive one • Share that this experience causes attachment to patients, especially the long-term patients, this is positive for both parties. Positive seeing them improve little by little • There is always variety in the workplace whether you are at the beginning or end of someone's journey • **Nursing is so emotive in comparison to other members of the MDT, it's a natural phenomenon**	Types of patients they care for	
• They like feeling that they can do their job properly, • A positive reason to stay is the assurance that you can deliver quality care • The numbers of patients in wards prevent this, you have to prioritise, with all patients receiving some care but not all care • Lack of appreciation where you could provide this quality of care? • Nurses describe their role, caring holistically, within a fantastic team, commenting on where would you find this elsewhere? Recognising that in the career pathway the move would be towards a specialist role, but adding that they didn't think they would make this move • One patient has complete care • **Is it too simplistic to realise that you have achieved everything that you could have possibly achieved?**	Provision of quality care	
• Many agree that as you become more experienced in CC you become a more autonomous practitioner, valued and respected within the MDT	Increased Autonomy	
• **CC empowers nurses.** • **The hierarchy is less obvious and there is a common use of first names. The MDT are approachable and visible** • **Agreement that this empowers nurses**	Empowerment	
• Personal feeling of reward, intrinsic reward sensation of working within that environment • would it be worth it when they are proud of what they do, the impact of helping someone to survive	Intrinsic reward	

and seeing them return to the unit to give thanks, is a powerful factor to support nurses staying in CC • Nurses talk about 'loving their job' • Agreeing with this 'love of the job' • Personal satisfaction of working within CC, knowing we are doing the best we can • Agreeing with this • **The nurses 'love of the job' and 'being a nurse' ensures that you remain in CC but one negative experience after another does make you question is it 'worth it', you consider the barriers, the financial reward and burnout, you consider a job elsewhere with less responsibility, but you remain** • Highlighting it as a rewarding job • **Stay because of how they feel internally** • **The intrinsic reward of working in CC and making a difference to someone's life can't be understated. To leave work and have that feeling or to receive feedback on a job well done is positive** • **Nursing offers intrinsic reward, general agreement** • **They realise they do a good job and strive to improve** • **What the CC nurse achieves is amazing and they are proud of their role** • **They reflect on personal insight not burnout** • **Comment that negative concepts have been voiced, but recognition that nurses remain in CC because there are positive experiences** •	Pride Personal insight	
• The nurses agree that it's a powerful memory having patients return to the unit following such an experience • Sharing experience of patients returning to give thanks • Such an intrinsic and extrinsic motivation seeing families continue with their life after such an experience • **The positive reward of seeing an acutely ill patient return with their family cannot be expressed, it's overwhelming, it's a motivating factor** • Bond between the CCN and the patient especially the long-term patients, this continues after they have left the environment • **Sense of achievement is experiencing patients return to the unit after their discharge, this confirms positively their decision to stay.** • **Nurses are close to the families**	Positive reward, patients returning Extrinsic reward	

• **A sense of achievement is felt when patients visit the unit, this is such a positive experience for the nurse, there is no greater satisfaction than that**		
• CCN's stay due to extrinsic factors such as flexibility in working hours which wouldn't be accommodated in the ward due to the reduced number in the workforce • Examples of a very specific shift pattern that is accommodated was given as an example • A contrasting opinion is offered by those working in a smaller unit, where the working hours are inflexible	Positive shift patterns	
• Half of the CC staff are seasoned practitioners without degrees, preventing them leaving as it is thought that a degree is required for promotion and jobs in other environments	Lack of qualification to work elsewhere	
• Contrasting opinion of CCN's aren't shortlisted for posts due to being too qualified for roles elsewhere, the concern that they won't stay – finding it difficult to move on • Difficulties in finding employment elsewhere, seen as too specialised, niche area	Too qualified to work elsewhere	
• Some have never worked in a ward area since registration • Seasoned staff came to CC when registered and remained throughout their career- staying as their personal lives develop have families, feeling comfortable. • View that seasoned nurses with increased length of service supposedly find it difficult to find posts in secondary care due to lack of ward experience • Recognition that it would be difficult to work in an environment that you have never been exposed to since registration	Lack of experience elsewhere	
• Lack of awareness of where you could move to • Lack of appreciation of where to go when you like to work within acute care environments	Lack of awareness of job opportunity	
• Nurses fear change • Fear working elsewhere • Some fear the change to go and work elsewhere • This would be a fearful change	Fear of change Fear of Working elsewhere	

• CCN's work in a protected environment in comparison to the ward nurses and would therefore not return to that work area	Protected Environment	
• Some staff do not want to mentor students, happy to 'do what they do' and no one questions or challenges this • Seen as having no ambition	Lack of personal drive	
• Realisation that they will never know everything – there is always something to learn • New learning all the time – this is positive element of the job • Realise that they won't know everything, and this is OK, always something to learn • Always something new after 20/30 years	Continued Learning	
• CCN nursing is a privileged role • Agreeing that this is a privileged role	Privileged role	
• **For this nurse longevity can be referenced to part time and full time working hours, although long days means that you are at work long hours, they do ensure that you have time to recover before the next shift or allow for additional bank shift working.** • **There is consideration that part-time staff can stay longer, because they have longer to recover.** • **Personality is identified as a factor relating to longevity in practice, can you 'take it'.** • **Support and feedback are essential to feel like you are progressing and want to stay.** • **Smaller CC units refer to seasoned nurses with longevity in practice (approx. fifteen years) in comparison to the tertiary centres where the skill mix can be dilute.**	Longevity in practice	
• **Nurse recognise the value of having a team of Speciality nurses who understand their pressures, the ACCP's from a nursing background empathise with the nurses**	Support from specialist roles	
• New starters need appropriate training, with supernumerary time	New starters to CC	New Starters in Critical Care
• Consideration needs to be given to the number of mentees that experienced staff mentor	Mentoring	
• Reflection on prior experiences of new starters • Recent experience • Influx of new starters	Learning from past experience	

• Not had new starters for a long time • Newly registrants who then left • Agreed about this lack of support • Reflected feedback of those recent new starters informed behaviour for new starters, increased the support • Reasons for attrition, due to being unsupported and lack of supernumerary status • The lack of support wasn't intentional, it was affected by the staffing levels, supporting the wards and experiences staff mentoring student nurses • Feedback was not given in a constructive manner • Examples of the participants feel this should have been given • Feedback could have been more constructive and provided in a learning manner	Influx of staff	
• There are expectations that there has to be some self-directed learning outside of the clinical workplace • Factors that affect self-directed learning • Influencing factors for self-directed study • Direction is required for this guided study to ensure the relevance of this additional work	Personal responsibility	
• CCN's reviewing inconsistency between the supernumerary periods across units • Length of time at a DGH where they had recently had significant numbers of new starters leave – four weeks • In comparison another DGH – commenting that the period is too short • Also admitting that this is flexible depending on the availability of staff and the capability of the new starter • Identified as too short by other participants • In comparison to this unit who have an induction or supernumerary period of 6-9 weeks (three times as ling) and still assess whether this is appropriate for the individual • Recognition that it should be longer • This participant couldn't identify what the protocol was in their unit, but highlighted that the responsibility of medication administration was withdrawn until they have been reassessed • CCN's feedback on competence following supernumerary status was not heeded, staffing numbers were the influencing factor	Supernumerary time	

• The potential response if new starters are not assessed on an individual basis – they do not cope • The responsibility is with the nurse in charge to support those new additions in the numbers, but the limitations of this is recognised, affected by dependency, acuteness, they cannot be supervised all the time • CCN identified preventing the nurses undertaking IV medication was deskilling new starters, lack of understanding that these were newly registrants that didn't have the skill • Supporting this concept, to enable new starters to concentrate on other aspects during their supernumerary period • **Nurses encourage them to stay, supporting and giving fed forward on what they can do.** • **The unit is recognised as having an education team, work related competency documents, and supervision periods to support new starters.** • Expectations of those that have been registered for six months	Deskilling nurses Induction	
• Nurses that have their temporary contracts fulfilled to permanent aren't always ready, they appear too confident and appear to know what they are doing • Raising issues on temporary contracts • Management do not seek feedback from existing staff on those on temporary contracts before supporting the post into a permanent position – based on interview technique alone • Suggestions for feedback to be included in interview process • In contrast to this unit where staff opinion on feedback is valued • The effect of feedback not being valued – this reduces morale as they recognise they will be working with the member of staff • The interview is not by a local manager, so the feedback isn't valued • Organisation based interviews not specific to CC, participant had also been exposed to organisation wide interview however on this occasion clinically related questions were asked depending on where they had identified that their preference for work was. But the current method of organisation wide	Recruitment to CC Temporary Contracts Organisation Interviewing	Critical Care Recruitment

interviews is based on Trust values and not clinically related. • There is no local recruitment at unit level • No local recruitment • Until now after the previous group that have mainly left • When organisational interviewing undertaken, attrition increases, community based practitioners with no hospital based experience were allocated to critical care, they had a lack of knowledge and understanding • CCN was allocated to CC • But is this right? Can everyone cope with this? • A CCN who was allocated to CC indicated that they struggled at first • Others highlight that she had also admitted to reducing hours to cope with the placement to CC, and that couldn't be offered in their unit • P1 admitted that if they had not agreed to her request of short shifts she would have left CC • Personality has some effect on this		
• Personal attributes were not considered at interview • Value of assessing the individual during recruitment, experience valuable • Coping ability was not considered at interview • Participants clarifying was this for all recruits? • This method of interviewing is used for all recruitment • Recruitment criteria • **There is a criterion for recruitment** • Interview technique based on values rather than including feedback on performance	Interview techniques	
• CCN's are involved in the recruitment at this unit • Senior staff used to interview prior to the organisational interviews, this was the experience by this participant • This participant is involved in interviewing and team attributes are valued, and considered in process • Nurse wanted to be interviewed by the team that they were applying for, needed substance to the interview	Interviewer	
• Newly qualified interviewed and recruited and on some units	New registrants	

• Value of recruiting those with experience including as a HCA in critical care • **This organisation accepts newly qualified nurses** • CCN works in a unit where newly qualified nurses aren't recruited, must have a minimum of six months post registration experience which may support the comment of deskilling if unable to administer intravenous medication		
• The point shouldn't be as to whether recruit newly qualified, more that it should focus on experience, has the newly qualified been exposed to CC? During the elective placement for a student nurse, you can identify if they have the skills, previous experience and exposure. Fundamental skills are not always evident, degree level nursing may mean they can write a good assignment, but do they have the appropriate skills? These are not always evident • The placement experience affects a student's nurses' ability • Agreeing with this comment • The placement circuit depends on numbers of students and where you are allocated, this participant listed a number of placements that offered little exposure to a variety of experiences, falls assessment clinics, so you had to rely on the theory aspect of the programme. • This CCN had acute experience during her student nurse training but the majority was non-acute and she remains in CC after four years after a attending a generic interview	Experience	
• Personality affects whether you stay or leave • CC nurse describes feeling proud when recruited to CC • Others agree to this feeling • Pride in being selected, for the interview and then the post. Felt supported with examples of feeling nurtured, exposed to four weeks supernumerary and was 'looked after'. This nurse recognises the changes with the organisation, appreciates starting when they did, and recognises how differently the new starters are looked after now. Highlights that this is not due to the lack of wanting to but the inability to do so.	Positive effect of recruitment	
• Personal effect of recruitment when it wasn't personal choice, this participant wasn't happy with the decision, they cried	Negative effect of recruitment	

• Those that thrive, recognise the learning that takes place in CC, *''it fits in, I've got all the pieces of the jigsaw and its now making sense''.* Education is important • Acknowledgement that they are thriving • Someone who is seen to be thriving is 'enthusiastic', 'wants to teach', sharing their knowledge, part of their personality, • When someone is doing well 'they blossom, and its lovely to see', their development is obvious • Confidence is a factor that helps nurses to thrive, positive reward, feedback all improved confidence and this is considered to not be some evident on the wards • The feedback is from all of the team • Peers and seniors give feedback • Feedback comes from the senior team, sisters and even those that are more experienced • Maintaining confidence during the first year is the key, from then you can thrive, but the difficulty is the first year • Need to be nurtured to thrive and last the first year • Agreeing that this is important • Local units have changed – pressures have prevented the nurturing • Agreeing that the first year is difficult • During the first year you need the following enthusiasm, fear of making clinical errors is high, and there is so much to learn, which can be affected by the lack of support and training • The support that is lacking is with the new starters.	Thriving in CC Definition of thriving Developing confidence Feedback Confidence an ability to thrive Nurturing in CC Low point Floundering in CC	
• If new starters have a lack of awareness of CC they tend to leave • Agree with this point • Some new starters have a limited awareness and believe think CC is an easy option, they tend to leave • Nurses that commence CC need to appreciate the role of the CCN, there is evidence that those that	Why staff leave CC? Lack of insight of role	Reasons for Nursing Attrition

have little understanding of the role and do not speak up for support 'crumble' • Reasons for coming to work within critical are, feel that they would be safer as a ward nurse with this experience		
• New starters attitude – some identify early on that CC is not for them • Some new starters gain ward experience first with the aim to help them adjust, but realise it's so different.	Recognition that role isn't for them	
• Variance between how new starters think they are performing and how the experiences staff feel on their performance, especially those that do not ask for support.	Feedback on performance	
• The lack of speaking up means that they may not be supported. • **But the lack of supernumerary area leads, and the demands of the unit support remains difficult.**	Lack of ability to ask for support	
• **Nurse compares a previous experience of working in CC to this current experience; a very different experience. The prior experience made them apprehensive, 'crying on the way to work', staff were unapproachable, and this affected the care that could be delivered.** • **As a 'proud nurse', she felt that she was 'letting patients down'.** • **CC can be emotive, and have difficult days but in the new unit, 'I love the team', she is comfortable within this team and can voice her opinion about situations.**	Unapproachable staff	
• **Examples were raised where staff leave CC and management do not consider the reasons why.**	Organisation disinterest in causes of attrition	
• **Bullying was cited as a reason by this CCN to leave the other unit.** • **Bullying is cited as a reason for staff leaving,**	'Bullying'	
• **This nurse believes 'if you don't fit', this affects the support you receive.**	'Fitting in'	
• **Nurse indicates that it is not the experienced staff that leave, the turnover relates to the new starters** • **Recognition that there are new starters and seasoned staff but limited middle range staff**	Who leaves?	

• **Mid-range staff are identified as being there approximately eighteen months, but staff aren't reaching this length of time.** • **Staff can be heard saying they are going to leave, they have been there about six months, and can identify that they will continue for up to one year then make a decision to stay or leave. They realise that this will be considered a good experience when applying for other jobs.** • **Nurses felt devalued when they experience had been devalued due to their longevity in practice, their experience was identified as limited because it was less than seven years.** • **Nurses have left CC due to feeling horrified, not capable** • **These nurses had both worked on wards with no previous exposure to CC, one left feeling incapable** • **Previous experiences made this CCN consider leaving the profession, but instead they moved to another CC unit. They now feel like they are progressing personally and professionally.**	Lack of recognition Feeling incapable Leave CC or the profession	
• When there are opportunities to teach and work through competencies, staff are moved to the ward areas • Agreeing that they are moved to other areas • Lack of insight of CCN activities when CC has reduced occupancy • Nurses feel that CC is under review and when there is a lower dependency they are moved to the wards, linked to having nothing to do, others consider this as negative, stigma attached to their role • Other reasons for attrition included being sent to the ward, and working across sites, which increased stress levels during a period of settling in. The selection to send these new starters was influenced by the skill mix • This is a reason for attrition	CCN's being reallocated to ward areas? When? Related to attrition	Ward Reallocation and the Effects on Critical Care Nurse

• Large numbers of staff have left CC in the previous twelve months • Attrition of staff is related to the stress and strain on working in multiple environments and not on CC		
• CCN's believe that they are perceived to be able to work in all environments, that CCN knowledge is wide and that they can work in any situation	CCN's are perceived as being capable to work anywhere Effect of being reallocated to wards	
• CCN complain that confidence is 'knocked' when being sent to emergency and assessment areas, • Acknowledge that A&E nurses refuse to work in CC, in similar position, when dependency low • Others agree • Working on wards increases anxiety • This negative opinion that CCN's are not busy when dependency is low, a preconceived opinion affects CCN morale • Recognise the fear of being sent to wards when experience has been limited to specialist acute environments caring for level 2 & 3 patients	Negative effect of being reallocated	
• Identification that managers both within and external to CC decides that CCN's can work anywhere • CCN opinion that local managers would prefer CCN's to remain in CC to complete competencies and have limited power to avoid this • Acknowledging a lack of adherence by local managers to dependency scoring tools when assistance is required in other work areas	Who authorises this reallocation?	
• CCN describes their role in the ward environment, 'pair of hands' rather than to lead a specific area, supported by a Standard Operating Procedure • Experience different for these CCN's, expected to lead 'bays' and this is undesirable • This CCN highlights how important the SOP is to support the work that they should be providing – ensuring that they can return to CC if required • Encouraging other CCN to voice opinion about this • Encouraging others be firmer on have clarity on what they will do, tasks such as personal care and vital signs monitoring	Expectations of CC nurse role on ward	

• CC nurse perception of expectations that they should perform leadership roles in the ward environment such as ward rounds and medication rounds, and how they feel these are different to the CC roles • CCN do not perform discharges and referrals to social work, they are different to their typical care • New starters to CC didn't expect to have to return to ward areas when dependency is low, they have chosen to leave the wards but due to their recent experience they are more current in practice so are the first to be sent • This affected some of the staff not all of them, some were able to cope • **Organisation does not recognise identity when wards require staffing, CC patients and their continuity is not recognised.**	Effect on new starters to CC Effect on CC on reallocation	
• Resilience helps you cope – yes agreed • **Resilience, in trying to not let the experience get them down** • **Nurses are resilient, and proud of what they achieve, believe in what they do and want to strive to do things better, which is why they stay in CC.** • Agreement that identity relates to the area of work • **Identity is difficult to relate to when organisationally CC relates to staffing numbers and occupancy.** • **Nurses feel like they are a number when there is no consideration for patient allocation.** • **Lack of appreciation for the self.** • **The CCN identity is not all that they are, its just part of you, you have your professional identity when you are at work, and your personal identity gets left behind.** • **At work, personal identity is put aside for the shift, you forget about it, focus on the experience at that time** • **The uniform is our identity** • **Become another person, 'dress up'** • **The close relationship with families expose our personal identity, they get to know the other identity, the personal one** • **Nurses agree**	CC Nurse Characteristics Resilience Identity	Characteristics of a Critical Care Nurse

• **There is an appreciation of one another's identity,** • **Personal characteristics could be identified and summed up and this is valuable so that we know everyone is coping** • **Need to be self-aware, CCN do not have a façade to be able to deal with all situations, emotions may not be externally visible, but the team assurance demonstrate an understanding of the type of shift you are having**		
• CC nurse attributes include caring nature	Caring nature	
• Personal attributes of organisation skills, OCD really, things have to be completed properly • Others agree that they have developed this OCD type nature since commencing in CC • Personal attributes or OCD behaviour • Suits this CC personality because they can plan and deliver care, prompt responses from members of the MDT, care for the patient holistically • CC nurse attributes include conscientiousness, methodical and neat, a list maker, demonstrating that these common personality traits across the group • Personality traits of being methodical • CC has a set way of working which they all like • Agree to this behaviour • Organisational methods, tick box behaviour • CC nurse like structure to their day, even though some work slightly different • But they have many common attributes • Organisational tools include the CC charts • These charts provide the prompts • They contain the information about your patient • These prompts are used to organise the CC nurse when they are busy providing structure, and reminders for care management, this provides personal satisfaction • **Time management is an important characteristic of a CCN** • **These characteristics such as time management need to be exposed to various clinical situations, you need to be able to adapt and prioritise depending to what is happening within the whole CC setting** • **As patients deteriorate nurses need to recognise that they are no longer managing that situation, but they are still learning. Support is needed to help them readjust to the new situation.**	Organisation skills	

• Caring for one acute patient • Personal satisfaction gained from seeing improvement over the long shift, recognition that it's a team approach but you're the consistent factor in that patients care • This behaviour is identified as control • Agreement that it is control • Being in control and acting autonomously • Control of your own space • This CC nurse achieves at work what they can't at home, having the control in the workplace, this is a personal achievement • A level 2 patient can disrupt this method of care, • Conflict with CCN management – patient's wishes versus CCN methodical organisational skills • Causes frustration for the CCN • CCN loses control • Lack of control with these patients • Lack of control • **CCN's like to be in control, and when you're not in control you are vulnerable** • **A deteriorating patient situation requires control and calmness, education and increasing knowledge can support the nurse in providing that** • Attributes of a CC nurse include the ability to monitor and notice the slightest of changes, this is a personal achievement • Nurses work in a methodological manner using structured assessment tools, this is specific to a CC nurse • These are attributes that you can use when working elsewhere, skills that are useful on the wards • **CC provides transferable skills which aren't always internally appreciated until they are exposed in another environment.** • **The nurse provides examples of working in another acute environment when a patient deteriorated and how they used their skills to manage this situation. The performance was externally and internally rewarded internalising that their knowledge and skills had developed, this was personally satisfying.** • **There was a lack of appreciation of how they had developed until an experience exposed them to manage a situation.**	1:1 care Control Technical/ Assessment skills	

• **Capable is identified as being adaptable, ward nurses have more of a routine, in contrast to critical care where you have a plan but a change in acuity of one patient effects that plan.** • **CC nurse characteristics, they need to be able to listen and interpret information**		
• **Factors that influence patient management spiralling out of control include requests from members of the MDT team and they need to be able to prioritise these decisions.** • **Those that are better at clinical decision making seem more capable** • **Clinical decision making is a key factor, identifying key individuals when situations are changing and verifying your plan with others for positive confirmation of the action** • **And those that are reflective**	Managerial skills Decision makers Reflectors	
• Aiming for a gold standard • Agree with this aim	High standards	
• Nurse question the difference in continuity of care for part-time and full-time workers. For the part time workers, they need a set method of working as they lack the continuity that nurse who are their more frequently might have. This ensures organisation of care is complete • Full time staff have more continuity in their care • This doesn't necessarily mean with the same patient, • It could relate to the relatives • Agree to this • Agreeing	Part versus full time	
• The wards are not organised appear chaotic • The lack of organised approach impacts on patient safety • Suggestion that nurses don't learn this structure • The time factor influences the structure on the ward • Attributes of a CCN looking more in depth, looking for problems. Problem solvers rather than just manging what you have been tasked with • Thorough working practices • A ward nurse is a coordinator of care, more detached in comparison to a CCN who understands their patient in detail, including the family. Standards to achieve	CCN versus ward nurse	

• Distinct personalities work within CC • Attributes of a CCN include the sense of humour • The emotive environment affects the sense of humour, shared sense of humour • **Characteristics of a CCN- humour is a little darker** • **Need to understand their limitations** • **Nurses need to be able to take constructive criticism from a variety of professionals, seniors and peers.** • **Those that work in this manner of positive verification of planning and respond positively to constructive feedback appear to do well** • **Feedback can be intimidating** • **CC has a questioning culture, not in a negative manner but as a developmental experience. Those that do not cope with this type of culture do not tend to cope well with CC** • **The nurses that ask for advice, and check their plan of care appear to do better, it prevents care spiralling out of control, they seek advice.** • **CCN offers that they didn't swear before commencing CC** • **The realisation that it is So much easier to moan** • **Nurses can moan about trivial matters, but when it matters, there is a general understanding of the value of each other** • **Characteristically nurse love to moan** • **This nurse highlights the advantage of gaining experience on a ward prior to coming to CC, and encouraging newly registrants to persevere and that 'things do get better'.**	Personality Humour Self -awareness Receivers of feedback Advice seekers Moaners Perseverance	
• Nurses value the team, the family • Nurses agree that CC is like a family • Recognition that working long shifts increases the length of time to meet all the staff • The nurses recognise that you spend more time with this family than you do your actual family, this is the reason for the closeness. • Others agree to this	CC as a team / family	The Critical Care Family

• How they see their CC family, helping each other, just getting on with supporting each other • Familiarity, seeing the same people helps with the adjustment	Value of the family	
• Nurse identifies the notion of CC as a 'clicky' environment for new starters • Others agree with this • The notion of joining that click for new starters, how difficult this can be, with high turnover of staff and agency staff.	'Clicks'	
• This nurse hopes that they are kind and recognises this behaviour, they experienced how difficult it was to be a member of the team and how it can be difficult to fit in Nurses identify that the shift patterns and not seeing the same people makes it difficult to fit in	Fitting in with the family	
• Recognition that the size of the unit and therefore the number of staff has a part to play in 'fitting in'. Continually meeting new staff during their supernumerary time when support and nurturing is valued in comparison to their local unit which is much smaller • This is harder in the larger units	Size of unit and effect on the family	
• CCN nurses raises the point that when working part-time you frequently do not see staff for months	Part time effect on the family	
• It is recognised that attrition has some effect on the family, the family changes • The seasoned practitioners are strong characters within the family, when they leave, the whole family is affected, it's like losing a sibling	Effect of attrition on the family	
• There is a closeness attending each other's special occasions, such as wedding, christenings and funerals, like family members • Nurses kindly regard ex family members even if they didn't know them, sense of feeling when they know they are severely unwell • Nurses share experiences of how they have supported ex- CCN's in times of difficulties, organising fund raising etc	Family behaviour	
• There is the wider family as well, the Consultants who have an open-door policy. They notice if the nurses are upset, they are part of the support mechanism, as are the physiotherapists.	The wider family	

• Agency staff or overseas nurses are part of the team as they are not transient, they stay long periods of time • The family makes the nurses feel safe • Others agree to this comment regarding safety and the family • Compared to how you can rely on your family, in times of difficulty, even when you are unsure of the outcome • Nurses recognise the importance of sharing the emotional experiences of working within CC, not having to go through it alone, the team can be relied upon to support the emotional labour • Recognition that the nurse working in close proximity will support you, be aware of what you are going through • Agreeing with this commentary • This is compared to relationships on the ward, who are not aware of what is happening in the next bay of the ward. Even colleagues, rather than close friends help when they see you struggle, not left alone to cope • Agreeing with the example of the ward behaviour • CC Outreach teams are exposed to this behaviour when they attend the wards, nurses limited knowledge of the environment outside of their limited area, and lack of interest to assist • The family are your emotional support • This is due to the lengthy time spent together through the same experiences • Highly emotional area, sharing of personal tragedy, they become your friends, the team will notice when something is not right. • Recognition that there is a life outside of the work environment, personal life and that each other need support. It is this that prevents you leaving CC, you are comfortable and belong to a family and you are unsure if you will have that elsewhere. Unsure that other places are welcoming • Unsure that other work environments will look after you • This is their safety net, it would be scary to move elsewhere, although nurse work agency elsewhere	Positive effect of the family	
• Nurses indicate that they can identify if they have a good team or a poor skill mix on the shift • Nurse describes the difference one person can make to a team, others agree	Teamwork	

• How experiences on CC can affect you confidence and nurses identify how your team, 'picks you up' and if this doesn't happen then this affects your sense of being on the unit and reason to leave • **This is where the teamwork helps, examples are raised which highlight significant changes to patient's conditions, and how this patient 'spiralling out of control' would increase the stress levels of a new starter. But this couldn't have been predicted.**	Positive effect of the team	
• **CCN is exposed to powerful life experiences, with lifelong memories due to the situations they are exposed to** • **These situations are why CCN's become so close, sharing these emotive experiences, families couldn't understand these experiences.** • **The team can empathise** • **The team understand the situation that you are going through without the nurse having to voice their feelings. There is a common understanding that they are there to support you** • **This team enables the nurse to remain in such an emotive environment, it's a social network** • **The team guide the nurse through the difficult shift. Experiences are reflected on and reflected back upon, especially those events which are tragic, only those experiencing it with you understand**	Experiences and mutual understanding	
• **These events would not be understood by your friends and family, you are isolated from them** • **You keep normal for your family** • **There is a sense of lack of perception and understanding from your family, the family events appear minor in comparison.** • **Families genuinely understand that nurses need time to decompress when they get home** • **The family of a CC nurse develop an awareness of the type of experience you have had that day** • **A nurse can be exposed to frequent death, and they are aware they shouldn't take this home, but families sense their mood.** • **Families question their longevity in the CC area, sensing their mood and suggesting that this may affect their long-term health**	Blood family would not understand Blood family lack of perception	

• Nurses describe the career pathway as leading to specialist or managerial roles rather than transferring to wards, this route is rare. • Lack of opportunities in CC • General agreement of this • This nurse perceives that there used to be more senior positions in comparison to previous years • Nurse disagrees stating that there were always more junior staff nurses • Nurse identifies that they have a career plan, but they are unsure if they can succeed, if these roles will be available • Immediate career plan is to become a sister/ charge nurse but unsure of the longer-term plan. Aware that if they choice to move out of CC they may not achieve the professional band that they have as a sister on the unit. • Long term career pathways listed as being a sister in palliative care, but this was seen in the distant future • **They have a career plan to return to their area of passion but find both areas satisfying** • Cannot visualise a local career pathway • Career progression commences with CC HE modules, but funding and capacity restricts this. The process to be considered includes interviews, 'acting up in a senior position' and additional roles and responsibilities, so to progress requires commitment • General agreement that this is the case • Professional reward is not linked to academic achievement • Still a requirement to wait for a position to become vacant • Recognition that some staff move out of CC to Specialist band 6 posts due to lack of career progression within CC. Funding for education modules that are required for senior positions remains difficult, another reason for nurses to leave CC. However, it is recognised that you are expected to perform this role without having the professional band on occasions due to skill mix and reduction in staffing numbers.	Career pathway Limited opportunities Examples of pathway Lack of clear pathway Early education career plan Professional versus academic Lack of staff movement Waiting game	

• Longevity of staff means there is limited movement in the senior hierarchy, often waiting for someone to retire • Lack of development and opportunity is the cause of experienced staff leaving • New role descriptors allow junior staff to now be classed as more senior but remain in the same professional band. • Increased responsibility but no reward for these new roles • Agreeing, with this commentary • The role descriptor clarifies that you are the support mechanism for the sister • This is identified locally but not rewarded professionally • There are disadvantages for this role, off duty becomes more restrictive and difficult to change • Lack of experience in other specialities reduces the avenues for the career progression	Additional roles with professional recognition Lack of experience	
• Staff realise that not enough education frightens new starters • Recognition that there aren't enough educators in roles on a continual basis • These nurses do not have educators as specific identified roles within the area • This CC has shared educator role, and focus on organisation activities • Educators have multiple roles, not specific to education • **Education should be more than mandatory training such as manual handling** • **Weekly programmes of education are difficult to attend due to time and patient acuity. It is no longer seen as possible to spend an hour or two away from the patients** • **Nurses are reminded of the cost of external education** • **This differs for the medical staff whoso education has protected time** • **The value of medical versus nursing education, medical is protected**	Education in CC Awareness of Lack of CC Educators Role of CC educators Factors which limit CC Clinical Education Medical versus nursing – protected time	Critical Care Education

• **Recognition that education time should be found for the nurse that appears to be struggling** • **Bedside teaching should be available** • **Agreeing with this** • **Agreeing** • **In addition to formal teaching away from the patient, this would include such aspects as blood gases.** • **The advantages of this type of teaching is that it promotes confidence and increases the nurses' ability to cope – more resilient** • **This is currently difficult to deliver, two nurses away from the bedside for an hour is logistically too difficult** • **Expectation that there is a personal requirement for learning, directed study**	Clinical education – bedside teaching	
• **Acknowledgment that certain nurses are on the 'radar' but there is limited time to reassure all staff**	Focused on key individuals on radar	
• **Nurse negatively reflects on how difficult it is to ask for education, staff are unapproachable, and they wouldn't ask for support** • **Nurse identifies a recent negative experience with the education team relating to their approach when they had requested support**	Negative experiences of clinical education	
• Staffing levels, and dependency of patient delivery of education, as staff are moved to the ward when there is a lower patient dependency • Awareness that it takes a long time to get a place on the CC course • CC nurse offers differing opinion that locally they can secure a place on the course within 6 months • This differs to this practice area • The CC course enables nurses to expand their roles, but the places remain limited and often nurses wait two years for a place due to the limited funding. Minimum of two years' experience is required prior to securing a place on the course, showing commitment to the work environment.	Variance in time to secure place on CC modules	
• Contracts have to be signed to say that the nurses won't leave the organisation if they secure a place, otherwise they will have to repay the cost of the course. • Similarly, these nurses agree to remain on the unit for two years post completion of the course. • And these would have to pay back the course cots if they leave the organisation, but they are not contracted to stay on the unit, but they are aware	Organisation requirement to support CC education	

that they wouldn't be able to complete the course as they couldn't achieve the competency documents if they left the unit. • Nurses compare their agreements with organisation for funding the course, relating to where they must work and for how long • Nurses agree to this commitment in principle • Agreement appears sensible • Staff shouldn't just leave if they have been supported to complete the course • Awareness of the funding costs of the course • Nurses highlight difficulties in securing places on other academic course, especially those that relate to mentoring. There is limited support for this due to the professional requirements and local arrangements regarding the amount of mentoring that takes place in clinical practice • Nurses on this unit have a criteria to fulfil before attending the interview for the CC course • Obstacles are highlighted as barriers to secure a place on the course, the new starters have a limited understanding of this plan. They need to understand that they need to complete local education programmes first, then attend an interview, which might take four to five years. • For this practitioner it took seven years to secure a place on the CC model, so you can see why they are professionally ready for development by the time they secure a place. 'wait your turn policy'. • Waiting your turn for a pace as others more experienced have already been waiting • The limited number of funded places is the cause of this • The theory alone does not prepare for career progression • Agreement with this • The reward is that following this you are a better CC nurse • Experience is essential, and the theory helps you understand that experience • Following the education, you still need to keep up to date • CC module bring new expectations for the nurse, these can be immediate like being expected to be in charge • The unit expects immediate reward, in times of need • It's as if they have checked that you are capable, all the hoops that you have jumped through to get on the course	Local contracts to ensure commitment to CC Criteria to secure position on CC education programmes CC Modules Experience still essential Organisation expectations for learners on CC education modules	

• New trust in you • The trust and responsibility are immediate, but maybe too soon for the CC nurse • This is the reason why CC nurse are expected to behave differently as it is seen that this is what they want from the course, which is good for some but that is not everyone's plan • Nurses feel that they are doing all the hard work, and yet there isn't a reward following the development. Experienced staff leave due to this waiting game, which affects morale as they see that that individual would have been a valuable assess yet other units have gained their experience. • This is not a new phenomenon • CC education offers opportunities for career development • **Education and the CC course increases resilience,** • **the more understanding you have the quality of care increases which increases the job satisfaction and intrinsic reward** • **This increases satisfaction in the work environment** • **But acknowledges that being on the course, enables reflection and increases the ability to cope in difficult situations, giving confidence that they can cope** • CC education can also be for intrinsic reward not only for professional advancement • Commences CC education for personal development rather than career progression • This CC nurse with many years' experience is undertaking learning is for personal development • Education is to improve performance • CC nurse identifies why they wanted to undertake the CC course, it wasn't about gaining a more senior role • Others agree • Personal reasons for completing the CC course • Nurses opinion of a band 7 role and realisation that it is not their goal, personal achievement, quality care, knowing they have done a good job is their aim • Other nurses agree with this intrinsic reward • Nurse experience of why individuals get a place on the course, to enable them to expand their roles	Post Education – limited or positive reward Intrinsic reward of education	

• Following the theory experience is required prior to professional development • CC nurse value the benefit of experience, this can be seen in the experienced nurses in various situations, they have lived it and seen it before, teaching can't provide this • Experienced practitioners know the signs to look for, these are the benefits of experience over knowledge • The CC course doesn't teach you how to be a band 6, there is a difference between what the course provides and what a professional role is • Differentiation between the course and professional roles • The role is about coordinating practice and manging beds • The role is about coordinating practice and manging beds • Management versus theory of critical care • The course opens these avenues for you – for the professional development • By the time they have a place they have the experience – they are ready for the professional development and senior role	Experience and education	
• CC nurses are ready for both sides of the coin, professional development and the course because they have waited so long to secure a place on the course. But that doesn't mean they are linked • In contrast, this CC nurse offers a different experience • The course is about personal development, to improve my care, to enable me to inform and teach others, support them better • Suggesting that there is a misinterpretation about the CC course and the relationship to a senior role • CC nurse identifies that there appears to be a difference between some CCN's reasons for completing the CC course and organisations reasons for you completing the course. There is an expectation that undertaking the course means that you want to go for promotion, rather than personal development.	Misunderstanding of why some complete the course	
• Being on the course alone is not enough for you to be promoted • Nurses perception of the sisters' role, which concentrates on managing the rotas	Professional reward post education	

• Senior roles have limited contact with the patients and limited time to support practitioners because they are having to 'cover shifts' • CC nurse raises awareness of the significance of mentoring and the difficulty to secure educational support in the form of funding • These CC nurses have to complete the mentorship module as a pre-requisite for the CC course • Unlike this nurse who still need to complete any mentorship training • The educational plan for the nurses is not always adhered to • Inconsistent criteria to secure places on the CC course, with this nurse highlighting that the competencies need to be completed prior to commencing the module • **Education is identified as a barrier to remining in CC.** • **Referring to those that offer little advancement to a patient care** • **Nurses are different in their approach, with some maintaining care and others progressing care, this nurse cant understand why those who have no interest in progressing care remain in CC.** • **As knowledge develops and with increased exposure, stressors are reduced but some nurses find this initial impact too difficult to cope with and leave CC.**	Lack of support for other education relating to mentoring Role of education in advancing patient management	
• **Working with an adverse climate is stressful, and the adverse situations are created** • **Adversity has a direct influence on the quality of care that CCN's provide** • **Nurses relate the ability to remain in CC with the ability to face challenges every day, when you may not be supported.** • **Reference to facing the 'good with the bad' and whether the nurses finds this acceptable.** • **Challenges for the CCN include the pockets of clicks** • **CC has lots of small 'clickys', people gathering together, this nurse suggests they 'keep their head down' and stay out of the clicks.** • **Staff encourage others to 'fit in' this includes engaging with social activities**	Challenges in CC Clicks in CC	Challenges for the Critical Care Nurse

• **Suggesting that if you don't fit in with the 'click' and you are not 'strong enough, they will destroy you', suggesting you need to be resilient if you don't join the 'click'.** • **This staff member was new to CC** • **When asked to clarify, this CC nurse feels that it might not be bullying, but you need to be resilient as 'life isn't easy in CC' and some nurses can't take it and leave.**		
• **Situations which require the nurse to immediately move on to caring for the next patient after performing end of life care management, having no time to debrief, or reflect demonstrates the lack of support from our management.** • **The nature of CC presents emotional and acute challenges, but there is an expectation that you can immediately move on from one challenge to another and forget about what has just happened.** • **The pressure of patient numbers, consistent flow of patients** • **The patient numbers add to the pressure and stress levels** • **The flow of elective patients effects the care given. This nurse identifies the pressure of time on discharging patients in preparation for the next, whilst ensuring that you prepare the patient for the ward and reduce the workload for the ward nurses. In attempt to reduce other nurses' workload you become stressed, the pace of work is so quick.**	Intensity of patient flow	
• **This team leader feels that individual recognition for the care given is 'non-existent'**	Lack of recognition	
• **This nurse differentiates between those nurses that monitor and record and there are those that actively progress the patient in their management of care; some offer little contribution to patient progression. These nurses do their job and go home, offer little contribution to other things.**	Nurses that contribute little to patient progression	
• **The sudden concept of autonomy when newly qualified can affect a nurse when coming to CC. As a student nurse they were confident, but even when supported some nurses find it difficult to cope.**	New autonomous role	

• **Working within a large tertiary centre was highlighted as very different for this nurse than a smaller unit, commencing in a smaller unit with less support they could still recognise how these newly qualified nurses were feeling.**	Lack of support, Tertiary centre versus smaller unit	
• **Nurses recognise the difficulties in trying to support more junior staff, with minimal experience, recognising their fears but battling with the ability to provide support for them** • **Highlighting that caring for their own patient means that they sometimes watch someone struggle because of the acuity of their own patient.** • **The difficulties in patient allocation are highlighted, allocating new starters in sider rooms affects the support you can give.** • **These nurses detail the organisation pressures that they are challenged with, the most challenging being bed pressures** • **There is recognition that they want to support each other but on occasion situations mean they know they can't.** • **A brief encounter checking that the new starter 'is alright' is very different to the experience that this nurse experienced when they were new to CC** • **They are faced with the challenges of staff shortages, which reduces the support and guidance for new starters, being the most experienced they have the most acute patient. They acknowledge that this behaviour isn't right, staff need support.**	Supporting junior staff	
• **Nurse allocation depends nurse attributes** • **Consistently caring for the acute patients can lead to burnout, as experienced nurses we are not exposed to the longer-term patients, which can be 'refreshing'.** • **An experienced nurse can positively affect a rehabilitation patient care management** • **Nurses describe predictable behaviour relating to patient allocation, which can lead to relentless exposure to the acutest of patients** • **The current skill mix means that there is a relentless allocation to the acutest patient** • **Nurse identifies that CC is not their passion, but the experience and education is developing them as a nurse, and senses that this is belonging.**	Nurse allocation Consistent exposure to acute patients – no respite	
• **This nurse feels unsure, some shifts increasing the vulnerability.**	Vulnerability in a senior role	

• **Others agree, feeling resilient in some situations, but now reflecting of their position in amore senior role they question their practice at times.** • **The difficult experiences no longer relate to their practice but situations relating to their management and supporting their team. This is linked to their current job satisfaction, the identify being less resilient when they 'feel that they have let others down'.**		
• **Belonging is defined as understanding that CC is challenging, and they are anxious to achieve that and succeed.** • **Sense of achievement is fulfilled if you can spend time with a new starter and review their competency documents, 'that's a victory'** • **Nurse describes a sense of belonging in CC, recognising that there are negative aspects to working there, but they wouldn't work in any other environment** • **The sense of closeness and support from the teams makes the nurse feel that they belong** • **Belonging is a reason to remain in CC** • **Agreeing with commentary** • It is important to feel like you belong, like being in a family • Others agree that you ned to feel like you belong • Participants clarify that other CCN in other units feel the same about belonging and it feeling like your family • Others agree • **Nurses can belong to their direct team without belonging to the organisation.** • **This nurse clarifies that they belong to the team but not the higher structure, the management** • **Definitely not the management** • **Recognition that as a nurse they commenced working within CC for the wrong reasons, they didn't feel like they belonged there.** • **But following exposure and experience the personal satisfaction of caring for these acute patients, they realise that CC is where they belong, they are happier. They acknowledge that this belonging took one or two years.**	Sense of belonging Definition of belonging Belonging and the family Not necessarily belong to the wider organisation No sense of belonging	Sense of Belonging

	Decision makers in CC	Decision Makers in Critical Care
• **CCN are not the decision makers, the medical team are** • **This nurse questions this response, suggesting that CCN are the patients advocate** • **Nurses opinion that nurses are not active in the decision making** • **Clarification of the point suggests that CCN are more active in the decision-making process with the Intensivist team but not the patient's speciality team** • **In support of the decision making of the nurse, this comment suggests that the speciality team do not make the grand plan, they are there for a short period. It is the CC team that include the nurses in the decision making, giving opportunity to raise concerns. Although admittedly this is an individual approach, with some more effective than others.** • **The lack of a standard approach of including the CCN is highlighted as a concern, decisions are dependent on the consultant at the time.** • **Agreeing that it is dependent on each personality** • **Nurses raises the point of human factors and the importance of being approachable to ensure that a nurse will address them with a problem or support.** • **Decision making remains dependant on Consultant opinion, it remains their overall decision and this is sometimes different to the CCN opinion** • **Everyone is entitled to an equal opinion, there should be a place for this, but there is no standardisation in who listens to the nurse** • **This elective surgery CCN offers a comparison suggesting that elective surgery is nurse led, the nurse is more autonomous in their decision making** • **Others agree with this point on increased standardisation in elective surgical CC areas** • **The nurse describes situation when this isn't the case, when the elective surgery becomes complicated then the medical team do not want to make a decision because of the lack of standardisation between the consultant team.**	Who are the decision makers? Advocacy Not active decision makers When are CCN's Active decision makers? Who affects the role of the decision maker? Elective CC versus emergency CC and decision making	

• **This is not seen as a common issue**		
• **In contrast, the junior medical team request advice and support from experienced CCN's, they have a more powerful relationship with them** • **Due to their lack of knowledge** • **The junior medical team are reliant on the CCN's support** • **CCN's are asked for advice from the junior medical team** • **CCN offer advice and support to the junior medical team** • **This is a position of power?** • **CCN's are also in a position of power over their patients and families who are vulnerable.** • **Families are in a vulnerable position and this powered needs to be used carefully**	Power relationships When does the CCN have power? Medical Power relationships with the family	Power Relationship
• **Exposure to other environment would enable CCN's to appreciate their development.** • **Suggestion were made for new starters to rotate to the ward environment in their first couple of years post registration, this would bring positive reward to both the clinical wards and the nurses when they receive feedback on their development.** • **CC senior team are more visual in comparison to the wards.** • **On the wards you work more independently, in CC they suggest there are supportive mechanisms in place as senior members are more available.** • **Ward needs to make unsupported decisions.** • **This nurse identifies that in contrast they feel that ward nurse has developed their decision-making skills. Mentors need to develop the skill of questioning rather than advising and nurses need to be less responsive to taking instruction and being lead** • **Examples are shared relating to the lack of decision making and behaviour that requires**	Ward environment versus CC Appreciation of environment Suggestions for rotation Visibility of senior staff Independent workers	Environments – the ward versus Critical Care

instruction rather than active decision making. There is a reliance on the senior team. **The group found the focus group experience a cathartic experience** **Positive effect of debriefing**		

Appendix 8: Phase 1 Interview Guide

Critical Care Nurses Thriving or Striving through Workplace Adversity
Interview Schedule for Initial Interviews

Initial interview

In line with the descriptive phenomenology approach the interviews will take multiple stages with the Initial Interview aiming to provide rich qualitative data from the Critical Care nurse's personal story.

Review Participant Information Sheet

Check Consent form signed

The question will commence with:

- Tell me about your Critical Care Journey so far, (your experience of employment, , length of service, professional history, professional development,

Probing questions may include:

- When did this happen?
- To what extend did this ….?
- What were your main concerns relating to this?

Additional questions:

- What is important to you in your work?
- Has critical care been a positive experience for you? Why?
- How has that affected your decision to remain in CC? Have you considered leaving?
- What has been rewarding?
- What tests you at work?
- Why have you stayed in critical care?
- (Why do you think other nurses leave?)
- What allows you to do your best/ what prevents you from doing your best?

Would you be willing to participate in a further interview if required?

Thank you

Appendix 9: Recruitment Poster

Have Your Say…

Critical Care Nurses Thriving or Striving through Workplace Adversity




The purpose of this study is to investigate Critical Care Nurses decision to remain in Critical Care. Registered nurses working within Critical Care are being asked to participate in this study.

Please email Nicky Witton for further information or if you wish to participate in an interview.

Nicky Witton, Chief Investigator, Lecturer, Critical Care Pathway Lead, School of Nursing & Midwifery, Keele University (n.witton@keele.ac.uk)

Iras Project Number 263561/ 01/12/18/ V1

Appendix 10: Participant Information Letter & Consent Form

Information Sheet

Study Title: Critical Care Nurses Thriving or Striving through Workplace Adversity

Aims of the Research
The purpose of the study is to explore and understand nurses' decision to remain in nursing, in Critical Care specifically.

Invitation
You are being invited to consider taking part in the research study: *Critical Care Nurses Thriving or Striving through Workplace Adversity.* This study is being undertaken by Nicky Witton, (MA, Education, RN).

Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read this information carefully and discuss it with friends and relatives if you wish. Ask me if there is anything that is unclear or if you would like more information.

Why have I been invited?
You have been invited to take part because you are a Registered Nurse working within Critical Care (CC). The initial interviews will explore the views of 8 CC nurses, one from each professional band 5-8 across two hospital sites. Depending on the initial data further interviews will take place.

Do I have to take part?
You are free to decide whether you wish to take part or not. I will go through this information sheet with you, describe the study in detail and answer questions you may have. If you do decide to take part you will be asked to sign two consent forms, one is for you to keep and the other is for my records. You are free to withdraw from this study at any time, without giving a reason. All information and data collected up to the point of withdrawal will be destroyed and not included in the data analysis.

What will happen if I take part?
If you decide to take part, after written consent has been obtained you will be required to attend an interview lasting up to sixty minutes. At the end of the interview you will be asked if you would agree to a second interview if required. The interviews will take place in your local hospital in a private room. This will be audio-recorded and transcribed.

What are the benefits (if any) of taking part?
Participants will have the opportunity to reflect and share their CC experience. Other possible benefits include the knowledge that from the analysis of the data strategies to retain CC nurses may be developed.

What are the risks (if any) of taking part?

The nature of the study does mean that questions are asked about potential complex work related issues associated to working within the Critical Care environment. If responding to these questions causes any emotional distress there are a number of support mechanisms that are available, including your line manager, professional union (Royal College of Nursing at https://www.rcn.org.uk/contact or UNISON at https://www.unison.org.uk/get-help) or members of the research team (details are included below).

How will information about me be used?

All information collected about you will be kept strictly confidential. A unique study number will be used rather than your name and place of work. With your permission the interviews will be audio-recorded, and written memos/ notes might be taken during the course of the interview. The discussion will then be transcribed, and I may use things that you have said as quotations in publications, but your unique code will be used so that you cannot be identified. If you wish to find out more about how your information will be used you may email me, the researcher on [redacted] or my sponsor at researchgovernance@keele.ac.uk to liaise with a Data Protection Officer.

Who will have access to information about me?

Safe electronic storage will be maintained with password protection on all computers and stored on the Keele University server. Hard copies of any files will be kept in a locked cupboard in my office at the Clinical Education Centre, Keele University. Only I will have access to the raw data and passwords. The data will be destroyed after ten years as per Keele's guidance.

Keele University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means we are responsible for looking after your information and using it properly. Keele University will keep identifiable information about you for ten years. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible. You can find out more about how we will use your information by contacting Nicky Witton at [redacted]

Who is funding and organising the research?

There is no funding for this research.

What if there is a problem?

If you have a concern about any aspect of this study, you may wish to speak to the me and I will do my best to answer your questions, you can contact me, *Nicky Witton* on [redacted] Alternatively, you may contact my research supervisor [redacted] on [redacted]

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study, please write to the Research Governance at the following address: -

Research Integrity Team
Directorate of Research, Innovation & Engagement
IC2 Building, Keele University. ST5 5NE

E-mail: research.governance@keele.ac.uk Tel: 01782 733371

In Summary

In this research study I, the researcher will use information from you. I will only use this information that I need for the research study. I will not inform anyone of your name or contact details.
I will keep your data safe and secure and only share with others if they really need it for the study. Your data will have a code number instead. I will follow all privacy rules. At the end of the study I will save some of the data, in case I need to check it. I will make sure no one can work out who you are from the report I write. The information above gives you more details about this

Thank you,

Nicky Witton
Research Lead
[redacted]

CONSENT FORM

Title of Project: Critical Care Nurses Thriving or Striving through Workplace Adversity

Name and contact details of Principal Investigator: Nicky Witton [redacted]

		Please tick box if you agree with the statement
1	I confirm that I have read and understand the information sheet V2 (10.12.19) for the above study and have had the opportunity to ask questions.	☐
2	I understand that my participation is voluntary and that I am free to withdraw to the point of transcription.	☐
3	I agree to take part in this study.	☐
4	I understand that data collected about me during this study will be anonymised before it is submitted for publication.	☐
5	I agree to the interview being audio recorded	☐
6	I agree to allow the dataset collected to be used for future research projects	☐
7	I agree to be contacted about possible participation in future interviews.	☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

CONSENT FORM
(for use of quotes)

Title of Project: Critical Care Nurses Thriving or Striving through Workplace Adversity
Name and contact details of Principal Investigator: Nicky Witton [redacted]

Please tick box if you agree with the statement

1	I agree for any quotes to be used	☐
2	I do not agree for any quotes to be used	☐

Name of participant	Date	Signature

Researcher	Date	Signature

Appendix 11: Interview Transcription (N2)

Interviewer (I)	Confirmation of name, professional role and consent following review of the Participant Information Sheet. Informed that notes will be taken, approx. time for interview and that audio has been turned on. Brief overview of format of interview given.
I	I thought it would be a really useful start for you to tell me about your critical care journey so far,
2:7	I qualified in 1975 and worked in other areas first and then I think in, urm, there was a shortage of critical care nurses at the [xxxx], and so obviously it was put out and I was quite keen, I had done a short placement there as a student and I applied. Unfortunately, the unit then got closed down as they didn't recruit enough staff and people were dispensed elsewhere to work. So, I then went to work somewhere else for about 8 months and then started probably in 1977, on critical care at the [xxxx]. Urm, as a staff nurse, and I really enjoyed it, and I then applied and became a Sister in 1978 and I've stayed in critical care ever since. Gosh, it seems like, urm [pause]
I	Since 1978, that is 41/ 42 years,
2:7	yes, and obviously I've worked all along, obviously I've only had maternity leave, I didn't leave at any point, I just, when I had the children, I had maternity leave, so I've worked in critical care, for 40 years, more. Urm, obviously I got my Sisters post then and I worked, carried on working at the [xxxx] for a long time and then, gosh I don't even know what date I then became the Nurse in Charge. [pause] that was when we were G grades, they were then, probably might have been, it was early 80's. Urm because I then gave up the in-charge role when I had [xxxx], when I went back after maternity leave, and that's when [xxxx] came and took over. Urm, gosh, it all sounds a bit boring because all I've done is critical care really. I didn't do my ITU course, even though I had been a critical care nurse, I didn't do my ITU course till quite late on really because that wasn't so, such a requirement as it is now, so I was quite late on in my critical care career before I did my ITU course. Urm, and obviously that just put everything into place really, stamped things that we had always done. Urm, gosh, [pause]
I	So the units did they change much in that time?
2:7	oh gosh yes, obviously the unit, initially I worked at the [xxxx] and that was just a three bedded critical care unit, urm, I don't even know what date [xxxx] opened, [xxxx] opened a small two bedded unit. Then it was decided the whole hospital organisation was changing, A&E was at the [xxxx], that as then being moved to [xxxx] site, urm and it was decided that the ITU needed to be a bigger unit, so that was extended to 5 bed, so the [xxxx] then stayed because then we still had all the emergency surgery there, but that then became two beds, and then obviously a rotation programme was then developed for staff from the [xxxx] to go to [xxxx], or rotate between the two. But at the time there wouldn't be any patients at the [xxxx] and we would move across. It was then, oh, I can't think of any of the dates, it then became a [xxxx] bedded unit, and, urm just as the NHS and everything else developed in terms of the patient numbers, patient care, the type of surgery that was being done, urm, HDU
I	that was 2000
2:7	yes that was 2000, after the ITU report, urm with Outreach and everything we had the [xxxx] beds then the unit expanded again (sigh) to [xxxx] beds, and then gosh, is it about 12/13 years that we went to, we integrated with, a [xxxx] unit was built, a [xxxx] building and then the units were integrated, probably, I would say about, it must be 13 year ago into a [xxxx] bedded unit although we currently only have [xxxx] beds funded and open. [large sigh]

I And during that time, that's your professional history, your professional development in that time, you started to talk about your ITU course

2:7 Again, I haven't done anything, have I, I am not academic, I have literally only done, I did my ITU course, I did my it's not mentorship, it was the 998 Teaching and Assessing course. And again, I did that probably quite late on. Because again I think educational things became more relevant to what we were doing whereas before you worked in your job, you got promoted, there wasn't the emphasis on those sort of things, so I probably, my generation probably, urm didn't look at those sort of things and obviously I never really intended to, urm, progress and get out of nursing, I didn't want to become a manager or do anything else. I was probably a bit complacent really and a bit lazy.

I So when you say you didn't want to become a manager, as a band 7 are you not classed as a manager?

2:7 oh yes but you've still got your, it's not the same as, you've still got that clinical input, haven't you, you're not completely just going to meetings, arranging things, and everything like that. I did find, obviously I did do that role for a few months, and that was a time I found hard because you weren't so involved in knowing what was going on clinically.

I What role was that, sorry?

2:7 When [xxxx] went, [xxxx] left I did that, [xxxx] job for, whatever her title was at the time, Unit Manager, or Head Nurse whatever. Urm, because I found that your time was consumed with, other things, influenced by other things from outside of the unit, meetings and things like that. So, you didn't always have a handle of what was going on clinically which I didn't enjoy, didn't really like.

I yes,

2:7 So I suppose our band 7 role although we are not clinical, we are still there, so if things go on you are still in the bedspace, helping and doing stuff like that. Urm. So, really, I am being complacent, I didn't really want to do anything else in terms of professional development, courses and everything

I And that's a long professional history isn't it, do you know what I mean? So, you have started to move on to what matters to you and you've just mentioned that it mattered to you staying very clinical, so what does matter to you, when you are at work?

2:7 Oh gosh, these days it's just so different, urm, because a lot of the time now I feel we are just problem solving, bed managing, is a big part of it, sickness, staff management and things like that but obviously you are still the clinical expert, supposedly, on the floor so you do, you are still called upon, asking your opinions about this is going on with the patient and everything, you get called into the bed space to look at things so it is those, so there is still that element that you can have clinical input with the patient, and I think often we we're a step away from it we can go into a bedspace and you can pick up on things that someone else might not have noticed, just little things you might look at a result, blood gas or blood result or obs or something else like that, and why this and that, so it is still those sort of things, it is still being able to talk to the patient and being able to help with the rolls, advising the staff on things, that they might not be aware of. So, I suppose that part of it is still really important, and I think that's why sometimes now that it less and less, because the unit is certainly a lot busier, so you would get to do that probably less. Urm, particularly on a day shift and I think that's why when doing nights you are able to be more clinically involved in what's going on, you do get involved a bit more when the patients are admitted and about those sorts of things, than you do on the day because the on the day a lot of it is, having, you know, having a hundred and

102		one permutations of what beds, what are you are doing with your beds and your
103		staff and planning for the next shift and everything. So, I think, that's got less on the
104		day shift clinical input wise
105	I	So patient contact to you is really important still?
106	2:7	yes,
107	I	And what else matters to you when you're in the work area?
108	2:7	well obviously, the team, the staff who I work with, urm, I am trying to think how to
109		say it, because we always seem to be, [pause] trying to get them to do things, trying
110		to tell them about that they haven't done, a lot of the time. Urm, I try to be quite
111		fair, and I try to encourage them, urm because I think they work really hard, I would
112		say, 95% of them, come to work and want to work hard and want to do a good job,
113		they don't want to make mistakes they don't want to be not doing their job and
114		everything, and I think sometimes we give them a bit of a hard time over it,
115		forgetting how hard they are working in their bed space. Urm and its, you know, its
116		easy for us to always be, a lot of the time I think we give them negative feedback
117		about things rather than being positive, I think they are doing a hard job and
118		sometimes I think why are we trying to make it harder being negative with them. So,
119		I try to, hope that I am encouraging, particularly some of the new ones, I like to be
120		able to say, you know you're doing really well, and things like that, so that is
121		important because, obviously we are looking at the unit and its integrated and it's
122		not integrated and rotation which isn't a word we want to use, they are looking
123		again reintroducing integration programme, buts that's very secret, nobody knows,
124		only the band 7's. Urm, because it's the youngsters who are the future and we need
125		to be investing in them and making them want to come to work, making them
126		happy, and not want to leave. Because obviously, as the unit has got bigger the
127		turnover of staff has increased, you know, whereas before we would have had a lot
128		more staff that stay longer than we do now, we have a lot of people who don't stay
129		that long
130	I	So you think turnover has increased so, and you say from before
131	2:7	yes
132	I	when are you classing the before and what was the difference and what point do
133		you think (2:7 spoke over the question)?
134	2:7	I think just how big, the unit
135	I	so size?
136	2:7	size of the unit, because I don't think, obviously you have got a lot more people you
137		don't know them (emphasised the *them*) the same way as you knew people when
138		you were a smaller unit, when you knew everybody, you virtually knew everything
139		about everybody didn't you, and the number, the bigger the unit the more staff
140		you've got, you don't have that with everybody, so you don't know everybody, in
141		the same way. And obviously everybody doesn't know each other, everybody's
142		capabilities or personalities and everything like that, so [pause]
143	I	And you think that has an effect, that knowing each other a bit more has an effect
144		on turnover?
145	2:7	[pause], urm, I think in a way it has, [long pause]. But I also think it's a bit of a
146		generational thing,
147	I	OK, what do you mean?
148	2:7	well I, I don't think they have got the same stamina as we had.
149	I	OK, how.
150	2:7	I think the younger ones, [pause]
151	I	can you discuss that more.

2:7 that have recently qualified, I'm not saying they want an easy life, but they don't seem to be able to take, sometimes the workload, and the pressures in the way that we did, I think, again that is a, you know with mental health issues there are much more common and obviously we have people that get stressed about things, and have issues, a lot more than we probably did, maybe we were just good at hiding it, we just got on with it, we didn't have, there wasn't the opportunity to talk and get referred for things, and certainly like when I was in the bed space and that. So, I don't know whether that's a generational thing

I So you say that there are issues and pressures, is that new or was that always.

2:7 [overspoke question], no I think that's always been the same, I think probably, obviously [pause] certainly the turnover of patients particularly on cardiac as that's the service that provides, isn't it, trying to get that throughput, and obviously, I think sometimes, that is probably an increase in pressure of what we had before, because we didn't have that facility before, did we. We didn't have the cardiac surgery and everything, so I don't think. But I don't think I, I don't think it's any different to, I just think, it's a just a different way they have been raised. What they have been, school ,you know, I look at my girls, I think, it was different we all, accepted things probably, maybe that we shouldn't have done, and got on with it, but wasn't really anything else that you could do. Some people fell by the wayside and some people needed support but again, I think, because we all knew each other, we knew when someone was not, because you knew them so well, you knew when there were slightly off and that, and everything, then we would be looking out for them a bit more, supporting them a bit more. And I think, now again because of how many there are you don't pick up on those things.

I So you don't think you can to use your term *you can't look out for them so* easily due to the size of the unit

2:7 yes, I don't think you can, [pause]

I OK, so what do you do to look out for somebody? What is it you do?

2:7 Oh, gosh, [pause] I don't know it's hard to define isn't it, because you might, you know, they might be a bit, quieter in their bed space or they might be a bit more emotional, or anything, so then, I think, we would, talk to them because we knew them, we would try to find out about things, you know, offer them help and I think, I don't know whether we, I don't know whether we always pick up on just little changes in people, because we don't know them as well.

I Did you infer that there are now more services to help them, mental health wise than there was before?

2:7 Yes, [pause] only because I think, it is more of an open topic isn't it, and so there is more awareness of how people might be feeling, and they might need health and support. Whereas before we might have done it amongst ourselves, but I don't think we would sort of, have ever, thought that they needed, it was very rare that we thought they needed any outside help or anything, that we ever went down those sort of routes, we sort of helped each other out, didn't we. We did do things like swop peoples shifts round or help them with their childcare, because they were struggling, there were always those sorts of things we did on a more personal level that we would have done, more than offered from outside

I So the outside services that you are saying are available now, you are saying that we don't pick up these nuances that something is going on, so would they have to refer themselves? You are saying there are more services, but you're not able to pick it up that somethings going on

2:7 well I think [pause], I think often, it happens when suddenly they might have a crying episode or something at work and then you realise, you suddenly think oh, they are

struggling a bit, or whatever. Obviously, you do pick up on somethings like, some of them, particularly some of the new ones, they might be a bit slower or you find them doing odd little things and then when you question them you find that they haven't come across this before and they don't feel they can ask people. There are different personalities and they have different experiences and sometimes I think it's because they start showing some emotional thing before you realise, unless it's something fairly obvious but I don't think we always realise until suddenly they go off crying because something's happened and then you find that they feel they are not coping and those sort of things, so [pause]

I OK, thank you. You use the terms *new ones*, who do you class as a new one?

2:7 [laugh] erm, I would still say 6-12 months, I would say up to 12 months, because everyone develops at different times don't they, some of them will come and they will fly straight away and within 6 months, although they are new you know they are OK, they seem to have settled well, you know developed, haven't had, whereas some, just take, are a bit slower, everybody develops at different times don't they, so to me, 12 months, up to 12 months I would say is a new one.

I Ok, thank you, so you have talked about what matters to you at work and you have mentioned a few topics about that, what makes critical care a positive experience for you?

2:7 Oh, god, urm, [pause]. Erm, [pause], I don't know what to say to that,

I Well, why have you stayed?

2:7 I have stayed because, and again its very different now, but I've stayed because of the, certainly the patient care, the one to one care and having all that challenge, and being able to see, you know, really sick patients and that's the thing that made me start there, and made me stay there for a long time, but certainly that one to one care and seeing really sick patients or helping families through times, and that is what has made me stay. But obviously that has changed over the years and I can't say, because obviously that isn't the same anymore, because I don't have that thing so I am not sure whether that's just, laziness, complacency, that's made me stay, fear of not, fear of doing something different. Because I can't imagine, not being able to give the same level of care, that people, I couldn't imagine working on a ward and not being able to even, know that you've been only able to skim the bare surface of providing essentials to the patient, and not being able to provide everything they needed really. And I think that's, that we are fortunate working in critical care and only having one patient or two patients that most of the time that you are able to do that. But I am not sure whether in long term whether that that was just, [pause] fear of going somewhere else.

I You talk about fear and complacency

2:7 Yeh, complacency, because you're comfortable, you don't, you just become very comfortable and I, and I suppose I would have been scared to go and do anything else

I Why would have you been scared to do something else?

2:7 Well it's just the fear of the unknown isn't it and knowing whether or not, not that you wouldn't be able to necessarily learn and develop into that job, but its, [pause] again a lot of it is to do with who the people you work with as well, because you do develop good relationships, a lot of the time you get to know people, you go into another team its completely unknown entity, you may not have the same relationships with them, you may not enjoy the job in the same way, certainly from the patient side of it and how, [pause] you know, not having the time and again that's to do with staffing levels, things like that on the wards. I just think when you hear some of the things now, we might complain and we think we are busy, got a

hard life but we haven't got it anywhere near as hard as the ward has got, in terms of you know just of silly things, like getting off on time, getting their breaks and everything, it's very rare that we don't, we might be really busy but its very rare that people miss their break, they might be a bit late off but that's not common place and everything, so [pause]

I And you talk of fear and you mention an example of not being able to deliver the same level of care, are there any other things that make you fearful to move on? And you mention a ward but there's lots of other aspects to nursing, are there any other things that make it fearful?

2:7 [pause] erm, [pause] I don't know just not be able to, not being up to it, not being able to change in a way, because obviously you would have to change, so I think that's part of it, like driving I couldn't work anywhere else I don't drive.

I OK, so you have limitations there

2:7 You know, that, you know obviously that if you really wanted to do something that wouldn't be an issue really but it's a consideration, rather than an issue. So, [pause] I don't know, again, I suppose it is the fact that how you know the staff and how they work, and they know and you work and everything as well.

I So change, change is fearful?

2:7 Yes, but, by the same token, as a unit we have gone through a lot of changes and although we haven't always embraced them all the time we know that because we've been through that change before, that we always know, those that have been there a long time always say well we've been through these changes before we've always come out of it at the end and its always been ok, but, you know it is still fearful of what, what the next change might bring, like we've got a new head of nursing we don't know what her, we don't know what we're going to face now, in terms of change so again there is that sort of worry, what changes might that bring, she a different personality to the last one, and you don't know do you, there's always little fears and worries about change isn't there, not necessarily major changes, small changes [pause].

I So what has been rewarding, what is, if you look back at your professional career, what has been rewarding,

2:7 [sigh] gosh this is really hard to talk about things like, to know what to say really, it all sounds, I don't know, [pause] I think it's hard having been there for such a long time to say what is rewarding, like a few years ago it would have been things like becoming a band 7, progressing like that, urm having recognition from people about your role and that they do sometimes see you as a role model, but I think the longer, you don't sort of think of that because being there for such a long time, but certainly they were things that I was proud of

I So

2:7 because you know I've, you don't know do you when you come into nursing how you are going to be, my dad said to me you'll never stick it, he did say that, you know, because, I was, you know I lived in a little village, never went out, didn't do anything, so I think he thought well she'll never be able to cope with moving away from home and all of those sort of things, and everything

I and you have for a long time,

2:7 Yeh,

I You said recognition has been really important, how has someone recognised you that was seen as positive, because you said that was rewarding? In what ways do you feel that you were recognised?

2:7 Again, I think it's just, when you are just chatting, and people just say things [pause]. People do, obviously particularly on a night shift people do say, certainly with my

group of colleagues the band 7's, how I look at the workload across the floor, people say you're a bit more, your fair, if so and so were on they wouldn't have moved somebody, because I would do things like, I won't have 5 people doubled up on general and nobody doubled up on [xxxx]. I will share the nursing staff out so that everybody has got a bit more of a balanced time, and everybody can and they aren't some people that are struggling that have two patients and they are really busy and somebody else has got a wardable patient, you know who is less dependent, so they will say so and so they wouldn't do that and if you are on, your always fairer about things and everything and I think people, and again that has changed probably in the last two years with the more new staff we have, urm people all say that I'm always approachable you know, that they can come and ask me about anything. They didn't feel that I would be scathing about something, you know they do get some snide comments from people, if they ask what they consider to be silly things and they say they we can come and ask you anything and we know you wouldn't be like that and that they can come and ask about anything. Urm, and again I think that's probably changed and again because people don't know you as well as before, because you get a lot of new people starting in a short space of time so, you don't get that, those sort of things really.

I So reward for you has been people been commenting that

2:7 yes, only commenting

I and that's been intrinsically rewarding, quite positive

2:7 yes, I find it so anyway

I thank you. So, what challenges you at work?

2:7 Err, [pause] [whisper], everything, urm, the medical team, again just the expectation these days of increased throughput, trying to accommodate that, urm trying to ensure that you have got enough staff to look after manage the patients safely, they are the biggest challenges because there's not, there aren't any shifts these days where there is the right number of staff on, that we should have. Urm, and often from the skill mix and the dependency of the patients we manage that, but there are time where, we are struggling to get people in, to be able to manage those patients, those are the things that are, and ensuring the patients are looked after safely, again in terms of new ones, the skill mix, particularly on a day shift its challenging and that's usually when you know, workload is the highest, certainly elective work coming though.

I So there are these challenges and you mention the medical team workload and you mention increased acuity of patients and throughput, but you've decided to stay

2:7 yes, because in a way, I suppose you thrive on the challenge as well, we were talking again last night, we were saying about the time I loved when I was there, was when we had all the flu patients and [xxxx] patients, were only on [xxxx], [xxxx] beds and it was busy and everyone really, good team work and everything and that was just, and that was really challenging but that's probably one of the best times

I So teamwork makes a more positive time

2:7 yes, yes everyone pulling together, it's now on some shifts you're really struggling and everything and something kicks off, everybody, most people rise to the challenge, everybody chips in and everything, but those are the times that afterwards you think it was a bit horrendous at the time but actually it's all worked out hopefully well, you feel that you've achieved something that day, you've done a good job, and although it was challenging that was better than some other mundane day where you were plodding along

I OK, so I think you have just said why you have stayed in critical care, haven't we?

2:7 yes, laziness, complacency,

I so have you considered?

2:7 [spoke over question] it is complacency, it is being, it's just because you're comfortable in your role and you don't want to, I don't know, it's hard to say after all these years, at what point did you never think of doing anything else [spoken really quietly]

I Did you ever think of doing something else?

2:7 yes, probably the first few years, because when I qualified I did female medical and I did trauma- orthopaedics and I did like trauma- orthopaedics, so I had looked at that when there had been things, I don't know what didn't make me then pursue it, but I had looked at that when there had been jobs. I don't know what didn't make me pursue it, but I had contemplated that because I had enjoyed that, being a Staff Nurse on trauma -orthopaedics at the [xxxx]. But I don't know then at what point you don't

I So you have never thought of leaving since?

2:7 no [pause]

I So why do you think others leave then? You mentioned early on that there was turnover increased and you're talking about a 40-year history, why are others leaving?

2:7 [pause] I think currently, recently probably because of the job situation generally shortages of nurses, there are a lot more opportunities for people and I think the youngsters, want to develop, want to move on very quickly don't they, the ones been qualified, a year or two [pause]

I by using the term youngsters do you mean in years, age or experience?

2:7 experience age probably,

I OK

2:7 So they have in a way that we probably didn't when we qualified they've often got their career plans thought out already haven't they, which was something that I wouldn't have had, and I think there's a lot more opportunities that come up for them and you can't blame them and having worked in critical care that gives them a good background for other things. Urm, I also think a lot of them, again its their perception isn't it, they are not sure, they haven't done a placement on critical care, they don't know anything about critical care, I think sometimes, I am not saying everyone, but some people think it's an easy option because they are only going to have one or to patients to look after and it then turns out to be, not what they had anticipated and I think , also for a lot of people when they come, it's a lot more stressful with the patients they are looking after, they are not expecting that and that's why they don't necessarily stay

I And what are the stressors that you mention?

2:7 [pause] [sigh] I think just, the demands on, because of the types of patients they might be looking after, I think some people don't deal well with patients being critically ill, and certainly a lot of patients find if we are doing palliative care on patients, withdrawal of treatment, a lot of them find that hard to deal with and it doesn't, it never gets any easier but then you don't seem to have to come to terms with those sort of things. Some people find that hard, urm and again I think the workload sometimes they find it too much [pause]. And I don't know if, if they think that the grass is greener, it isn't always. Because these days we are, everybody is working constantly, trying to get more work done aren't you, in the same amount of time.

I Do you think workload has increased?

2:7 yeh, yes

I and you mentioned end of life care as a stressor, you highlighted that one

2:7 yes, because I do think, that some staff struggle with that, urm and I that sometimes on the unit people will want to go to cardiac for a time because they don't have as many patients die as general do, and they do say that. The workload is, it's different, the patients aren't, they might be sick for a short time and they recover really quickly and they are not there being ventilated for days or coming in and then dying really quickly. So often when they have had a time of that they will want to go and work on cardiac for a little while because they know they are not going to have those issues about making decisions about withdrawal of treatment, or limiting treatment, or end of life care and things and they, it gives them a bit of respite from it and do you they come back, so they are having a breather from it

I and do they come back?

2:7 yes, they come back

I are there any other areas that cause such stress like end-of-life care?

2:7 [pause] urm [pause] I don't know really, I think people find public perception or expectation hard sometimes, urm what families expect out of you, I think sometimes that is hard for people, because, again, not always but again they don't always die but the expectation is you can cure everybody and you can do everything so I think that is, its not that the patients always die but that's when you are going through the worst critical illness, and there is the pressure from the relatives, on you, asking you, wanting you to do things and always being able to and sometimes, often it works out ok in the end but you might go through several days of it being like that, and I think sometimes people find that tough to deal with those relatives sometimes, rather than what's going on with the patient

I So they are the two main stressors, end of life care and dealing with families, they haven't changed in the history of critical care

2:7 no, no

I so why have you managed to cope with that?

2:7 that's hard to say because I, I certainly think that is a generational thing, it's a bit like they talk about people in the war, belt and braces and you just got on with it, because that is what you did and everything, and I think that is some of it, and I cant say that its any different because I do think there is a bit, we, a bit you know, like how the sickness is, now we would have thought, you might have felt unwell but you think, oh there's not many people on, I'm going to let my colleagues down, and they might not have enough people for the patients, whereas now in terms of the younger generation and I'm talking in terms of years not experience, they wouldn't think that, it's the slightest thing and they are ringing in sick and they're off, whereas we, the older generation in years, the more mature people don't, we don't go off sick at the drop of a hat unless we are really, and again I think it is a generational thing

I And what is it in you that does that?

2:7 I don't know, I think because we had things like loyalty and all those sort of things meant more and I think that's the way we were raised, to respect and to be loyal and everything and Im not saying they are not loyal but I think they see it in a different way, its hard to explain but I just think like our parents we would have said something and they would of if you had been alive in the war all that sort of thing, they just got on with it, they weren't ill, they just did these and I think we just did these things, I think we have more stamina, why is it? People say that to me how do you keep coming to work? What with my knees, but its not anything I would ever entertain, that's the way it is, you've got a job, you're paid to come and do it, just do it. I don't know, it's hard to say [pause] but I do think it is, but then I think if we look again and I talk about my family, none of us have ever been out of work, including

458		my brothers and sisters, my daughters, don't go off sick at a drop of the hat, so
459		that's hard to say that's a younger, generational thing in terms of years, but then is
460		that because they I've always worked, and that's the role model they've had,
461		because you know they wouldn't dream, go off at a drop of a hat or, [xxxx] gets
462		more stressed than [xxxx] but again that is because that's what they have always
463		seen, that's how we've been
464	I	So the study is about those that remain in critical care
465	2:7	yes, I know
466	I	so if I put that to you, why do you think, what is it that allows some people stay for a
467		very long time, are there any characteristics or why do you think some people stay a
468		long time?
469	2:7	You know, I have no idea, I'm trying to think, of what if there's some personality
470		characteristic or [pause] I don't know. I honestly can't say, I think of the other
471		people that have been there a long time and I am trying to think, what is there
472		about all us [pause] that made us stay, and I don't know [pause}
473	I	And are there, can you see a group of people that stay?
474	2:7	yes
475	I	OK
476	2:7	because I think of people like [xxxx] and [xxxx] have retired now but I think of [xxxx,
477		xxxx, xxxx, xxxx], you know those people, [xxxx], you think of all those people, [xxxx],
478		you think of all those people and you think what is it about us, because we are all
479		different people, all different personalities
480	I	and when you look at people more junior in bands can you see some of them that
481		are likely to stay for a long time?
482	2:7	yes [pause] and there are, in terms, it depends what you term, there are some
483		people that have been there a long time, people like [xxxx], [xxxx], [xxxx], and some
484		of the overseas nurses, they have been there since they came, they have stayed on
485		the unit, [xxxx], [xxxx], they are all still there, no of them have moved
486	I	so why do they stay?
487	2:7	[sigh] [long pause] I don't know
488	I	Are they, I have used a couple of terms in the title, are they doing well, thriving or
489		are they staying
490	2:7	some of them are just surviving, probably they are just staying aren't they, and
491		certainly obviously one or two of them I could think are, do other things like,
492		working in agencies so they haven't thrived on the unit, progressed on the unit, they
493		have stayed as they are, but some of the them are thriving, they have progressed in
494		their careers, haven't they, [xxxx] starts her band 6 secondment, she didn't get
495		shortlisted this time, but they have gone on and progressed, become band 6's got
496		promotions, urm some of the others that have been there a few years have gone to
497		Outreach, but then there's a lot of them that have been there a long time who are
498		the same, they might have done their ENB 100 but they certainly don't want to
499		progress any further, they have stayed at that level, and I cant say, why some of
500		them would want to progress and some of them want to stay at that level, some of
501		it might be family issues and they don't want, and often we get comments certainly
502		when we talk about applying for a band 7, they are like 'oh god we wouldn't want
503		your job', but why?
504	I	But they want to stay in critical care
505	2:7	they want to stay in critical care, but again, is that they see us not having the same
506		sort of patient contact, and that sort of stuff and they see that often we are dealing
507		with, fighting fires about staffing and beds and those sort of things, and managing

508		sickness and stuff like that that they don't see as an attractive part of the role
509		[pause]
510	I	we have been talking for about 50 minutes, and to recap then we have
511	2:7	[interrupted I/ spoke over] I'm not feeling that I have been very helpful
512	I	… talked about what matters to you in work, has critical care been a positive
513		experience to you, I don't think we said much around that, that's something we
514		might just go back to, what has been rewarding, what are your challenges at work,
515		why have you stayed, have you considered leaving, we have talked about other
516		nurses leaving, and what allows you to do your best or what stops you doing your
517		best, so overall do you think critical care has been a positive experience, you've
518		certainly been there 41years,
519	2:7	I can only say yes can't I [bright lively response], [laugh] why would you stay
520		somewhere and be miserable, [pause]
521	I	I don't know, Is it easier?
522	2:7	well it probably is easier, but then I don't think that you could sustain that for 41
523		years, you couldn't go to work every day like that and be miserable. There's got to
524		be, there can only be a very small percentage of that that you could be miserable for
525		the rest of it has got to be positive, you couldn't sustain that, not for that length of
526		time I don't think. Even me, feeling that its fearful and I am being complacent about
527		it, you get stuck in your comfort zone, you couldn't be miserable for that length of
528		time and carry on, I don't think you could
529	I	if you had to sum up why you have stayed
530	2:7	because I do love, I do love what I do even though its changed over the years, so
531		even though, I might moan a bit about it bed stuff, you know, staffing levels and just
532		sometimes feeling like all you are is a bed manager on some days, I do feel, 90% of
533		the time I do still enjoy what I am doing. Because I do still feel that I have made a bit
534		of a difference, if you have managed to get all those cases done when you came on a
535		8 o'clock in the morning and you didn't think you were going to be able to do them
536		all and you've managed to jiggle things around and by encouraging things to keep
537		badgering people you've managed to get most of them done. But then some days I
538		go home, and I think, I don't know what I have done that day, you can't really think,
539		you haven't stopped but you can't really think what you've done or achieved. So, I
540		do still enjoy some of those things, it's what makes you tick. You know I just think, I
541		don't know what personality trait it is, some people are able to handle those
542		pressures and everything better than other people can. I don't know, maybe
543		sometimes my expectations aren't as high as other peoples, you know in terms of,
544		you know, some people expect to be praised and glorified and everything all the
545		time and it's not like that is it
546	I	So you don't mean your expectations in care delivery
547	2:7	no
548	I	you mean expectations them examples given back to you, so that's recognition, OK.
549		So, you have stayed more for internal rather than what people have shown you, are
550		you saying?
551	2:7	yes [long pause] don't know, I can't explain it, it's hard to define really, if I had only
552		done 20 years it might have been different, to think about why you might have, but I
553		don't know. It certainly isn't anything you think about when you start off is it, that
554		you will spend all of your career in one place
555	I	that wasn't your plan?
556	2:7	may be the fact that how the unit has developed and the changes, those changes
557		were enough for me.
558	I	Changing in size, changing in speciality

559 2:7 just that those changes although they have come and you've worried about them,
560 they are actually what has lead you to carry on, to be able to go on for the next few
561 years, you've had those, maybe those changes were just enough. Challenges that
562 your facing and still do. Even now the integration isn't, nightmare. I can't think
563 I you can't think, [pause]. Thank you, so are you happy that we have gone through all
564 those things? Is there anything that you want to add to anything you've said or
565 something you thought when you looked at the information about the study that
566 you want to add?
567 2:7 I don't think so, no, I don't feel that I've been very helpful
568 I would you be happy to be interviewed again.
569 2:7 I would, yes.
570 I thank you; I will turn the audio off (55:52)

Appendix 12: Analysis: Meaningful Statement to Theme (N2)

Critical Care Nurses Thriving and Striving through Workplace Adversity

Initial Interviews: Formulating Meanings

Index:

- 5:1:1 (7) – professional band 5: site 1: 1st interviewed: (7th line in transcription)
- 7:1:2 (10)- professional band 7: site 1: 2nd Interviewed (10th line in transcription

Meaningful Statement	**Initial Impression / Formulated Meaning**	**Theme**
Meaningful Statement: Emotive		
7:1:2 (27) Urm, gosh, it all sounds a bit boring because all I've done is critical care really	Very early comment about not doing very much	Negativity regarding professional progression
7:1:2 (94) Oh gosh, these days it's just so different,	Times have changed, *when asked what matters*	Negativity
7:1:2 (248) I don't know what to say to that,	Initially unable to express what matters to her or why she has remained in CC	Initial responses limited, vulnerable
7:1:2 (250) I have stayed because, and again its very different now, but I've stayed because of the, certainly the patient care, the one to one care and having all that challenge and being able to see, you know, really sick patients and that's the thing that made me start there, and made me stay there for a long time,	Stayed due the nature of the patient care, acuity of care, the challenges that presents and 1:1 care giving	Concept of CCN
7:1:2 (257) that one to one care and seeing really sick patients or helping families through times, and that is what has made me stay.	Acuity of care and supporting families a reason to remain,	Concept of CCN
7:1:2 (255) But obviously that has changed over the years and I can't say, because obviously that isn't the same anymore, because I don't have that thing so I am not sure whether that's just, laziness, complacency, that's made me stay, fear of not, fear of doing something different. Because I can't imagine, not being able	Over time the challenges has changed, important that the level of care is maintained, But is it now 'complacency', 'lazyness' or 'fear'	Fear of other work context-standards Uncertainty of self - Laziness/complacency

to give the same level of care, that people, I couldn't imagine working on a ward and not being able to even, know that you've been only able to skim the bare surface of providing essentials to the patient, and not being able to provide everything they needed really.	Insight into that level of care could not be sustained on the ward	
7:1:2 (265) But I am not sure whether in long term whether that that was just, [pause] fear of going somewhere else.	Fear of moving elsewhere	Fear
7:1:2 (269) Yeh, complacency, because you're comfortable, you don't, you just become very comfortable and I, and I suppose I would have been scared to go and do anything else	Comfort, scary thought to move elsewhere	Fear versus complacency
7:1:2 (87) Urm. So, really, I am being complacent,	Complacency or choice? Clear about preference to remain patient centred	Complacent
7:1:2 (248) I don't know what to say to that,	Initially unable to respond when asked what makes critical are a positive place for you	Conceptions of the job- vulnerable
7:1:2 (250) but I've stayed because of the, certainly the patient care, the one to one care and having all that challenge,	Remained in ICU due to nature of care delivery	Conceptions of the job – patient centred
7:1:2 (252) being able to see, you know, really sick patients and that's the thing that made me start there, and made me stay there for a long time,	Acuity of patients, initially a reason to stay *(sounds like this may have changed)*	Conceptions of the job – patient centred (intimating this had changed)
7:1:2 but certainly that one to one care and seeing really sick patients or helping families through times, and that is what has made me stay. But obviously that has changed over the years and I can't say, because obviously that isn't the same anymore	Nature of care delivery and close family contact was initial reason to remain, over time this has changes	Changing conceptions of the job
7:1:2 (254) because I don't have that thing so I am not sure whether that's just, laziness, complacency, that's made me stay, fear of not, fear of doing something different. Because I can't imagine, not being able to give the same level of care, that people, I couldn't imagine working on a ward and not being able to even, know that you've been only able to skim the bare surface of providing essentials to the patient, and not being able to provide everything they needed really.	Identified 'fear' laziness' 'complacency', fear of not being able to 'nurse' in the same manner, care delivery not seen as achievable within the ward environment	Uncertainty / vulnerable Comparison to ward context

7:1:2(265) But I am not sure whether in long term whether that that was just, [pause] fear of going somewhere else.	Fear	Conceptions changed, changed to fear with longevity
7:1:2(269) Yeh, complacency, because you're comfortable, you don't, you just become very comfortable and I, and I suppose I would have been scared to go and do anything else	'scared' to leave – became too comfortable	Fear and longevity
7:1:2(273) Well it's just the fear of the unknown isn't it and knowing whether or not, not that you wouldn't be able to necessarily learn and develop into that job,	Fear of the unknown, knowledge – the new knowledge cant this be learnt?	Fear – work context
7:1:2(278) you may not enjoy the job in the same way	Implying they still enjoy the 'job'	Fear inability to maintain those standards in other work context
7:1:2(292) I don't know just not be able to, not being up to it, not being able to change in a way, because obviously, you would have to change,	Questioning capability and ability to change	Fear of competence
7:1:2(297) You know, that, you know obviously that if you really wanted to do something that wouldn't be an issue really but it's a consideration, rather than an issue.	Relating to not being able to drive, logistics are a consideration	Logistics about moving
7:1:2 (317) [sigh] gosh this is really hard to talk about things like,	Again finding it difficult to talk about self	Vulnerable
7:1:2 (326) because you know I've, you don't know do you when you come into nursing how you are going to be, my dad said to me you'll never stick it, he did say that, you know, because, I was, you know I lived in a little village, never went out, didn't do anything, so I think he thought well she'll never be able to cope with moving away from home and all of those sort of things, and everything	Background influences, families commentary on her ability to 'cope'	Family perceptions of her capability
7:1:2 (379) I suppose you thrive on the challenge as well,	Challenge is a motivator	Motivation
7:1:2 we were saying about the time I loved when I was there, was when we had all the flu patients and cardiac patients, were only on A side, 6 beds and it was busy and everyone really, good team work and everything and that was just, and that was really challenging but that's probably one of the best times	Discussion with colleagues about what is important, periods of high intensity seen as a positive experience	Community examples of good times

I (394) I OK, so I think you have just said why you have stayed in critical care, haven't we? 7:2:2 (396) yes, laziness, complacency,	Following dialogue on an intrinsic reward, returned immediately to 'laziness' and 'complacency' – self-critical in a negative manner	Self-critical
7:1:2 (398) it is complacency, it is being, it's just because you're comfortable in your role and you don't want to, I don't know, it's hard to say after all these years, at what point did you never think of doing anything else [spoken really quietly]	[why is she so quiet, less confident, or ashamed], articulated that no longer thought about moving, self-reflective	Professionalism – at what point do you no longer consider moving
7:1:2 (403) yes, probably the first few years, because when I qualified I did female medical and I did trauma- orthopaedics and I did like trauma-orthopaedics, so I had looked at that when there had been things, I don't know what didn't make me then pursue it, but I had looked at that when there had been jobs. I don't know what didn't make me pursue it, but I had contemplated that because I had enjoyed that, being a Staff Nurse on trauma -orthopaedics at the Royal. But I don't know then at what point you don't	Early in career had thoughts speciality change – not career change	Aspiration – initially to move Aspiration – at what point do you no longer consider moving
7:1:2 (514) I have no idea	When asked why people leave Why stay? Immediate responses tend to be negative	Confidence to speak?
7:1:2 (533) [sigh] [Long pause] I don't know	And the same when asked why they stay	Confidence
7:1:2 (536) some of them are just surviving	'just surviving' – interesting point	CCN conception - surviving
7:1:2 (558) I'm not feeling that I have been very Helpful	Negative response when I suggested a recap at 50 mins	Confidence/ helpfulness
7:1:2 (566) I can only say yes can't I [bright lively response], [laugh] why would you stay somewhere and be miserable, [pause]	Not miserable at working there, but given a negative response rather than a positive one, like I have enjoyed it	Inability to articulate positive reason to stay but highlights she isn't miserable about staying
7:1:2 (569) well it probably is easier, but then I don't think that you could sustain that for 41 years, you couldn't go to work every day like that and be miserable. There's got to be, there can only be a very small percentage of that that you could be miserable for the rest of it has got to be positive,	Elaborated on reason to remain, easier, mainly positive experience, comfort zone, referred to length of service and it 'had' to be positive to sustain that length of time	Nurse construct -is not be miserable the same as being happy ??

you couldn't sustain that, not for that length of time I don't think. Even me, feeling that its fearful and I am being complacent about it, you get stuck in your comfort zone, you couldn't be miserable for that length of time and carry on, I don't think you could		
7:1:2 (577) because I do love, I do love what I do even though its changed over the years, so even though, I might moan a bit about it bed stuff, you know, staffing levels and just sometimes feeling like all you are is a bed manager on some days, I do feel, 90% of the time I do still enjoy what I am doing.	Positive reference, 'love it', acknowledged role had changed to more managerial tasks, enjoy it more than not	Work context – ITU has changed, frustration about role, reference to 'love' work
Meaningful Statement - Knowledge		
7:1:2 (28) I didn't do my ITU course, even though I had been a critical care nurse, I didn't do my ITU course till quite late on really because that wasn't so much a requirement as it is now, so I was quite late on in my critical care career before I did my ITU course. Urm, and obviously that just put everything into place really, stamped things that we had always done. Urm, gosh, [pause].	The main CC qualification wasn't required till late in her career, already a senior member of staff	Job role conception
7:1:2 (60) Again, I haven't done anything, have I, I am not academic, I have literally only done, I did my ITU course, I did my it's not mentorship, it was the 998 Teaching and Assessing course. And again, I did that probably quite late on.	Later in career when completed the specialist CC and teaching certificate. Not a requirement for developing in earlier career.	Job role conception
7:1:2 (63) I think educational things became more relevant to what we were doing whereas before you worked in your job, you got promoted, there wasn't the emphasis on those sort of things, so I probably, my generation probably, urm didn't look at those sort of things and obviously I never really intended to, urm, progress and get out of nursing, I didn't want to become a manager or do anything else. I was probably a bit complacent really and a bit lazy.	Focus on educational requirements came later in her professional career, didn't feel the need as didn't plan to move out of nursing Progression wasn't dependant on certification type of knowledge, more experiential	Job role conception
7:1:2 I didn't really want to do anything else in terms of professional development, courses and everything	Complacency and laziness referred to again with reference to education attainment Is this complacency??	Role conception/ identity
Meaningful Statement - Regret		

Meaningful Statement - Professionalism *honesty, integrity, demeanour, reliability, competence, ethics, commitment, positivity, respect, (more than technical expertise) critical thinking, communication skills*		
7:1:2: (491) I think because we had things like loyalty		Role conception
7:1:2 (491) all those sort of things meant more and I think that's the way we were raised, to respect and to be loyal and everything and Im not saying they are not loyal but I think they see it in a different way, its hard to explain but I just think like our parents we would have said something and they would of if you had been alive in the war all that sort of thing, they just got on with it, they weren't ill, they just did these and I think we just did these things,	Comparison to war like attributes	Role conception / identity
7:1:2 (497) I think we have more stamina, why is it? People say that to me how do you keep coming to work? What with my knees, but its not anything I would ever entertain, that's the way it is, you've got a job	Personal attributes, stamina	Role conception/ identity
7:1:2 (500) you're paid to come and do it, just do it	Harsh critique, need to just get on with it, now matter what	Culture
7:1:2 (501) , but then I think if we look again and I talk about my family, none of us have ever been out of work, including my brothers and sisters, my daughters, don't go off sick at a drop of the hat, so that's hard to say that's a younger, generational thing in terms of years, but then is that because they I've always worked, and that's the role model they've had, because you know they wouldn't dream, go off at a drop of a hat or, Hannah gets more stressed than Kerin but again that is because that's what they have always seen, that's how we've been	Generational comparison, family role models, her parents and her expectations of her children	Culture differences
7:1:2 (537) certainly obviously one or two of them I could think are, do other things like, working in agencies so they haven't thrived on the unit, progressed on the unit, they have stayed as they are, but some of the them are thriving, they have progressed in their careers, haven't they, Des starts her band 6 secondment, she didn't get shortlisted this time, but they have gone on and progressed, become band 6's got promotions, urm some of the others that have been there a few years have gone to Outreach, but then there's a	Response to thriving or surviving – small numbers are thriving, Examples of why some are not thriving being financially secure, working additional hours prevents progressions (thriving)- potentially a job not a career	Conceptions / professionalism

lot of them that have been there a long time who are the same, they might have done their ENB 100 but they certainly don't want to progress any further,	Named examples have been in ITU 20years, achieved band 6 position, some have progressed with certificated knowledge rather than professional band – why is progression so lengthy or not achieved?	
7:1:2 (546) have stayed at that level, and I cant say, why some of them would want to progress and some of them want to stay at that level, some of it might be family issues and they don't want, and	Examples of why some do not want to progress	Professional mobility
often we get comments certainly when we talk about applying for a band 7, they are like 'oh god we wouldn't want your job', but why?	Senior band not seen in a positive light	Professional mobility
7:1:2 (552) they want to stay in critical care, but again, is that they see us not having the same sort of patient contact	Close patient contact, the speciality is important to remain	Conceptions of CCN
7:1:2 (553) that sort of stuff and they see that often we are dealing with, fighting fires about staffing and beds and those sort of things, and managing sickness and stuff like that that they don't see as an attractive part of the role [pause]	Examples why the senior role is not so attractive, reduced patient contact / limited clinical application	Professional mobility
Meaningful Statement - Management		
7:1:2 (72) oh yes but you've still got your, it's not the same as, you've still got that clinical input, haven't you, you're not completely just going to meetings, arranging things, and everything like that. I did find, obviously I did do that role for a few months, and that was a time I found hard because you weren't so involved in knowing what was going on clinically.	Professional band related to a clinical rather than managerial type role- important to remain clinical	Conceptions of CCN senior role
7:1:2 (80) because I found that your time was consumed with, other things, influenced by other things from outside of the unit, meetings and things like that. So, you didn't always have a handle of what was going on clinically which I didn't enjoy, didn't really like	Exposure to a managerial role, confirmed the move away from direct patient care	Conceptions of a CCN
7:1:2 (85) So I suppose our band 7 role although we are not clinical, we are still there, so if things go on you are still in the bedspace, helping and doing stuff like that.	Important to remain patient centred – assisting and clinically based rather than away from the clinical focus	Conceptions of CCN/ role identity

7:1:2 (303) as a unit we have gone through a lot of changes and although we haven't always embraced them all the time we know that because we've been through that change before, that we always know, those that have been there a long time always say well we've been through these changes before we've always come out of it at the end and its always been ok, but, you know it is still fearful of what, what the next change might bring,	CC sees lots of change, yet remain reticent about it	Culture
7:1:2 (309) we've got a new head of nursing we don't know what her, we don't know what we're going to face now, in terms of change so again there is that sort of worry, what changes might that bring, she a different personality to the last one, and you don't know do you, there's always little fears and worries about change isn't there, not necessarily major changes, small changes [pause].	Examples of organisational change, again fear used as a term even against small changes	Culture and change
7:1:2 (319)] I think it's hard having been there for such a long time to say what is rewarding, like a few years ago it would have been things like becoming a band 7, progressing like	Is it hard to remember what reward is or is it that reward is not seen ?? Early in career progression was the reward	Intrinsic reward
7:1:2 (320) recognition from people about your role and that they do sometimes see you as a role model, but I think the longer, you don't sort of think of that because being there for such a long time, but certainly they were things that I was proud of	Intrinsic reward from staff about her management style – feels proud	Intrinsic reward
Meaningful Statement - Leadership		
7:1:2 (94) , because a lot of the time now I feel we are just problem solving, bed managing, is a big part of it, sickness, staff management and things like that but obviously you are still the clinical expert, supposedly, on the floor so you do, you are still called upon, asking your opinions about this is going on with the patient and everything, you get called into the bed space to look at things so it is those, so there is still that element that you can have clinical input with the patient, and I think often we we're a step away from it we can go into a bedspace and you can pick up on things that someone else might not have noticed, just little things you might look at a result, blood gas or blood result or obs or something else like that, and	Times have changed, advisory role as a leader, clinical expert, visible in clinical area Role is very important, clinical expertise	Conceptions of a CCN Importance of remaining clinical- bedside nursing

why this and that, so it is still those sort of things, it is still being able to talk to the patient and being able to help with the rolls, advising the staff on things, that they might not be aware of. So, I suppose that part of it is still really important,		
7:1:2 (108) I think that's why sometimes now that it less and less, because the unit is certainly a lot busier, so you would get to do that probably less.	Less time clinical	Conceptions of CCN – identity
7:1:2 (110) particularly on a day shift and I think that's why when doing nights you are able to be more clinically involved in what's going on, you do get involved a bit more when the patients are admitted and about those sorts of things, than you do on the day because the on the day a lot of it is, having, you know, having a hundred and one permutations of what beds, what are you are doing with your beds and your staff and planning for the next shift and everything. So, I think, that's got less on the day shift clinical input wise	Even less on a day shift due to interruptions of managerial responsibilities	Identity
7:1:2 (119) yes	Clinical contact remains important	
7:1:2 (122), because we always seem to be, [pause] trying to get them to do things, trying to tell them about that they haven't done, a lot of the time. Urm, I try to be quite fair, and I try to encourage them, urm because I think they work really hard, I	Need to be fair, ensure staff receive positive feedback CC is hard work	Support/ fairness/ reward
would say, 95% of them, come to work and want to work hard and want to do a good job	Nurses want to do a good job	Conception of CCN
7:1:2 (128) and I think sometimes we give them a bit of a hard time over it, forgetting how hard they are working in their bed space.	Recognition that nursing staff are sometimes given a hard time	Hard work
7:1:2 (130) its easy for us to always be, a lot of the time I think we give them negative feedback about things rather than being positive,	Negative feedback is more common	Reward, negative rather than positive feedback
7:1:2 (132) sometimes I think why are we trying to make it harder being negative with them.	Recognition of negative feedback to staff is common	Reward, negative rather than positive feedback
7:1:2 (133) I try to, hope that I am encouraging, particularly some of the new ones, I like to be able to say, you know you're doing really well, and things like that	Aim to ensure positive feedback	Feedback / reward
7:1:2 (139) because it's the youngsters who are the future and we need to be investing in them and	Recognition of good leadership – investing in future / remaining staff	Reward

making them want to come to work, making them happy, and not want to leave		
7:1:2 (337), I think it's just, when you are just chatting, and people just say things [pause]. People do, obviously particularly on a night shift people do say, certainly with my group of colleagues the band 7's, how I look at the workload across the floor, people say you're a bit more, your fair, if so and so were on they wouldn't have moved somebody, because I would do things like, I won't have 5 people doubled up on general and nobody doubled up on C side. I will share the nursing staff out so that everybody has got a bit more of a balanced time, and everybody can and they aren't some people that are struggling that have two patients and they are really busy and somebody else has got a wardable patient, you know who is less dependent, so they will say so and so they wouldn't do that and if you are on, your always fairer about things and everything and I think people	Positive return for leadership style, external feedback, positive feedback	Intrinsic reward, personal characteristics
7:1:2 (350) people all say that I'm always approachable you know, that they can come and ask me about anything	Approachable leadership style valued	Support
7:1:2(351) They didn't feel that I would be scathing about something, you know they do get some snide comments from people, if they ask what they consider to be silly things and they say they we can come and ask you anything and we know you wouldn't be like that and that they can come and ask about anything.	Approachable manner valued	External reward
7:1:2 (355) , and again I think that's probably changed and again because people don't know you as well as before, because you get a lot of new people starting in a short space of time so, you don't get that, those sort of things really.	Less notable with increased staffing numbers, feedback changed	Conceptions changing
7:1:2 (360) yes, only commenting	Personal reward, gaining verbal feedback	Reward
7:1:2 (364) Err, [pause] [whisper], everything, urm, the medical team	The medical team are the challenge	Organisational challenges
Meaningful Statement - Support		
7:1:2 (199) yes, I don't think you can, [pause]	Size of the unit affects the support you can give to the staff, the support has reduced	Support

7:1:2 (201) I don't know it's hard to define isn't it, because you might, you know, they might be a bit, quieter in their bed space or they might be a bit more emotional, or anything, so then, I think, we would, talk to them because we knew them, we would try to find out about things, you know, offer them help and I think, I don't know whether we, I don't know whether we always pick up on just little changes in people, because we don't know them as well.	Challenges of a lager unit in noticing when support is needed, Knowing a person helps in the identification of when support is needed	Support Support
7:1:2 (210) Yes, [pause] only because I think, it is more of an open topic isn't it, and so there is more awareness of how people might be feeling, and they might need health and support. Whereas before we might have done it amongst ourselves, but I don't think we would sort of, have ever, thought that they needed, it was very rare that we thought they needed any outside help or anything, that we ever went down those sort of routes, we sort of helped each other out, didn't we. We did do things like swop peoples shifts round or help them with their childcare, because they were struggling, there were always those sorts of things we did on a more personal level that we would have done, more than offered from outside	MH issues are more open Support used to be provided inhouse, now external organisational services used – increased referrals to services Used to be a more personal service	Culture/ support Culture/ support
7:1:2 (224) I think often, it happens when suddenly they might have a crying episode or something at work and then you realise, you suddenly think oh, they are struggling a bit, or whatever.	Issues are identified later, more explicit signs are observed rather than small behaviour changes	Culture / support
7:1:2 (226) you do pick up on somethings like, some of them, particularly some of the new ones, they might be a bit slower or you find them doing odd little things and then when you question them you find that they haven't come across this before and they don't feel they can ask people.	Newer staff appear less forward in asking for support/ help	Changing culture affects support
7:1:2 (231) There are different personalities and they have different experiences and sometimes I think it's because they start showing some emotional thing before you realise, unless it's something fairly obvious but I don't think we always realise until suddenly they go off crying because something's happened and then you find that they feel they are not coping and those sort of things, so [pause]	Staff do not have the same exposure so it isn't so obvious when they haven't experienced this before, late signs of coping observed such as emotional outbursts	Organisational changes changing culture /support

Meaningful Statement - Attrition		
7:1:2 (143) whereas before we would have had a lot more staff that stay longer than we do now, we have a lot of people who don't stay that long	Attrition appears to have increased, some not staying very long	Culture change
7:1:2 (152) size of the unit, because I don't think, obviously you have got a lot more people you don't know them (emphasised the *them*) the same way as you knew people when you were a smaller unit, when you knew everybody, you virtually knew everything about everybody didn't you, and the number, the bigger the unit the more staff you've got, you don't have that with everybody, so you don't know everybody, in the same way. And obviously everybody doesn't know each other, everybody's capabilities or personalities and everything like that, so [pause]	Staff don't know each other as well, less of a family Staff don't know each other, both personally or professionally	Community change Community
7:1:2 (162), urm, I think in a way it has, [long pause]. But I also think it's a bit of a generational thing,	Additional attributes for attrition – generational attributes	Attrition – culture change
7:1:2 (165) well I, I don't think they have got the same stamina as we had.	Attributes that have changed, relating to age/ generation	Role Conception comparison
7:1:2(169) that have recently qualified, I'm not saying they want an easy life, but they don't seem to be able to take, sometimes the workload, and the pressures in the way that we did, I think, again that is a, you know with mental health issues there are much more common and obviously we have people that get stressed about things, and have issues, a lot more than we probably did, maybe we were just good at hiding it, we just got on with it, we didn't have, there wasn't the opportunity to talk and get referred for things, and certainly like when I was in the bed space and that. So, I don't know whether that's a generational thing	Younger generation and comparison to stress and workload, less ability to cope, increased MH issues, Acknowledgement that older generation may be less inclined to share MH issues and more services in comparison to previous years	Resilience Resilience
7:1:2 (186). But I don't think I, I don't think it's any different to, I just think, it's a just a different way they have been raised. What they have been, school, you know, I look at my girls, I think, it was different we all, accepted things probably, maybe that we shouldn't have done, and got on with it, but wasn't really anything else that you could do. Some people fell by the wayside and some people needed support but again, I think, because we all knew each other, we knew when someone was	Pressures of CC haven't changed, considered that upbringing has, generational attributes have changed, older staff more accepting Previously more likely to 'just get on with it' More familiarity with each when there was smaller staff	Resilience Resilience

not, because you knew them so well, you knew when there were slightly off and that, and everything, then we would be looking out for them a bit more, supporting	numbers and smaller unit which ensured recognition of when support is needed	
7:1:2 (195). And I think, now again because of how many there are you don't pick up on those things.	Negative impact of larger unit, reduced recognition of when support is needed	Effects of large units' Organisational issues
7:1:2 (294) like driving I couldn't work anywhere else I don't drive.	Personal logistical reason to remain on ITU	Logistics of mobility
7:1:2 (301), I suppose it is the fact that how you know the staff and how they work, and they know and you work and everything as well.	Importance of relationships to identify when support is needed	Fear of change
7:1:2 (415) [pause] I think currently, recently probably because of the job situation generally shortages of nurses, there are a lot more opportunities for people	Increased opportunities elsewhere	Attrition – increased opportunities
7:1:2 (417), want to develop, want to move on very quickly don't they, the ones been qualified, a year or two [pause]	Reduced promotion in CC, waiting game	Career aspiration
7:1:2 (422) So they have in a way that we probably didn't when we qualified, they've often got their career plans thought out already haven't they, which was something that I wouldn't have had,	This generation have career plans, older generation this wasn't so evident in all staff	Career aspiration
7:1:2 (424) and I think there's a lot more opportunities that come up for them and you can't blame them and having worked in critical care that gives them a good background for other things.	Increased opportunities and CC provides a good experience for those opportunities	Career aspiration
7:1:2 (427) Urm, I also think a lot of them, again its their perception isn't it, they are not sure, they haven't done a placement on critical care, they don't know anything about critical care, I think sometimes, I am not saying everyone, but some people think it's an easy option because they are only going to have one or to patients to look after and it then turns out to be, not what they had anticipated	Perception of CC, 1:1 perceived as an easy option Limited insight into CC before working there	Role conception (perception)
7:1:2 (432) I think , also for a lot of people when they come, it's a lot more stressful with the patients they are looking after, they are not	Lack of insight into the emotional labour of CC	Emotional labour lack of role conception

expecting that and that's why they don't necessarily stay		
7:1:2 (515) personality characteristic or [pause] I don't know. I honestly can't say, I think of the other people that have been there a long time and I am trying to think, what is there about all us [pause] that made us stay, and I don't know [pause]	Immediate response, limited insight or reflection *(atypical of this person)*	? characteristics which lead to longevity
7:1:2 (521) because I think of people like Maggie and Rena have retired now but I think of Maggie, Rena, Julie, Maca, you know those people, Theresa, you think of all those people, Eggy, you think of all those people and you think what is it about us, because we are all different people, all different personalities	A range of CC staff identified who have been there 30 years +, with differing personality traits, quite different individuals	Identifying numerous CCN's who have demonstrated longevity but does not understand why
7:1:2 (527) yes [pause] and there are, in terms, it depends what you term, there are some people that have been there a long time, people like Steve, Ger, Donna, and some of the overseas nurses, they have been there since they came, they have stayed on the unit, Des, Angel, they are all still there, no of them have moved	These are examples of 20years plus, again different personalities, *but actually these are in their own cliques (family groups, very close)*	Community and longevity
7:1:2 (580) Because I do still feel that I have made a bit of a difference, if you have managed to get all those cases done when you came on a 8 o'clock in the morning and you didn't think you were going to be able to do them all and you've managed to jiggle things around and by encouraging things to keep badgering people you've managed to get most of them done. But then some days I go home, and I think, I don't know what I have done that day, you can't really think, you haven't stopped but you can't really think what you've done or achieved. So, I do still enjoy some of those things, it's what makes you tick	Positive commentary about remaining in CC, personal, reflective	Reward – self satisfaction Self-fulfilment
7:1:2 (588), I don't know what personality trait it is, some people are able to handle those pressures and everything better than other people can. I don't know, maybe sometimes my expectations aren't as high as other peoples, you know in terms of, you know, some people expect to be praised and glorified and everything all the time and it's not like that is it	Not expecting glory, positive reward is related to not having high expectations of receiving this	Self- fulfilment
7:1:2 (599) it's hard to define really, if I had only done 20 years it might have been different, to	This wasn't her original plan	Career aspiration

think about why you might have, but I don't know. It certainly isn't anything you think about when you start off is it, that you will spend all of your career in one place	The changes have personally been enough, accepting of achieving highest professional band that still remains clinical. Unit expansion demonstrated enough changes over the time period	
7:1:2 (604) may be the fact that how the unit has developed and the changes, those changes were enough for me.	Internal reasons rather than external reward	Self-fulfilment
7:1:2 (607) just that those changes although they have come and you've worried about them, they are actually what has lead you to carry on, to be able to go on for the next few years, you've had those, maybe those changes were just enough. Challenges that your facing and still do. Even now the integration isn't, [pause] nightmare. I can't think	CC has been challenging, and the integration appears to remain a challenge	Self-fulfilment
Meaning full statement - Work Environment		
7:1:2 (180) *workload and pressure*], no I think that's always been the same,	Workload and pressures haven't increased over the years	Organisation issues, no change
7:1:2 (181) certainly the turnover of patients particularly on cardiac as that's the service that provides, isn't it, trying to get that throughput, and obviously, I think sometimes, that is probably an increase in pressure of what we had before, because we didn't have that facility before, did we. We didn't have the cardiac surgery and everything	Identification that the nature of elective cardiac surgery brings about additional pressure requiring quicker throughout	Identified work pressures (not there previously)
7:1:2 (279) certainly from the patient side of it and how, [pause] you know, not having the time and again that's to do with staffing levels, things like that on the wards. I just think when you hear some of the things now, we might complain and we think we are busy, got a hard life but we haven't got it anywhere near as hard as the ward has got, in terms of you know just of silly things, like getting off on time, getting their breaks and everything, it's very rare that we don't, we might be really busy but its very rare that people miss their break, they might be a bit late off but that's not common place and everything, so [pause]	Comparison to workload on wards, organisational issues such as lack of time to provide care and lack of staff breaks and not leaving work on time- more noticeable on wards compared to CC	Work context comparison
7:1:2 (364) again just the expectation these days of increased throughput, trying to accommodate that, urm trying to ensure that you have got enough	Challenges for CC skill mix, staff availability, workload and	Challenges (acceptance of these)

staff to look after manage the patients safely, they are the biggest challenges because there's not, there aren't any shifts these days where there is the right number of staff on, that we should have. Urm, and often from the skill mix and the dependency of the patients we manage that, but there are time where, we are struggling to get people in, to be able to manage those patients, those are the things that are, and ensuring the patients are looked after safely, again in terms of new ones, the skill mix, particularly on a day shift its challenging and that's usually when you know, workload is the highest, certainly elective work coming though.	patient safety relating to patient acuity and skill mix Challenge is ensuring elective work is managed	Challenges – staffing numbers Challenges – patient acuity Challenges – workload
7:1:2 (436) I think just, the demands on, because of the types of patients they might be looking after, I think some people don't deal well with patients being critically ill	Stressor highlighted - Increased emotional labour	Stressors – acuity of patients
7:1:2 (438) and certainly a lot of patients find if we are doing palliative care on patients, withdrawal of treatment, a lot of them find that hard to deal with and it doesn't, it never gets any easier but then you don't seem to have to come to terms with those sort of things	Stressor- palliative care, withdrawal of treatment	Stressors – end of life care
7:2:1 (441) Some people find that hard, urm and again I think the workload sometimes they find it too much	Stressor- workload	Stressors – workload
7:1:2 (443) And I don't know if, if they think that the grass is greener, it isn't always. Because these days we are, everybody is working constantly, trying to get more work done aren't you, in the same amount of time. 7:1:2 (447) yeh, yes.	Lack of insight into CC role, potentially some nurses think CC is easier being 1:1 care delivery Stressor- more workload in the same amount of time	Stressors- workload
7:1:2 (449) yes, because I do think, that some staff struggle with that, urm and I that sometimes on the unit people will want to go to cardiac for a time because they don't have as many patients die as general do, and they do say that. The workload is, it's different, the patients aren't, they might be sick for a short time and they recover really quickly and they are not there being ventilated for days or coming in and then dying really quickly. So often when they have had a time of that they will want to go and work on cardiac for a little while because	At this point 7:1:2 states workload has increased- conflicting earlier point Examples of coping mechanisms for emotional labour / and stress of end of life / palliative care	Stressors – end of life care Coping – resilience, bounce back

they know they are not going to have those issues about making decisions about withdrawal of treatment, or limiting treatment, or end of life care and things and they, it gives them a bit of respite from it		
7:1:2 (463) [pause] urm [pause] I don't know really, I think people find public perception or expectation hard sometimes, urm what families expect out of you, I think sometimes that is hard for people, because, again, not always but again they don't always die but the expectation is you can cure everybody and you can do everything so I think that is, its not that the patients always die but that's when you are going through the worst critical illness, and there is the pressure from the relatives, on you, asking you, wanting you to do things and always being able to and	Causes of moral distress and emotional labour - relative and family care	Stressors – family expectations Stressors- end of life care, expectations of family members
7:1:2 (470) sometimes, often it works out ok in the end but you might go through several days of it being like that, and I think sometimes people find that tough to deal with those relatives sometimes, rather than what's going on with the patient	This may be an initial family reaction which eases as they desensitise to CC	Stressors- family expectations during early admissions – families do 'desensitise'
7:1:2 (478) that's hard to say Nicky because I, I certainly, think that is a generational thing, it's a bit like they talk about people in the war, belt and braces and you just got on with it, because that is what you did and everything, and I think that is some of it, and I can't say that it's any different because I do think there is a bit, we, a bit you know, like how the sickness is, now we would have thought, you might have felt unwell, but you think, oh there's not many people on, I'm going to let my colleagues down, and they might not have enough people for the patients, whereas now in terms of the younger generation and I'm talking in terms of years not experience, they wouldn't think that, it's the slightest thing and they are ringing in sick and they're off, whereas we, the older generation in years, the more mature people don't, we don't go off sick at the drop of a hat unless we are really, and again, I think it is a generational thing	Age (generational) helps you to cope Sense of solidarity Maturity - not years of experience but in age brings solidarity, - comparison to war, belt and braces when comparing to sickness and absence	Resilience of older generation – compared to 'war' Solidarity Coping/ resilience and age
Meaningful Statement - Teamwork		
7:1:2 (121) well obviously, the team, the staff who I work with,	Second most important factor to work in CC following patient care	Sense of Community – important factor

7:1:2 (275) but its, [pause] again a lot of it is to do with who the people you work with as well, because you do develop good relationships, a lot of the time you get to know people, you go into another team its completely unknown entity, you may not have the same relationships with them	*When asked why she would be scared to do something else*- knowing your team is important, fear of other working relationships This can affect the positive nature of the work	Community – fear of unknown community
7:1:2 (386) yes, yes everyone pulling together, it's now on some shifts you're really struggling and everything and something kicks off, everybody, most people rise to the challenge, everybody chips in and everything, but those are the times that afterwards you think it was a bit horrendous at the time but actually it's all worked out hopefully well, you feel that you've achieved something that day, you've done a good job, and although it was challenging that was better than some other mundane day where you were plodding along	R*elating to positive working environment* – the team is valued, working together Teamwork especially evident during the challenging shifts	Community spirit
Meaningful Statements - Standards		
7:1:2 (263) And I think that's, that we are fortunate working in critical care and only having one patient or two patients that most of the time that you are able to do that	A privilege to be able to maintain those standards	Privilege

Appendix 13: Analysis: Clustering of Themes

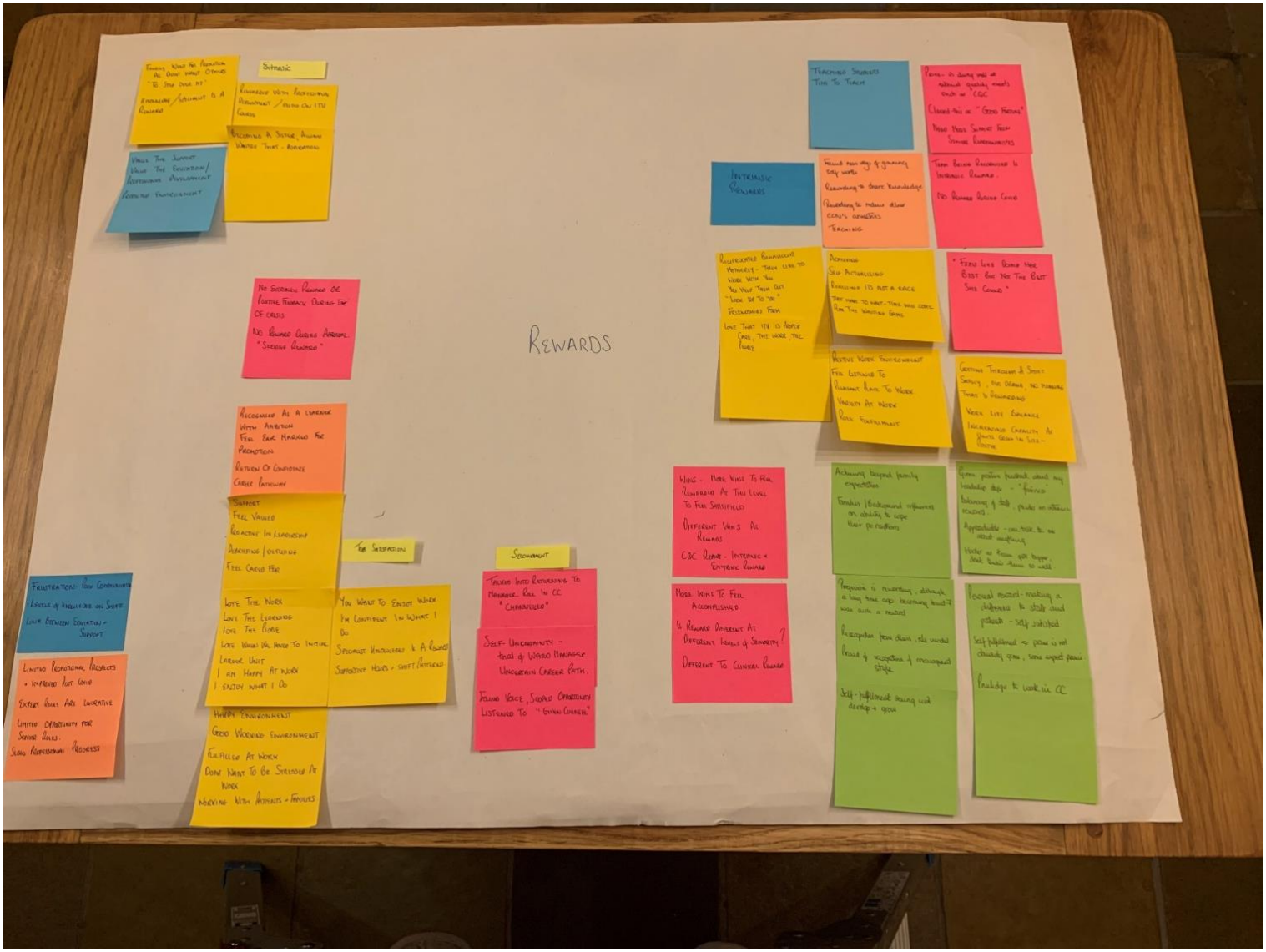

Constructs of CCN
Role
Autonomy
Ambition
Values
Identity
Voice
Stress
Attention
Resilience
Band 6
Band 7
Band 8


EMOTIONS
LOVE
REGRET
FEAR
INITIAL FEELINGS
OUTSIDER
BURNOUT
LOSS
FULFILLMENT
RESILIENCE
CONFIDENCE
JEALOUSY
FRUSTRATION


Organisation Responsibilities
Recruitment
Skill mix
Attrition
Staff leaving
Retention
Culture
Stress
Work environment
Organisation
Covid
Frustration
Moral Distress
Financial Impact


ITU COURSE
Values
Career Pause
Geographic Mobility
Influences
Culture
KNOWLEDGE
Types of Knowledge
Experiential Change
Level of Knowledge
Poor Experience
Organisation Responsibility
Developing Practice
Knowledge Bases
FRUSTRATION
BARRIERS
Staffing Affects Education / Services
Challenges – Custom & Practice
Research


LEADERSHIP
Values
Community of P
Changing leadership
Frustrations
Recruitment


REWARDS
Extrinsic
Intrinsic Rewards
Teaching Students Time To Teach
Team Recognition Is Internal Reward.
No Formal Recognition Given
Feeling Like Doing More Best But Not The Best She Could
Recognized As A Leader With Ambition
Feel Ent. Married For Promotion
Return Of Confidence
Career Fulfillment
No Socially Rewarded Or Positive Feedback During The Of Crisis
No Rewards Outside Annual "Success Reviews"
Support
Feel Valued
Reactive To Leadership
Parenting / Outside
Feel Cared For
Job Satisfaction
Love The Work
Love The Leadership
Love The People
Love What We Have To Initial
Leave Unit
I am Happy At Work
I Enjoy What I Do
You Want To Enjoy Work
I'm Confident In What I Do
Specialist Knowledge & A Reward
Supportive Heads + Staff / Attitudes
Secondment
Talked Into Returning To Manager. Rec In CC "Channeled"
Seek- Uncertainty - Lack of Work Manager Uncertain Career Path.
Found Voice, Seeks Opportunity Listened To "Given Career"
Frustration: Low Confidence
Limited Promotional Prospects + Interest Not Good
Extra Roles Are Lucrative
Limited Opportunity for Senior Roles.
Slow Professional Progress
Happy Environment
Good Weekend Engagement
Fulfilled At Work
Don't Want To Be Stressed At Work
Working With Patients + Families
Wins - More Want To Feel Rewarded At This Level To Feel Satisfied
Different Wins As Rewards
CQC Rewards - Intrinsic + External Rewards
More Wants To Feel Accomplished
Is Reward Different At Different Levels of Seniority?
Different To Clinical Rewards
Achieving beyond family expectations
Families / Background influences on ability to cope their perceptions
Positive feedback about my knowledge skills - "Patience"
Relationship of staff - provides an effective structure
Appreciation - constant & on small successes
Visible as known, safe support, check back down to ward
Recognition is rewarding - although a long time ago becoming Band 7 was quite a moment
Perception from others, the model
Result of acceptance of management style
Self-fulfillment seeing ward develop + grow
Personal reward - working a difference & staff could feedback - Self satisfied
Self fulfillment - person is not clinically given, some expect praise
Privilege to work in CC

Appendix 14: University & Heath Research Authority Approval

20/DEC/2019

Short Project Title: **Critical Care Nurses Thriving or Striving through Workplace Adversity**
Sponsor RG code: **RG-0297-19**
IRAS ID number: **263561**
Chief Investigator: **Nicola Witton**

Sponsor Regulatory Green Light

Dear Mrs Witton,

The following documentation has been received by the Research Integrity Office:

- REC approval letter, dated 11 January 2019, and all conditions are confirmed as having been met
- HRA approval, dated 18 December 2019

Subject to appropriate approval / agreement by participating sites, the study may now commence. It is your responsibility to ensure that the HRA processes for confirming capacity and capability are followed (http://www.hra.nhs.uk/resources/hra-approval-guidance-for-sponsorschief-investigators-working-collaboratively-with-nhs-organisations-in-england/), that appropriate training is provided, site initiation visits are arranged if required and that agreements with sites are in place prior to the start of recruitment.

The Research Integrity Office must be contacted if any advice is required regarding compliance with regulatory issue or if there are any doubts about participant safety, reporting requirements or scientific integrity of the study.

Yours sincerely

[redacted]

[redacted]
Research Integrity Manager
Directorate of Research, Innovation and Engagement
Keele University

cc:

Directorate of Research, Innovation & Engagement
Keele University, Staffordshire ST5 5BG, UK
www.keele.ac.uk +44 (0)1782 732000

Appendix 15: Site Access Letter

[redacted]
NHS Trust

Research & Development Directorate
[redacted]

From: [redacted]
Research & Development Directorate
[redacted]

Tel: [redacted]
Fax: [redacted]

Mrs N Witton
[redacted]

Date: 23rd January 2020

Dear *Nicola,*

Letter of access for research – Critical Care Nurses Thriving or Striving Through Workplace Adversity

This letter should be presented to each participating organisation] before you commence your research at that site. The participating organisation(s) is/are: [redacted]

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **24th January 2020** and ends on **15th February 2021** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from [redacted]
Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from the individual organisation(s) of their agreement to conduct the research.

Chairman: [redacted]
Chief Executive: [redacted]
Preventing Infection - Protecting Patients

A Teaching Trust of the University of Birmingham

Safe & Effective | Kind & Caring | Exceeding Expectation

use the NHS Number

POSITIVE ABOUT DISABLED PEOPLE

The information supplied about your role in research at the organisation(s) has been reviewed and you do not require an honorary research contract with the organisation(s). We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to the organisation(s).

You are considered to be a legal visitor to the organisations premises. You are not entitled to any form of payment or access to other benefits provided by the organisation(s) or this organisation to employees and this letter does not give rise to any other relationship between you and the organisation(s), in particular that of an employee.

While undertaking research through the organisation(s) you will remain accountable to your substantive employer but you are required to follow the reasonable instructions of the organisation(s) or those instructions given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the organisation(s) in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the organisations policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the organisation(s) in discharging its/their duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisations premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at that organisation.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 2018. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the organisations premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation(s) do not accept responsibility for damage to or loss of personal property.

This organisation may revoke this letter and any organisation(s) may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation(s) or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 2018. Any breach of the Data Protection Act 2018 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in each participating organisation and the R&D office in this organisation.

Yours sincerely

[redacted]

R&D Directorate Manager

[redacted]

cc: R&D office at [redacted]
HR department of the substantive employer – Keele University