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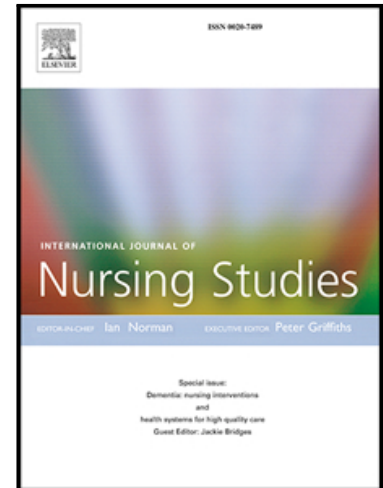
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ABSTRACT:

Background: Healthcare is delivered in a culture of ongoing change, with many nurses highlighting the impact of this on their own wellbeing. However, there is a dearth of literature focusing on how nurses care for themselves as they try to provide compassionate care in a challenging job.

Objectives: This study explored nurses' experience of self-care and self-compassion and how this may relate to compassionate care giving towards patients.

Design: A constructivist grounded theory approach was used to develop a theoretical understanding of nurses' experience.

Settings: This study included participants from two National Health Service (NHS) Trusts within the United Kingdom (UK).

Participants: Purposive and theoretical sampling were used to recruit general, mental health and learning disability nurses, at different levels of seniority.

Method: Between September 2015 and March 2016 semi-structured interviews were conducted. Analysis was completed in line with the process set out within constructivist grounded theory. Using constant comparison and memo writing, analysis moved from initial coding to focused coding, through to theoretical coding, resulting in the production of core concepts and categories, and theory development.

Results: Thirty participants were included in the study. Three concepts were derived from the data: 1) 'Hardwired to be caregivers' – vocation versus role, 2) Needing a stable base, 3) Managing the emotions of caring. All three concepts linked to a core process: needing permission to self-care and be self-compassionate. Nurses needed permission from others and from themselves to be self-caring and self-compassionate. An inability to do this affected their wellbeing and compassionate care giving to others. Interviewees described how they struggled particularly with self-compassion. Helping nurses to be proactively more self-caring and self-compassionate may increase their ability to manage emotions and prevent some of the negative consequences of nursing such as burnout and compassion fatigue. A conceptual framework is proposed which identifies that formal permission (e.g. within nursing guidance) may be necessary for some nurses to look after themselves.

Conclusion: Findings identified the need for permission as key in enabling nurses to self-care and be self-compassionate, which may facilitate them to address patients' needs. The study highlights the importance of self-care and self-compassion within nursing education and nursing guidance.

KEYWORDS: COMPASSION, COMPASSIONATE CARE, NURSING, SELF-CARE, SELF-COMPASSION

What is already known about the topic?

- There has been a focus on compassionate care giving, but little is known about how nurses care for themselves.

- The ability to apply self-care and self-compassion may reduce levels of compassion fatigue, burnout and vicarious traumatisation and foster resilience.

- Self-compassion is positively associated with wellbeing and life satisfaction.

- It is unclear how nurses perceive and experience their own self-care and self-compassion in a role that can be both physically and emotionally demanding.

What this paper adds

- Nurses require permission to be self-caring and self-compassionate and can take the form of giving permission to the self through the process of taking ownership and responsibility for his or her own wellbeing, or receiving more formal permission from another.

- Many factors can facilitate or impede such permission, including identity, early experience, feeling safe, living with uncertainty and managing the emotions of caring.

- Nursing guidance, policies, reports, the media and nursing colleagues instilled the notion that patients take priority. Whilst this was important for the role of a nurse, it was often interpreted in isolation, without consideration of the nurse's own needs, which were pushed aside in favour of others.

- Participants held a good understanding of self-care and the facets it encompassed and what it entailed for them. However, the tendency was to use self-care as a reactive coping strategy rather than as a proactive, preventative measure. If nurses are able to manage the emotions of caring by being self-aware and recognising when they need to apply self-care and self-compassion, then they may feel more able to offer compassionate care to others.

1. INTRODUCTION:

The focus of this paper centres around three terms: self-care, self-compassion and compassionate care. Self-care is defined within existing literature as the process of taking steps to and engagement in activities to establish and maintain health (World Health Organisation (WHO), 1983; Department of Health (DoH), 2005; Lee & Miller, 2013; Webber et al 2013). Literature defines self-compassion as the ability to turn compassion inwards, to be kind to the self, and to acknowledge our humanity, imperfection and fragility (Neff, 2003; Heffernan et al, 2010; Lindstrom, 2014). Whilst these two terms are inward facing, compassionate care is outward facing (with patients as a focus). It is defined within current literature as a collaboration and relational process of care, achieved by entering into the patient journey in order to relieve suffering (Fox, 1990; Nussbaum, 1996; Von Dietz & Orb, 2000; Frank, 2004; Cozens & Cornwell, 2009; Dewar et al, 2014).

Nurses tend to be closely associated with compassion in healthcare (Bivins et al, 2017). They spend large amounts of time with patients and are involved in basic and complex (sometimes intimate) care processes. In practice, they deal with multiple stressors simultaneously, in increasingly complex environments (Crary, 2013). Literature spanning a range of countries suggest that nurses appear to be under pressure to deliver care and meet targets in organisations undergoing substantial change, resulting in increasing levels of stress, burnout and attrition from the profession (Lavoie-Tremblay et al, 2008; Boyle, 2011; Rudman & Gustavsson, 2011; Li et al, 2014). It is unclear whether nurses can utilise self-care and self-compassion when facing these pressures in order to deal with their own internal processes and emotions or to cope with the environment in which they work.

Compassion in healthcare has been an area of debate in recent years on an international scale (Sinclair et al, 2017). At the same time, self-compassion as a concept has been discussed through the work of people like Kristen Neff (2003) and Paul Gilbert (2010). Increasing compassion for oneself and others is thought to decrease stress, improve staff wellbeing and patient care (Lamothe et al, 2014), whilst also maintaining organisational commitment (Lilius et al, 2008).

The term compassion and the concept of compassionate care have been embedded within international nursing policy (DoH, 2009; Curtis, 2003; Canadian Nurses association (CAN), 2008; American Nurses Association (ANA), 2011; DoH, 2012; Nursing & Midwifery Council (NMC), 2015; Sinclair et al, 2017). There has been a rising focus on compassionate care giving but little about how health professionals care for themselves. In a role that exposes them to difficult situations, such as death, illness, deterioration, and ethical dilemmas, which can lead to distress and conflicted feelings (Davidhizar, 1993; McAllister & McKinnon, 2009), it has been suggested that to provide compassionate care, nurses need to be self-compassionate (Mills & Fraser, 2014). Literature on fostering resilience and preventing burnout among healthcare professionals exists (Marsh, 1996;

Friborg et al, 2003; Newman, 2003; McAllister & McKinnon, 2009; Skovholt & Trotter-Mathison, 2011; Durkin et al, 2016), which has overlaps with self-care and self-compassion. However, it does not fully explore these concepts and how they are experienced, although it highlights that nurses may be required to foster self-care abilities to remain resilient in their work (Delgado et al, 2017).

An ability to be self-caring and self-compassionate may reduce levels of compassion fatigue, burnout and vicarious traumatisation, whilst improving staff retention and engagement, and job satisfaction (Maslach, 2003; Sabin-Farrell & Turpin, 2003; Dominguez-Gomez et al, 2009; Newall & MacNeil, 2010, Elwood et al, 2011 & Abaci & Arda, 2013). Within the existing literature, self-compassion has been associated positively with wellbeing, life satisfaction, emotional intelligence and effective coping strategies (Heffernan et al, 2010; Barnard & Curry, 2011; Reyes, 2012; Senyuva et al, 2013; Zessin et al, 2015; Durkin et al, 2016). However, it is not known how self-compassion and self-care are experienced in everyday nursing practice, how they can be cultivated, and the barriers to their use by nurses. The literature proposes a link between self-care, self-compassion and compassionate care giving (Gustin & Wagner, 2013; Dewar et al, 2014; Mills et al, 2014), but only a limited amount of research has explored self-compassion and self-care in nursing (Blum, 2014; Mills et al, 2018) and how these elements influence the delivery of compassionate care. A greater understanding of these areas will support nurses to care for themselves whilst providing quality, compassionate care for patients.

To explore these ideas and to develop a model to inform nursing practice, a Grounded Theory study was conducted. This study stemmed from a perceived need by the authors, who have a background in nursing/and or compassion in healthcare, to look at self-care and self-compassion as experienced by nurses and how they relate to, and may influence, the provision of compassionate care for others. The final conceptual framework proposes that nurses require permission (internal and external) in order to self-care and offer themselves compassion.

2. THE STUDY:

This study explored nurses' personal experiences of self-care and self-compassion in practice. It resulted in the production of a conceptual framework for use within nursing education, nursing guidance for safe and effective practice, nursing policy and nursing practice.

2.1 Aims

The study sought to explore:

- What are nurses' experiences of self-care and self-compassion?

- How do these experiences relate to compassionate care giving?

2.2 Design

A constructivist grounded theory approach was adopted, guided by the work of Charmaz (2014). Charmaz (2014) proposes the notion of theory generation, with Grounded Theory methods being used flexibly in order to recognise the role of the researcher and the ways in which theories are developed within the context of social and power relations. The interpretive nature of Charmaz's approach allows for the role of the nurse researcher, taking their personal and professional experience into account, alongside the existing knowledge informing the field of inquiry.

2.3 Sample / Participants

It was anticipated that the findings would have wider relevance if data were collected from more than one clinical setting and spanned a variety of nursing specialties (Williams, 2002). Therefore, two National Health Service (NHS) Trusts were used for recruitment.

Initially, a recruitment poster was sent via email to the research departments and nurse leaders situated in both NHS trusts. When nurses expressed an interest, they were sent the participant information sheet and consent form. Fifty-three nurses expressed an interest; 30 were recruited, consented and interviewed. The remaining 23 did not respond to further correspondence or found it difficult to arrange a time to meet. Purposive sampling was employed in this initial stage of recruitment, to ensure participants were chosen based on the qualities and variables they possessed and to find people who could shed light on the topic of interest through knowledge or experience (Bernard, 2002; Etikan et al, 2016). Theoretical sampling, as suggested by Charmaz (2014), was used as the study progressed, with participants asked to identify suitable colleagues who could enrich the emerging theory. For example, it became apparent from the data that it would be useful to sample nurse leaders and newly qualified nurses to expand some of the emerging categories and to follow-up leads within the data. Data collection ceased after 30 nurses were interviewed as data saturation was reached.

2.4 Data Collection

Data were collected via semi-structured interviews, which took place in a clinical setting (n=27), in a university office (n=2) or in a participant's home (n=1). Data were collected between September 2015 and March 2016. All interviews were conducted by the lead author, lasted an average of one hour, and were audio recorded and transcribed verbatim. Table 1 provides examples of the questions asked during the interviews.

Table 1: Examples from Topic Guide

- What do you understand by the term self-compassion?
- How able are you to care for yourself during times of stress?
- What happens regarding self-care within your workplace?
    - Is there anything that facilitates self-care?
- What are your thoughts regarding providing compassion to your patients?

Additional topics were added to follow lines of inquiry as the research evolved. These included motivations for going into nursing, nursing identity, impact of leadership, professional persona, impact of caring for patients, responsibility and permission.

2.5 Ethical Considerations

Approval to conduct the study was sought from the University ethics committee and from relevant NHS Research and Development departments.

McCosker et al (2001) highlight that consideration must be taken by the researcher if sensitive phenomenon is being researched. This was recognised within the participant information sheet and participants advised that support be sought if needed. Distress was expressed during some interviews (n=5) as participants acknowledged that they were not able to care for themselves, remembered difficult experiences, felt they had been mistreated by their organisation or expressed sadness at changes within the NHS. These issues were dealt with in the room and a follow up email. Many of the participants, not just those who had experienced distress, reflected that they found the process of talking during the interview to be cathartic, adding it had caused them to think about how to care for themselves more in the future.

2.6 Data Analysis

Initial coding allowed for familiarisation with the data. This entailed line-by-line coding to become aware of potential categories and processes (Charmaz, 2006), with initial codes being grounded in the data. Focused coding was then used to identify emerging core categories, remaining grounded in the data to some extent, but involving some clustering of ideas. The last stage of coding, theoretical coding then enabled the saturation of the core categories identified during focused coding, with the use of constant comparison allowing the analysis to become much more analytical and interpretive, in order to advance towards concepts and an emerging theory. Charmaz (2014) states that theoretical codes are used to theorize the data and focused codes help to tell a coherent, analytical story. Within this study theoretical coding clarified and sharpened the analysis, enabling the move from initial coding through to the final core process and development of the conceptual framework. Memo writing was utilised throughout to help with this process, by focusing on any coding changes or modifications, any explanations, reflections, ideas for theoretical sampling or any links to the existing literature (Pidgeon & Henwood, 1996). An example memo can be found in Box 1:

Box 1: Memo – 'Halcyon days of nursing'

'Halcyon days of nursing' – 22.03.16

Participant DQ2 spoke about the 'halcyon days of nursing', during the 1980's, 1990's and early 2000's. On further discussion the changing NHS and culture was blamed on the move to a more business-like model.

Many of the participants reflected the changing face of the NHS and nursing in general with many reasons for the changes being cited, including the above. Other changes featured the change in nurse training, negative healthcare enquiries with lessons learnt, changing management structures, more experienced staff leaving ward-based environments, a more threat focused environment and the constant restructuring.

This will require further exploration as to whether there is any research looking at the changes in nursing or whether it is a more narrative experience at present. It seems to be a recurring theme throughout the data.

A link has also been made around not being able to have fun at work anymore (participant RGN12). Why did this change? Have rules and guidance changed so much that staff feel unable to experience or have fun anymore. Is this reality or perception?

'we gave ourselves permission to have fun and we don't do that anymore (no) and I don't think we're good at doing that with our teams as well' (RGN12)

Table 2 highlights how analysis moved from raw data to a more conceptual understanding of what interviewees had discussed.

Each transcript was stored within NVIVO, which supported data analysis. NVIVO was used following coding on paper in an attempt to manage the vast array of collected data. NVIVO provided an audit trail, adding rigour to the analysis process.

Table 2: Example of how analysis moved from raw data to concepts (moving from surface level description and summarizing towards interpretation and a broader conceptual understanding)

Initial codes were developed to help give a sense of the data

Focused Codes	Categories	Core categories & Description	Concepts
			Theoretical Coding
-Having no understanding of the key concepts -Role modelling as a precursor -Being unable to engage (Recognition not leading to action) -Being blocked -Needing to recognise and engage with the self -Learning process	-Training and experience -Background and early experience -Needing role models	Motivating Factors -The nursing story and background appears important – what motivated them to nurse and how does this relate to the nursing identity. -A focus on background, early experience and early role models appears key.	'Hardwired to be caregivers' Becoming and being a nurse (Are nurses hardwired to be caregivers? What is it about their story / journey that makes this so? Nurse as self versus nurse as professional role. These can be separate or more blurred depending on numerous internal and external factors. This appears related to the ability to give or receive permission in order to care for the self).
-Nursing character -Nursing Identity -Hardwired to be caregivers -Professional role / identity -Changing roles -Possessing and presenting certain characteristics -Fear of change -Feeling punished -Needing a sense of self	-Nurse as self -Nurse as a role -Nursing Character -Possessing compassion	Nursing Identity -Self-identity, and the factors involved in this awareness. -Possessing a particular nursing character with core values. -Is compassion innate or can it be learnt and nurtured as part of the nursing identity? -Identity as a fluid process. Nurse as self and nurse as role, with these appearing blurred at times and may change related to commitment to the organisation, how the nurse has been	Giving self-permission (The ability to do this appears directly related to the factors involved with nursing identity and the motivations to nurse, including early messages, leading to

		treated and whether they feel valued.	accessibility and acceptability).

2.7 Study rigour

Rigour was demonstrated by the application of four criteria for trustworthiness proposed by Charmaz (2006, p182): Credibility; Resonance; Originality; and Usefulness. The use of Grounded Theory and following its guidelines enhanced the credibility of the current research. Polit and Beck (2008) identify triangulation as a way of improving credibility. Within this research, data were collected from a range of sources, from interviewees working in different nursing disciplines, over two NHS trusts. Triangulation was also achieved through the process of discussing the data as a team.

Resonance was demonstrated using two approaches. Firstly, theoretical saturation was reached after interviewing 30 participants, whereby no new data or leads were arising and categories were sufficiently dense. Secondly, member checking was utilised. Sandelowski (1993) identifies the twofold purpose of member checking as gaining feedback from participants pertaining to the interpretation of the data collected and allowing participants access to their data. Birt et al (2016) suggest that 'within a constructivist epistemology, it can be used as a way of enabling participants to reconstruct their narrative through deleting extracts they feel no longer represent their experience, or that they feel presents them in a negative way' (p1803). Throughout interviews, paraphrasing and summarising were employed to check the interviewer's understanding of what the participant was saying. Each participant was sent their transcript to review. All were happy with their transcripts, with no data being removed aside from a couple of words, which they felt could impact anonymity.

3. FINDINGS:

Table 3 provides an overview of the characteristics of nurses recruited based on their discipline, years of experience and role; 6 were male and 24 females. The blue lines split the groups into those who were Registered General Nurses (RGN), Registered Mental Health Nurses (RMN), Registered Learning Disability Nurses (RNMH) and those who were Dual Qualified (DQ).

Table 3: Participant Characteristics

Participant Discipline and Number	Years qualified	Role
RGN1	11	Non-Clinical Role
RGN2	29	Senior Clinical Role
RGN3	39	Non-clinical role
RGN4	36	Clinical Role
RGN5	9	Clinical Role (Trained outside of UK)
RGN6	32	Clinical Role
RGN7	29	Clinical Role
RGN8	12	Clinical Role
RGN9	17	Clinical Role (Trained outside of UK)
RGN10	40	Senior Clinical Role
RGN11	11	Senior Clinical Role
RGN12	30	Senior Clinical Role
RGN13	7	Senior Clinical Role
RGN14	29	Senior Clinical Role
RMN1	3	Community Clinical Role
RMN2	1	Community Clinical Role
RMN3	6	Community Clinical Role
RMN4	5	Clinical Role
RMN5	31	Senior Clinical Role
RMN6	28	Senior Clinical Role
RMN7	4	Community Clinical Role
RMN8	8	Community Clinical Role
RMN9	15	Community Clinical Role
RMN10	28	Community Clinical Role
RMN11	19	Senior Clinical Role
RMN12	31	Senior Clinical Role
RMN13	16	Senior Clinical Role
RNMH	7	Community Clinical Role
DQ1	33	Senior Clinical Role
DQ2	31	Senior Clinical Role

3.1 The concepts

The core concept to emerge from the data analysis was "Needing Permission" to be self-compassionate and self-caring. This core concept (which is described in more detail below) was informed by three concepts: Hardwired to be caregivers; Needing a stable base; and Managing the emotions of caring.

3.1.1 'Hardwired to be caregivers' – vocation versus role

The notion of 'Hardwired' refers to the innate need to nurse, motivations to enter nursing and how they fit with identity.

> *'you've attracted people who are of that mind set, you want to care for others, you are essentially carers, otherwise you wouldn't do the job. The nurses that aren't that way inclined tend not to be good nurses. So I think we are already in a sense hardwired to be, to be givers (ok), rather than looking after ourselves more' (RGN6)*

The journey to being a nurse appeared to be an important concept when looking at permission to apply and accept self-care and self-compassion. Nursing identity incorporated ideas of character, sense of self and compassion as an inbuilt trait.

> *'you've got to be erm you know a certain character, a certain personality erm it's such a rewarding job but it's a hard job, it's hard work you know, harder than it's ever been'* (RGN14)

> *'my view is that you're born a compassionate individual or you're not but there are some situations that people are put in that reduce that level of compassion, their ability to display it'* (RGN12)

For each nurse this is likely to be different, shaped by early influences, experiences and role models. Hence, individuals will have varying ideas about 'being a nurse'. Some viewed it as a vocation and others more as a profession or a role. There appeared to be a link between the notion of nursing as a vocation, which brings with it an element of self-sacrifice, making self-care and self-compassion more difficult.

> *'a lot of people say, 'oh nursing is what I do', but a nurse is who I am and when I'm not at work I feel a bit lost'* (RGN11)

> *'I think that sometimes people think that because you're a nurse and that's what you do for your job that you're always your job and you're always a nurse' (RMN7)*

A contrasting viewpoint appeared to be that if nursing is regarded as a profession, a job or role, then self-compassion and self-care could be more accessible and acceptable. However, data suggested a lack of clear distinction between nursing as a role or identity, with nurses often changing their viewpoints as their careers and experience progressed, or if events occurred that caused them to question their loyalty to the profession or organisation.

3.1.2 Needing a Stable Base

Data suggested that nurses need to feel safe and secure in themselves and their workplace to be self-caring and self-compassionate.

'you have to feel contained don't you as an individual and as a team and everything else, because of, you know if one, if you start to not feel that, then it starts to spread out to everything else doesn't it' (RMN3)

A number of factors can get in the way of a stable base, such as the working environment, jobs being at risk and having effective, clearly defined leadership.

'brilliant practitioners that were competent people would be coming in, in tears hiding in our recovery rooms and sort of saying 'oh god I've got to go back'...I don't think they're necessarily better or any worse than any other trust but I think they just do not value the resource they have and that's pretty apparent because we can't retain people' (RMN12)

'the best wards I've worked on is where you have really good nurse managers who recognise that terrible things happen and that sometimes staff need time out to actually process that' (RGN6)

The effects of increased pressure in the workplace, a business-orientated approach to healthcare delivery and a broken system appeared to have a de-stabilising effect; nurses could end up feeling like '*automatons*' rather than professional carers, with technical skills more highly valued compared to

relational ones.

> *'Mental Health nursing used to be about a dynamic process responding to the environment through visibility, engagement, presence and now like I say automaton is that the priority is that you've got to well I don't know you've got to do your paperwork'* (DQ2)

Data analysis showed how the changing NHS and public perceptions could interfere with a nurse's ability to feel safe and secure.

> *'If I said to people when I first started I'm a nurse I would have been perceived as an angel, you're absolutely wonderful, I don't know how we could manage without you ...public perception has changed very much so we're perhaps not seen as these, you know these wonderful beings as we once were, we're seen as maybe human beings that are fallible'* (DQ1)

3.1.3 Managing the emotions of caring

Participants wanted and needed to care for others to feel valued. It was proposed that patients come first, a notion instilled through nursing guidance and expectations of their workplace, which was also an internal driver. However, whether this should be to the detriment of oneself was questioned.

> *'I always would put my patients first but actually if I've got no self-compassion for myself and I'm not looking after myself I can't give my patients a hundred per cent so it works both ways really'* (RGN14)

> *'I think people can probably provide compassionate care, the problem is their own wellbeing may suffer because, because they're not able to be self-compassionate or self-caring so that their compassion may be almost too great if you like in terms of looking after people and not looking after themselves'* (RGN4)

Participants acknowledged that nursing could be difficult, requiring them to develop coping strategies in order to manage. This included 'turning a page' and becoming hardened through repeated exposure

or closing off.

> *'so you've got all these things going on and real horrible things erm you know real significant self-harm and traumas that children go through and you're just like 'ok right what's happened now, oh someone's been raped, oh what's happened now oh there's a suicide and you're like ok next thing lets go see' and sometimes we just get a bit hardened to that (mmm) and then when it catches all up on you and you think oh no this is awful, this has happened in one day, it's not very nice'* (RMN8)

Interviewees proposed that nurses are sometimes viewed as a resource rather than as human beings who can become exhausted when overwhelmed or placed under pressure, with burnout occurring when there is an inability to cope.

> *'you know it's tragic, you do walk on wards and find nurses who burst into tears when you ask them about things and it happens and they're getting themselves so stressed out and we don't, we don't teach them to look after themselves, we don't teach them how to recognise when things are going wrong for themselves. We teach them to recognise it in the patients (mmm) but not in themselves or in their colleagues'* (RGN2)

If participants were overwhelmed, burnt out or unable to apply self-care or self-compassion, there was a risk of 'thinner care'.

> *'it certainly makes the care that they give thinner or so it can seem, coz they're spreading themselves so thin and I think it's valuable that we look after ourselves'* (RNMH)

Findings suggest that to manage the emotions of caring, an element of permission to be self-caring and self-compassionate was required. However, balancing compassion towards the self and others was called for, as was an awareness of whether self-care and self-compassion were being used proactively in order to cope with negative effects of nursing, or reactively (when self-care and self-compassion were only accessed when nurses were already struggling).

3.1.4 Core concept: Needing permission

As mentioned above, interviewees described how permission for self-compassion was needed from themselves and from others. Permission may be given to the self by looking at the need to take ownership for one's own wellbeing. A barrier to doing this was related, by interviewees, to how self-compassion was perceived; it could be viewed as a weakness and, therefore, potentially problematic.

'I think as a profession in general we are very very bad at giving ourselves permission to look after ourselves…I was gonna say in the past but even now it is seen as a weakness, which is very sad… you are expected to push yourself to do things and I think it is about giving people permission to, just to look after themselves' (RGN2)

Conversely, an ability to be self-compassionate was depicted as a skill; if learnt it had the potential to be protective and beneficial. Hence, rather than being seen as a soft skill, it has power and can transform experiences of caregiving. There also appeared a need to understand the meaning and potential rewards of self-compassion, which again called for an acknowledgment of nurses' humanity, by self and others, alongside their professional role.

'we have to maintain a professional status I totally get that but actually we're only human and if something very very difficult and emotive is happening obviously you can't lose it and be in floods of tears…but I think it's perfectly acceptable to show that you're feeling that' (RGN14)

'the self-compassion it has to be allowed, you have to allow it, you're allowing yourself to feel it, but you also have to hope that your managers, your colleagues have room for that as well, have room for you to feel it, recognise that they need it too' (RGN4)

Numerous barriers to self-care and self-compassion were recalled by participants that were internal (e.g. nursing identity and character) or more external (e.g. the environment, targets related to care-giving expected by organisations). As a consequence, permission from another in attending to their needs was proposed. Participants mentioned the importance of formal and informal permission to be able to challenge practice, to go off sick, and to lessen the guilt of being away from work. There was a sense that this was process and policy driven, which may not be flexible enough to respond to varying professional or personal situations, acting as a potential barrier.

'nurses in particular have this thing that you plough on, you know 'what are you upset for', you plough on (yeah) and I do have concerns when the quest for personal resilience and you know sort of ends up looking like 'well each person for themselves'…I think organisations do and should have a duty to take responsibility for staff' (RMN1)

'it can't just be about you as an individual having to take responsibility, yes of course we've all got to look after ourselves, we've all got responsibility for our own health and wellbeing but I think as an organisation we work for we're meant to be a caring organisation, that says it all to me. If you can't care for your staff who can you care for' (RMN11)

3.2 Conceptual Framework

Figure 1 depicts the final conceptual framework constructed through the data analysis. It provides a visual representation of a process that may be used to inform policy, practice and education. The need for permission appeared to be central so participants felt able to be self-caring and self-compassionate. For some it was about giving themselves permission (internal) and for others it was about receiving permission (i.e. from their manager or more globally from their organisation). It could also be a combination of the two. Data suggested that if self-care and self-compassion were more understood and embedded within nursing education and the workplace culture, this would serve as a form of permission. Furthermore, a nurse's wellbeing and need to care for the self have to be acknowledged by society and patients so nurses feel they have been given permission.

The concept 'Hardwired to be caregivers' noted the impact of nursing identity and sense of self, with this often influencing whether self-care and self-compassion were viewed as acceptable when patient care was perceived as the priority. How identity was viewed appeared to impact upon acceptability of caring for the self.

The need for a stable base within a culture of change was explored, with participants identifying that if they felt safe and secure, whether this comes from the self or the environment in which they work, then permission to care for the self was present. They acknowledged that when feeling destabilised, uncertain or unsafe, they were less likely to care for themselves and more likely to experience negative emotions, with this impacting on their overall wellbeing and their ability to provide compassionate care.

Having permission, and being able to be self-caring and self-compassionate, appeared from the data to link to managing emotions that could affect compassionate care giving. There was a sense that to care for others, you must care for yourself; however, this was not seen as an easy process. Self-care and self-compassion tended to be viewed as coping strategies that were only used when participants were 'close to the edge', 'burning out' or 'becoming overwhelmed' with caring. Yet participants acknowledged that self-care and self-compassion could be employed more proactively by taking time to reflect on their needs, accepting their humanity and being kind to themselves. Data suggested that if participants were able to self-care and be self-compassionate, this would positively impact their own wellbeing and prevent them from delivering 'thinner' care, thereby enabling them to offer the compassionate care that they wanted to provide.

Figure 1: Needing Permission – Conceptual framework
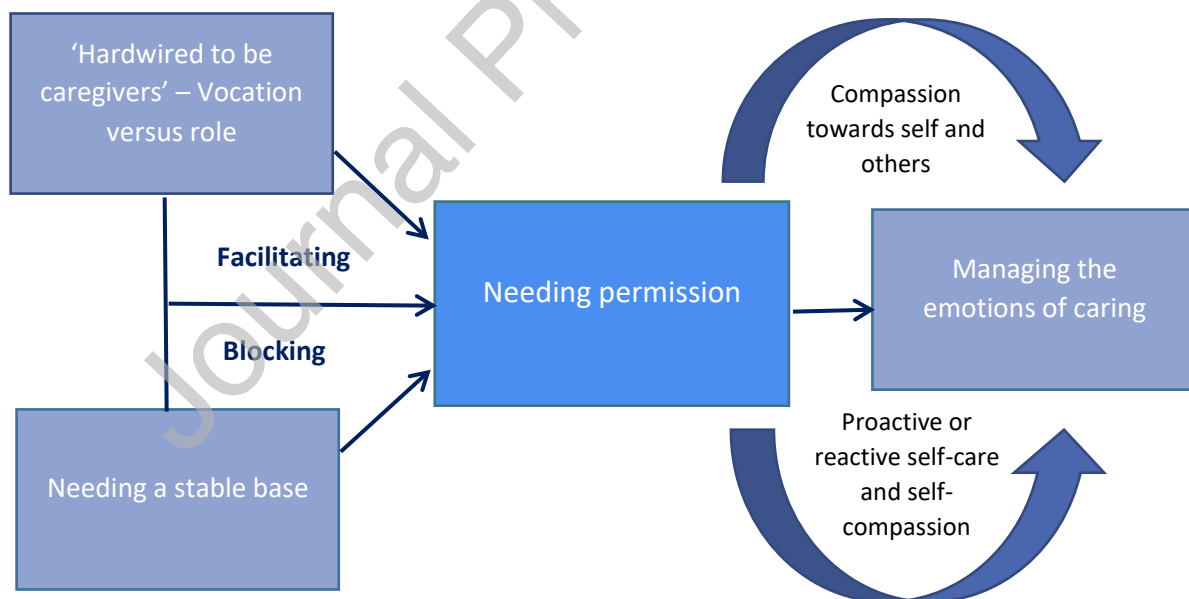
4. DISCUSSION AND IMPLICATIONS:

Due to the dearth of existing knowledge relating specifically to self-care and self-compassion in nursing, originality and usefulness of the study were demonstrated by offering novel insights and the

development of new concepts and a conceptual framework. These findings and new insights have implications for future nursing practice, education and policy.

The conceptual framework presented above situates permission as central in enabling nurses to care for themselves; this links to the management of emotions that can transpire from caring for others. Previous literature and research have not addressed this concept of permission, focusing instead on the difficulties of applying self-care and self-compassion due to embarrassment, guilt and fear of being viewed as selfish (Mills et al, 2014). Literature has also focused on fostering resilience and burnout (Marsh, 1996; Friborg et al, 2003; Newman, 2003; McAllister & McKinnon, 2009; Skovholt & Trotter-Mathison, 2011; Durkin et al, 2016; Delgado et al, 2017), but has not sought to draw out and interpret the specific meaning of self-care and self-compassion for nurses.

The existing literature focuses on instilling self-care within patients (Orem, 1981, 1985; Webber et al, 2013; Richards, 2013; Davidhizar, 1993) as opposed to such activity for healthcare staff. These ideas, alongside nursing guidance, may contribute to a belief that nurses' self-care and wellbeing are not priorities. Participants showed a lack of awareness of how ignoring their own needs may jeopardise their primary aim of caring for others, but acknowledged a frustration that they were not able or not permitted to care for themselves alongside caring for their patients. This point has not been previously raised within the existing literature.

Findings within this study highlighted that nurses live with uncertainty due to the constant change within the NHS, compounded by portrayals of nursing within the media following negative healthcare inquiries (CIPOLD, DoH, 2013; Francis, 2013; Bubb, 2014; Kirkup, 2015). The changes discussed within the data focused on service restructuring, poor staffing levels and jobs being at risk, which all seemed to have a de-stabilising effect and ultimately impacted on nurses' ability to be self-caring and self-compassionate. These challenges are also experienced by nurses in other countries and, therefore, findings from this study are likely to have meaning for nursing outside of the NHS (Jourdain & Chenevert, 2010; Li et al, 2011).

Participants identified a holistic approach to self-care, resonating with definitions of this term in the literature (WHO, 1983; DoH, 2005; Lee & Miller, 2013). However, whilst existing literature has focused on preventing ill health, findings from this study suggested nurses could recognise when they were unwell and needed to actively address this, but felt unable to act on warning signs and early stages of illness because they did not have the internal and/or external permission to be proactive. Hence, self-care was often used reactively, rather than as a preventative measure as suggested by Webber et al (2013), who proposed that self-care should be used to avert disease and illness. Reflective practice is used internationally within nursing education as a tool to embed these core ideas around recognition of impact (Ruth-Sahd, 2003; Oelofsen, 2012), enabling nurses to reflect on the

impact of their everyday practice, and therefore may be used as a means of giving themselves permission to care for themselves.

Interventions proposed within existing literature to help nurses manage the emotions of caring and to enhance wellbeing are supervision (Lyth, 2000; Edwards et al, 2005; White & Winstanley, 2010; Koivu et al, 2012; Buus et al, 2013), focusing on safety and reflexivity, staying professional and managing feelings. Schwartz rounds (George, 2010, 2016; Goodrich, 2016) can enable staff to reflect upon thoughts and feelings related to their job in a safe environment during protected time. Likewise, mindfulness (Grossman et al, 2004; Pipe et al, 2009; Hoffman et al, 2010; Cunningham et al, 2013; Halm, 2017) can reduce negative psychological states such as stress, anxiety and depression, whilst also improving self-awareness and nurturing skills. These interventions and models have proven useful to nurses but may not be available or accessible in every setting. The conceptual framework depicted within this study calls for permission for nurses to care for themselves both proactively and reactively; adopting some of these interventions within healthcare organisations may show that the emotional impact of caring is recognised and warrants attention by individual practitioners and teams.

Identity and motivations to nurse were key ideas within the interview data when thinking about permission to care and be self-compassionate. A focus on others, referred to by interviewees and in the existing literature, is key to society's construction of nursing and the notion of patients coming first (DoH, 2009, 2015; NMC, 2015). Embedding the ideas of self-care and self-compassion early on in nursing may be important in nurses' receptiveness to these activities as a means of keeping well and their ability to continue interacting with patients as desired. Current literature identifies the need for more focus on student and newly qualified nurses in dealing with the realities and challenges of this profession (Maben & Macleod Clark, 1998; Allcock & Standen, 2001; Freshwater & Stickley, 2005; Hunter & Deery, 2005; Maben et al, 2007; Lavoie-Tremblay et al, 2008; Rudman & Gustavsson, 2011; Msiska et al, 2014; Jack & Wibberley, 2014). The findings of this study provide knowledge in how to care for the nursing workforce in a proactive way.

4.1 Strengths and Limitations

There was a dearth of literature related to the field of inquiry; hence, the research offers new and significant knowledge that could a) influence nursing practice and policy, b) underpin further research and c) impact upon nursing education. Participants reflected on the importance of the research; the eagerness and ease of recruitment highlighted that it was a topic of interest.

If the study were to be repeated it would be interesting to sample children and young people's nurses (RNCs) to ascertain any similarities or differences in their experiences and the meaning of self-care and self-compassion to them. There was a lack of data related to positive recollections of self-care and

self-compassion. This could signify that interviewees had a particular experience or story to tell relating to the topic of interest, or positive experiences were fewer or harder to access. Sampling from other geographical locations might further enhance our understanding of the phenomena explored in this study.

4.2 Practice Implications

4.2.1 Nursing practice and policy

Within nursing policy and guidance (CAN, 2008; ANA, 2011; NMC, 2015), there is a focus on caring for patients, but little emphasis has been placed on the care of staff. As this study has highlighted, active engagement in self-care and self-compassion is required; even if recognised within nursing policy and practice, adequate provision, formal acknowledgment and legitimisation appear necessary for it to occur. The ability to self-care and be self-compassionate should be embedded within nursing culture to enable nurses to use these approaches continuously rather than in a reactive manner in response to difficult situations. If given this permission, it may make caring for the self a part of nurses' duty of care.

Receiving permission to care for themselves from early on within their nursing career may aid in facilitating its acceptability in everyday practice. Alongside these early key messages, nurses need to feel safe and secure at work, requiring a stable base to cope with and manage day to day distress associated with their role. Feeling supported and valued and having effective leadership were cited as key facilitators to achieving a stable base. West and Bailey (2019) suggest effective leadership should incorporate compassion, with a strong commitment to the team and a clear sense of purpose. Alongside a recognition of key healthcare challenges and wellbeing needs of staff within this (C de Zulueta, 2016), and responsibility for collective leadership within organisations (West et al, 2014).

4.2.2 Nursing research

Although this study has added to the dearth of literature related to the topic of interest, there are areas for further research. For example, research suggests that self-care and self-compassion may have a positive impact within nursing (Heffernan et al, 2010; Reyes, 2012), yet how this is achieved is unclear. Qualitative research has provided an insight into experience and meaning. Further mixed method research may be useful, so that alongside experience, relationships can also be tested (e.g. influence of engagement in self-care on compassion fatigue and burnout). Research with other healthcare professionals could explore similarities

and differences to those outlined above and further develop the study's conceptual framework, establishing whether it has resonance beyond nursing.

4.2.3 Nursing education

Nurse training did not seem adequate in enabling individuals to be self-caring and self-compassionate. Findings suggested that nursing identity played a key role in accepting permission to self-care and be self-compassionate. This often developed before but also during nurse training. Therefore, if the concepts within this study were embedded into nursing education, nurses may feel able to care for themselves from early on in their careers. This may protect them from the more negative effects of caring such as burnout and compassion fatigue. It could also enable them to be positive role models to future nurses.

5. CONCLUSION

This study set out to explore nurses' experiences of self-care and self-compassion, alongside looking at how this related to compassionate care giving. Findings showed that nurses must feel comfortable with the idea of caring for themselves in the first instance; a default position appeared to be self-blaming and self-critical, which could be tied to a perceived nursing identity as giving to others.

Self-care and self-compassion seem to be used only when nurses are already struggling, rather than in a proactive way to prevent burnout and compassion fatigue. Short-term coping strategies were employed in favour of longer-term ones, to enable nurses to carry on and see the next patient, which put them at risk of providing 'thinner' care.

Participants recognised the importance of caring for themselves as well as others but were unsure how to do so in their everyday working lives. Permission was seen to be key - from the self and others. Individuals needed to take ownership for self-care and self-compassion. Yet recognition from their managers, organisation and the nursing culture was also important. This more formal permission appeared to make the concepts of self-care and self-compassion acceptable, negating feelings of guilt and enabling nurses to continue providing the compassionate care to patients that they valued and that gave them job satisfaction.

CONFLICT OF INTEREST None to declare

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