What keeps nurses happy? Implications for workforce well-being strategies

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Abstract

Aim The aim of this article is to present selected findings from a doctoral study on the subjective well-being and subjective experience of mental health problems in UK mental health nurses. Here the concept of ‘nurses’ well-being’ is explored.

Method Data were drawn from a survey of 237 mental health nurses about their mental health and well-being and from interviews with 27 mental health nurses with personal experience of mental health problems and high subjective well-being.

Results While nurses’ subjective well-being is relatively low, some use strategies to support their well-being in and outside the workplace. Activities outside work that improved their wellbeing were physical exercise, mindfulness practice, spending time in nature and listening to music. Well-being was associated with clear boundaries between home and work life, regular clinical supervision and translating learning from work with patients to nurses’ own lives.

Conclusion Healthcare employers’ staff health and well-being strategies should be informed by nurses’ insights into what works for them. This may mean offering opportunities to take part in well-being activities. There are also opportunities to improve staff well-being through shared initiatives open to nurses and patients, and through an inclusive and empowering approach to staff engagement.

Keywords
burnout, management, morale, staff welfare, ward managers, workforce

Introduction

The health and well-being of the nursing workforce is vital to the health and well-being of their patients, not only because of the effects on safe staffing of absenteeism, presenteeism, staff sickness, turnover and retention, but also in terms of morale and patient safety (Gärtnér et al 2010, Maben et al 2012). Healthcare workers experience high levels of mental ill health and distress (Boorman 2009). Addressing this is a policy priority in the UK to the extent that a ‘staff well-being’ Commissioning for Quality and Innovation (CQuIn) standard was added to the 2015 NHS Standard Contract (NHS England 2016) requiring NHS organisations to develop employee well-being schemes.

While much has been written about healthcare workers’ stress and burnout, there has been less focus on their well-being from a ‘happiness’ or positive psychology perspective. In happiness research, ‘global’ subjective well-being (SWB) is differentiated from ‘domain-specific’ SWB, wherein people evaluate or experience a part of their life, such as work or home life, positively.

Global SWB can be defined as a combination of people’s overall experience of positive and negative emotional states (the hedonic aspect), with their overall estimation of life satisfaction (the evaluative aspect) and their sense of meaning or purpose (the eudaimonic aspect) (Waldron 2010).

As Slade (2010) points out, positive psychology, or the study of happiness, as opposed to the study of pathology and mental distress, has much to offer mental healthcare, aligning well with the recovery-oriented approach prevalent in contemporary mental health practice. A positive psychology approach means identifying and enhancing what works, rather than focusing on and reacting to distress and pathology.

Research on nurses’ SWB identifies a correlation between their happiness and some means by which this can be improved.
Qualitative studies suggest that nurses can improve their SWB through personal development and self-care, by using relaxation and mindfulness techniques, enhancing a mind-body-spirit connection and making healthy lifestyle choices (Rose and Glass 2006, 2009, 2010, Drury et al 2013), developing personal coping mechanisms (French et al 2011), developing a ‘work persona’ and managing the ‘porous’ boundary between work and life (Mackintosh 2007, Skinner et al 2011). Certain traits and approaches to life, such as hardiness (Abdollahi et al 2014), defined as the extent to which people handle life events with commitment, control and challenge (Khoshaba and Maddi 2008), are associated with higher SWB.

The literature on health and social care workers’ well-being often refers to ‘self-care’, meaning strategies used to look after one’s own health and well-being. Self-care is conceived as the actions people take to cope with stress and burnout or compassion fatigue (Kravits et al 2010), and self-care strategies are regarded by some authors as vital for mental health professionals (Barnett 2007, Telepak 2010). Synonymous with the concept of self-care is self-nurturance, when individuals make holistic healthy lifestyle choices.

Self-nurturance in nurses is associated with life satisfaction and a happier work environment (Nemec 2007, Nemec and James 2007). Jacobs (2013) found that nurses who undertook more exercise and healthy eating had higher Satisfaction with Life Scale (SWLS) scores and less depression.

Well-being interventions such as mindfulness training (Lan et al 2014) and meditation (Pal 2011) affect happiness and stress management positively in nurses (Pal 2011, Ward 2011), doctors and social workers (Shier and Graham 2011, McCann et al 2013). These practices may also be likened to the ‘self-nurturance’ described by Nemec (2007) and Rose and Glass (2010).

Social environments also affect nurses’ well-being. Managerial involvement and mutual support with colleagues influence well-being (French et al 2011), just as peer relationships, collaboration and positive working relationships are central to work engagement and satisfaction for nurse managers (Zwink et al 2013). Workplace well-being is also associated with flexible and fair working arrangements (Freeney and Tiernan 2009) or working part time (Harris et al 2010, Skinner et al 2011).

In summary, research suggests that nurses’ SWB is associated with numerous individual, personal and social factors, while working environments and satisfaction with work play a part in global and domain-specific SWB.

**Aim**

The aim of this study was to explore how UK mental health nurses, with personal experience of mental health problems and high SWB, negotiate, use and manage their own mental health and well-being. The implications of the findings for the care and treatment of nurses with mental health problems are discussed elsewhere (Oates et al 2016, 2017). This article focuses on two sub-themes relating to nurses’ SWB that are of interest to nurse managers: activities to improve well-being and well-being in relation to work.

**Method**

This was a sequential explanatory mixed methods study following the methodology described by Cresswell and Plano-Clark (2011). Phase one was an online survey, and phase two was a set of semi-structured interviews. Results from the statistical analysis of survey data were used to inform the semi-structured interview topic guide.

**Ethics**

Ethical approval was given by the author’s institution. Participants were given details of the study protocol, procedure and aims, gave informed consent to take part and could withdraw from the study up to the point of analysis. Pseudonyms are used throughout the reporting and analysis to maintain confidentiality and anonymity.

**Data collection**

An online survey was sent to mental health nurse members of the Royal College of Nursing and the Mental Health Nursing Association, of the union Unite, between January and September 2013. The survey comprised questions about demographics, SWB and personal experience of mental health problems. Three SWB measures were used, the Office for National Statistics (2012) Subjective Well-Being Questions (ONS SWBQ), the SWLS (Diener et al 1985) and the Warwick Edinburgh Mental Well-Being Scale (Tennant et al 2007).

There were 237 survey responses. Calculating an accurate response rate was impossible because the exact number of nurses who read the survey invitation could not be confirmed. 27 survey participants took part in semi-structured interviews exploring the themes raised in the survey.
Interview participants were purposively sampled, meaning they were approached for interview because they scored a high SWB according to the three SWB scales, and reported some personal experience of mental illness. The rationale for purposive sampling was to capture data on a previously unstudied group, namely nurses with high SWB who also had personal experience of mental illness.

**Data analysis**

Survey responses were analysed using statistical analysis software SPSS version 21 and descriptive statistics, including mean, standard deviation (SD), were calculated and T-tests and one-way analyses of variance were undertaken. Interview transcripts were analysed using Braun and Clark’s (2006) phased thematic analysis approach, which allows researchers to ‘ground’ analysis using themes that emerge from the data and pursue themes that address the research questions.

**Findings**

**Participants**

A total of 237 nurses completed the online survey; their demographic profile was similar to UK mental health nurses in previous studies (Edwards et al 2000, Johnson et al 2011). Most survey participants were female (71.6%, n=169), most were white British (85.7%, n=203) and most worked full time (75.7%, n=174); more than one third were aged between 40 and 49 years (34.2%, n=80).

Of the interview participants, 22 (81.5%) were female and five (18.5%) were male; their nursing experience ranged from newly qualified to 35 years. They worked in a range of nursing roles, including bank nurse, ward nurse, community nurse and specialist cognitive behavioural therapist, and lived and worked across the UK.

**Survey findings**

Survey participants had relatively low SWB compared with participants in general population studies (Oates et al 2017), and their mean SWB was low across all three measures. They were ‘slightly satisfied with life’ according to the SWLS, had low ONS SWBQ life satisfaction, low happiness, medium anxiety and a medium sense that life was worthwhile. Demographic factors, such as age, gender, household size and work status were not significantly associated with scores on the SWB measures (Oates et al 2016).

**Interview findings**

Thematic analysis of the interview transcripts identified four core descriptive sub-themes under the major theme of SWB: ‘activities to aid my SWB’, ‘other people and my SWB’, ‘attitudes for SWB’ and ‘SWB in relation to nursing work’. Across the four core descriptive sub-themes, three underlying interpretive themes emerged, manifested in an underlying common language used to describe exactly how other people, work, attitudes and experiences positively affect SWB. The underlying themes were ‘choice and control’, ‘distancing and connecting’, and ‘nurturing myself’. Findings for two of the descriptive sub-themes, ‘activities to aid my SWB’ and ‘SWB in relation to nursing work’, are presented here with interwoven reference to the underlying themes, as these are the most pertinent to nurse managers.

**Activities to aid my well-being**

Four linked activities emerged as central to good SWB: exercise, practising mindfulness, being in nature and listening to music. Participants talked about how the activities supported their SWB by giving them time and space for themselves. They created a distance between themselves and their work or between themselves and difficult situations.

The activities were also ways of self-nurturing: ‘I cycle to work, so, from that perspective, I’m 20 minutes if I cycle from work, so, by the time I get home, it’s drifted off my shoulders’ (Lucy) and ‘It’s about having a bit of space where I’m just doing something for me’ (Rose).

The perceived benefits of exercise for SWB included ‘clearing the head’ (Yvonne), controlling thoughts, and distancing from difficult situations. Yvonne undertook triathlons and trained for competitions, and said sport helped her feel ‘healthy and balanced’.

Jackie was a regular runner who took part in competitions, while others took Zumba or yoga classes, attended gym sessions or went for walks. Norman cycled, and played badminton with a work colleague. Exercise was also associated with the other ways of enhancing well-being: being in nature, music and mindfulness.

For many, physical activity was associated with being outside: ‘Swimming outside in the lakes and the rivers and the seas’ (Yvonne), or dog walking in woods and by the sea. For Fiona, physical activity was associated with not thinking too much, and taking a break from thinking.
Participants used mindfulness techniques to manage difficult emotional responses to situations and ‘bring things into perspective’ (Zoe). They talked about learning the techniques through books or courses associated with their nursing work, and continuing to practice these on their own. They promoted mindfulness to partners and patients: ‘That is lived experience and I find it beneficial now to be able to say to them, “I use it and these are the times I use it, and actually it’s really helpful for me so it could be helpful for you. Give it a go; don’t just dismiss it.”’ (Christine).

Mindfulness was associated with having control and choice about how they felt, and about having perspective and awareness. Through mindfulness, the interviewees could manage their internal responses to a situation. Christine used a ‘descriptive’ technique to ‘bring me back into the moment, bring me back into myself’. When participants talked about mindfulness, the underlying themes of self-nurturance and creating both distance from and connection to others emerged: ‘... to step back and just look at the situation for what it is, and not let it take over. Which is... really helpful. So being aware of the thoughts before it being distressing’ (Lucy).

Practising mindfulness was a way of looking after the self by changing a response to distress. While this could be learned, it could also be something more innate. Christine’s mindfulness training at work had led her to identify and name some of her pre-existing approaches as ‘mindful’. In this case ‘mindfulness’ was a disposition or trait that she could now name and consciously use rather than a new skill. Participants described how ‘being in nature’ made them happy. This was often associated with taking exercise, when participants talked about running, cycling or walking by the sea or in woods. For Chloe, Fiona and Rob the sounds of nature were particularly beneficial. Being in nature was about connecting with something beyond human that could bring about a change in their mental state.

Chloe described the profound effect being in nature had on her view of life: ‘So, what I’m saying is, is that, me stood by a beach, I’m the microcosm and it just reminds me that everything that I come across, everything that I’m experiencing at the minute is really small, and it’s just, like, it’s nothing, it is a blip in time and, you know, it kind of, gives me some perspective.’ Being in nature enabled a sense of connection and distance, and it was a way that participants could nurture themselves. Participants connected with the macrocosm and the ‘natural’ world: ‘Being in nature’ created a distance between the person and the environment of the home, hospital or office.

Music was frequently associated with SWB, whether making or playing it. Rob and Ryan were in bands and playing music with other people brought them pleasure. Music helped them to connect with people. Fiona, on a more solitary note, described the benefit of sitting at home playing a musical instrument. Listening to music was also associated with exercise and movement, whether being played while running or being ‘turned up loud’ (Monica) when driving away from a difficult day at work. Music was a means of changing and controlling mood. Ryan referred to his experience of mindfulness classes at work to articulate the power of music: ‘I get a similar thing when I listen to music, sort of almost escapism I suppose, clearing your mind and just focusing on what you’re listening to or what you’re doing at that moment.’

Subjective well-being in relation to nursing work

‘I’m quite a positive person and quite open, so take a step back from things, you know, and let things not get to me as much, which I can personally offer support for. You know, student nurses and newly qualifieds’ (Lucy).

Participants’ overall SWB was associated with how they managed their work. They were all working with people in crisis and distress, and described working in teams and organisations in which there were tensions and challenges. Feeling positive, or not, about life in general was associated with what resources they considered they had to address their responses to work: ‘One of the things I would say: don’t live on top of your work. As far as possible have clear boundaries about when you work and even if you’re working at home have clear boundaries’ (Fiona).

The nurses described how they separated their home and work life as a way of maintaining their SWB. Analogies used included physical distancing and compartmentalisation. Some respondents talked about the use of self-awareness to notice how work was making them feel: ‘Yes, because I noticed myself getting very tense and awareness of how my muscles feel, that sort of thing, and so I’m able to let go and not sort of be gripping on to the chair or whatever’ (Norman).

For some, being able to distance themselves from work was associated with having self-worth and valuing one’s own views: ‘I suppose, over 20 years, that’s what I’ve learned. Work is work, and you do it then,
and home time is home time and you do that then, and, you know, if I don’t well... I’ve got quite good now at switching off’ (Yvonne).

There was a work self and a home self. Interestingly, even when participants were experiencing mental health problems they felt capable of managing other people’s problems at work, for example Jackie talked about experiencing depression, but being able to put on a ‘work face’ nonetheless. The nurses set limits on how much of their self they revealed at work, both with service users and colleagues. Diana worked with children who were abused and had a young family herself, and she described using a visualisation technique to put her work concerns ‘in a box’ at the end of each working day.

Clinical supervision was commonly seen as vital to SWB at work, and an opportunity for participants to reflect on their practice and seek guidance from peers or seniors. This was part of how nurses self-nurture. It affected SWB positively by providing a safe space to explore difficult cases and to seek reassurance and connectedness with others. Joanna and Neil, who both work with young people with traumatic family histories, relied on supervision to contain and contextualise their work. Joanne said: ‘I am very much aware of vicarious trauma and, because I’ve got that, I learned quite early on in my career... I’ve always ensured that that doesn’t happen to me. I’m always the one to use supervision at work.’

Not all participants were involved in regular supervision, and those who were not saw it as a failing of their service or organisation. Where an employer did not provide supervision, two participants arranged their own. Some participants were supervisors themselves and saw this as a significant responsibility. They enjoyed this aspect of nursing practice, in terms of supporting others and because it allowed them to connect with their colleagues. Clinical supervision was regarded as affecting SWB positively by distancing the nurses from challenging situations and connecting them to colleagues. Making sure that supervision arrangements were in place was a form of self-nurture.

Being mental health nurses gave participants access to opportunities of learning ways to boost their SWB. As identified earlier, a common aspect of participants’ comments about SWB was that the skills they used to look after their SWB had been learned from, or formalised through, their work. Respondents brought their distinct professional perspectives to bear; for example, Patty, a cognitive behavioural therapist, said she used cognitive behavioural therapy (CBT) relaxation techniques to manage her anxiety and to ‘challenge negative thoughts’. Carrie was also a CBT practitioner, and described her improvement in well-being in CBT terms, talking about behavioural activation through going for walks and keeping a ‘positive log’ every day, akin to a gratitude journal. Ellen talked about her personal ‘wellness recovery action plan’ (WRAP) (Copeland 1997), using mental health practice terminology to describe her approach to her SWB. Christine, and other respondents who worked with people with personality disorders, described using work-learned techniques to manage their own mental health, such as mindfulness. This use of therapeutic techniques also helped Christine connect better with her patients.

**Discussion**

The survey found that mental health nurses’ SWB in general was below national averages (Oates et al 2016). This makes the case to address nurses’ well-being. While the survey revealed no associations between demographic and workplace factors and SWB, the mental health nurses who were interviewed made connections between their SWB and certain activities, and aspects of their relationships with other people and with work. A common language was used to describe how or why attitudes, experiences or relationships promoted SWB, according to three underlying themes: ‘nurturing yourself’, ‘distancing and connecting’ and ‘choice and control’. The interview findings are supported by previous research on SWB in other populations and on aspects of positive mental health in nurses and their colleagues, particularly coping and resilience (French et al 2011, Skinner et al 2011, Drury et al 2013).

When asked to say how they looked after their SWB, participants described various ways in which their well-being was promoted and maintained. These included having a healthy work-life balance and making a clear distinction between home and work life, as well as regular clinical supervision. The nurses talked about how they looked after their SWB by separating work life from home life and setting limits on the effect of work on the home. This was in the context of creating some ‘distance’ from work, creating ‘a balance’ and having choices about their working circumstances.

There is a body of evidence to support the participants’ views that work-life balance is vital to SWB (Rose and Glass 2009, Ward 2011). Having a good work-life balance is
linked to what Luthans and Jensen (2005) called ‘positive psychological capital’ in American nurses and is a characteristic of ‘resilient practitioners’ of social care (Beddoe et al 2013). Perceiving a balance between work and home life is associated with the affective and evaluative aspects of SWB (Gröpel and Kuhl 2009). The nurses had learned to balance work and home over their careers and related their SWB to skill at negotiating what Skinner et al (2011) described as a ‘porous boundary’ between work and home. Skinner et al’s (2011) participants described ‘negative spillover’ between work and non-work life, not least because of nurses’ personal commitment and investment in work. In contrast to Skinner et al’s participants, the nurses in this study described how they maintained a boundary between work and home successfully.

Clinical supervision was considered an important way of maintaining SWB in relation to work, and an important aspect of nurses’ self-care, and this is borne out in previous studies. Nurses value the emotional support formalised by clinical supervision (Edwards et al 2000, Royal College of Nursing 2013), it is integral to their sense of professional satisfaction and quality of care (Rose and Glass 2006) and it positively affects their job satisfaction and experience of stress (Hyrkas 2005). Nurses with ‘efficient clinical supervision’ have better well-being at work than their colleagues and are more motivated and committed (Koivu et al 2012a, 2012b). However, mental health nurses who attend clinical supervision groups can also experience higher stress and perceive their shortcomings more (Severinson and Hummelvoll 2001), and this could be linked to their development of a heightened moral sensitivity.

This study suggests that nurses’ SWB can be enhanced through their work as well as outside it. The positive effect of coping and well-being interventions aimed directly at nurses has been measured in several studies (Ostermann et al 2010, Appel et al 2013, Bolier et al 2014). Nurses in this study did not have well-being promotion interventions aimed at them, and instead had picked up techniques to enhance well-being incidentally or had learned a new language at work to describe what they used themselves informally. A unique finding is how the interview participants described their own SWB through the lens of their professional perspective. They applied their learning from work to understanding and managing their own SWB. This is not discussed in the literature reviewed for this study. When researchers have spoken with nurses about their coping skills and strategies, this has not been explicitly linked to the skills they may be teaching service users as part of their work (Burnard et al 2000). This suggests there is more that employing organisations can do to support the SWB of nurses.

**TABLE I. Implications for nurse managers**

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<thead>
<tr>
<th>Findings</th>
<th>Implications for nurse managers</th>
<th>Examples</th>
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<tr>
<td>Generally, nurses have low subjective well-being, but some have high well-being. We do not know enough about what ‘happy nurses’ do to stay happy</td>
<td>» Well-being strategies should aim to improve nurses’ well-being</td>
<td>» Include well-being monitoring as part of staff surveys and evaluation of well-being initiatives</td>
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<tr>
<td>Four linked activities emerged as central to good nurses’ well-being: exercise, practising mindfulness, being in nature and listening to music</td>
<td>Well-being strategies should incorporate ways of supporting nurses to access these activities</td>
<td>» Offer ‘short burst’ well-being activities during shift breaks</td>
</tr>
<tr>
<td>Well-being at work is associated with clear boundaries between home and work, access to clinical supervision, and learning skills to improve well-being through clinical work</td>
<td>» Well-being strategies should acknowledge the effect of working practices on well-being.</td>
<td>» End-of-shift debriefs</td>
</tr>
<tr>
<td>Underlying themes were ‘choice and control’, ‘distancing and connecting’, ‘nurturing myself’</td>
<td>Well-being strategies should empower nurses to make decisions about what works for them</td>
<td>» Review flexible working arrangements and shift patterns</td>
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their nursing staff. There is potential for shared learning and using well-being-enhancing practice between mental health nurses and their patients.

Limitations
This article presents selected findings from a wider study of mental health nurses’ well-being and mental health. Exploration of other themes and concerns is published elsewhere (Oates et al 2016, 2017) so this article, which focuses on subjective well-being, does not provide a comprehensive account of the research project.

A limitation of the study is the cross-sectional approach to the interviews, albeit part of a sequential mixed methods design. The study would benefit from a longitudinal aspect, repeating interviews with study participants, or a comparative element comparing nurses’ views with those of their managers.

Another limitation is the incalculable survey response rate. The method of accessing survey participants meant the researcher had no direct access to potential participants and that access was mediated through group emails and newsletters. The sampling limitations affect generalisability, although the final sample was demographically representative of UK mental health nurses.

The qualitative phase of the study followed a robust thematic analysis approach and was appropriate to addressing a gap in the literature, by addressing personal experiences and perspectives rather than quantifying a phenomenon. Interviews with this purposive sample of mental health nurses with high SWB and experience of mental health problems offered a unique insight into their subjective experience of nursing practice.

Implications
Table 1 summarises the implications for nurse managers and suggests how well-being strategies may reflect the findings of this study. A caveat to the approaches suggested is that this study showed that nurses value choice and control, and clear boundaries between home and work. This suggests that top-down workforce well-being strategies should account for the limited extent to which some nurses may wish to engage with organisational approaches to employee happiness. The nurses in the interviews were ‘happy’ and active in their work.

References
Boiler L, Ketebar S, Nieuwenhuijzen K et al (2014) Workplace mental health promotion online to enhance well-being of nurses and allied health professionals: a cluster-randomised controlled trial. Internet Interventions. 1, 4, 196-204.
promoting their own well-being. This suggests that employers should explore initiatives that empower and enthuse nurses to self-care as they see fit, rather than determining what those activities should be.

The positive effect of coping and well-being interventions directly aimed at nurses has been measured in previous studies (Irving et al 2009), and research on nurses’ SWB has characterised them as ‘lifelong learners’ for whom training and development are vital to their commitment to their roles (Brunetto et al 2013).

Employers should have policies that enable nurses to manage the boundary between nursing work and home life, and ensure that clinical supervision is available. They should also consider how therapeutic techniques and practices learned by nurses as part of their work can benefit them as individuals not just as practitioners.

‘Recovery colleges’, which have been set up as part of mainstream mental health services in various parts of the UK, have a philosophy that is supported by this research. In these settings service users and staff attend training together and learn together (Perkins et al 2012, Alois Zucchelli and Skinner 2013). Shared well-being sessions in a recovery college may be the ideal way to address staff and patients’ well-being.

Conclusion
The findings suggest possible interventions that could be developed and tested to improve nurses’ SWB. These include mindfulness, exercise, music making or being in nature, as well as workplace strategies such as clinical supervision, addressing work-life balance and offering nurses the opportunity to learn well-being skills that benefit them and patients.

A unique finding of this study is that nurses translated learning and skills from work to their personal lives and to their active approach to understanding and supporting their own SWB.

An important message for nurse managers is that ‘happiness’ and well-being expertise is out there in the workforce. Staff well-being strategies could take a ‘positive psychology’ perspective by reflecting the insights of nurses who are subjectively well and coping, rather than focusing on stress and burnout.


