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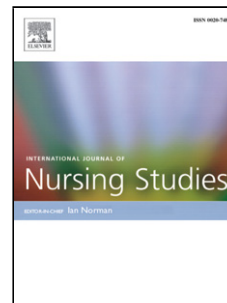
Distress in working on dementia wards – a threat to compassionate care: a grounded theory study

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Acknowledgements

Compassionate Systems: A qualitative study of structural and interpersonal aspects of managing work pressure in dementia wards

Contribution of the Paper

What is already known about the topic?

- Front-line staff working with older adults with dementia often work for long hours in stressful, difficult environments which presents a challenge to compassionate care
- Nurses tend to begin their training with good levels of compassion but that this diminishes either during the course of training or in the early years after qualifying
- Self-compassion and mindfulness are likely to facilitate compassion to others and therefore to benefit patient care

What this paper adds

- Neither Values Based Recruitment nor merely training compassion to existing staff is necessarily likely to significantly improve compassionate care
- Organisational structures can hinder compassionate care and the natural resilience of staff could be enhanced through structural factors (such as regular breaks and adequate space and resources)
- Strong professional values which may instil in care staff a belief in not displaying emotions at work may hinder the practice of self-compassion and mindfulness

Distress in working on dementia wards – a threat to compassionate care: a grounded theory study

Objectives: Nurses and health care workers are under increasing scrutiny from the general public and other professionals over their capacity for compassion. For example, in the UK, recruitment of nurses includes assessment of compassion through 'Values Based Recruitment'. However, compassionate care can be hindered when working in very challenging and pressurised environments. The study aimed to explore the experiences of managing work pressures in front-line NHS staff caring for older adults with dementia. One aspect of the analysis was to explore the factors that facilitate or hinder self-compassion and mindfulness, since these ways of responding to extreme pressure are likely to facilitate compassion towards others.

Method: Ten front-line staff (a mixture of nurses and Health Care Assistants) from three inpatient dementia wards took part in qualitative interviews which were then analysed using constructivist grounded theory methods.

Results: A theoretical framework was generated which highlighted the role of structural and interpersonal types of work pressure on individual responses and ways of managing pressure. A range of helpful and unhelpful strategies were employed and although many participants appreciated the importance of taking time to process and reflect on difficult emotions and experiences during work, there were significant structural and personal barriers to practicing mindfulness and self-compassion more fully. A sense of professionalism along with various organisational factors meant that much processing of difficult emotions had to take place largely out of work hours.

Conclusions: Recruiting staff with high levels of compassion and training compassion to existing staff are not likely to significantly improve compassionate care alone in the context of extremely challenging work environments. Rather, organisational changes need to be made to model and reward self-compassion; staff training should focus on self-compassion and mindfulness, without which compassion to others is hindered. Strong professional values which may instil in care staff a belief in not displaying emotions at work should be considered carefully by professional bodies in order to provide guidance from pre-qualification onwards about how to balance professional conduct with appropriate expression of emotion in response to extreme situations.

Keywords: compassion; dementia care; grounded theory; mindfulness; nursing; occupational health; professionalism; qualitative research; self-compassion; work stress.

Introduction
There are an estimated 44.4 million people living with dementia worldwide (Alzheimer's Disease International, n.d.) with the majority (62%) living in developing countries. In the UK 850,000 people are living with dementia (Alzheimer's Society, 2015), posing one of the most significant challenges for UK health services.

Dementia care has been under scrutiny in the UK press and in government and policy circles. The 'systemic failings' identified in Mid-Staffordshire by the Francis Report (an independent public inquiry) affected many people with dementia in the hospitals concerned, with issues around the lack of compassionate care applying particularly to this population. Following the Francis Report, there has been a push towards 'compassionate care' in the UK National Health Service (NHS) with NHS Trusts investing in both internal and external bodies to train staff to increase their levels of compassion. Training providers commissioned by the NHS are now required to adopt 'Values Based Recruitment', "an approach which attracts and recruits students, trainees and employees on the basis that their individual values and behaviours align with the values of the NHS Constitution" (Health Education England, n.d.). Those values are putting patients first, valuing every person, a commitment to quality care, striving to improve lives, inclusion and compassion (Health Education England, 2014). However, the conceptualisation of compassion as a trait, which is either present or absent in an individual, is contrary to evidence that both nurses (Smith, 1995) and doctors (Shapiro, 2008) tend to begin their training with good levels of compassion but that this diminishes either during the course of training or in the early years after qualifying (Maben, Latter & Macleod Clark, 2007). It is therefore important "to understand what interferes with learners' impulses and desires to express empathy towards patients" (Shapiro, 2008). One likely hindrance is the nature of the work environment itself.

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Front-line staff working with older adults with dementia often work for long hours in stressful, challenging environments (Deutschman, 2000). Research suggests that staff working in older adult inpatient services are exposed to different types of stressors compared to those in outpatient and community services (Pinner, Hillam, Branton, & Ramakrishnan, 2011). Caring for older adults with dementia can be exceptionally stressful due to the behavioural and psychological symptoms of dementia which can sometimes result in abusive behaviour towards staff (Beck and Shue, 1994). For staff working with older adults with dementia, client aggression and threat appraisal have been significantly associated with staff work stress (Rodney, 2000). The management of these behaviours in particular and subsequent staff distress represents a significant part of the workload for older adult services (Lawler, 2002).

A small body of research has examined the ways in which front line staff working with dementia clients experience and respond to work pressure. These have measured stress and coping alongside other variables such as attachment and self-efficacy (Kokkonen et al., 2014) aggression, personality, cognitive appraisal and coping (Rodney, 2000) and turnover (Margallo-Lana et al., 2001). Qualitative approaches have also been used to explore the experience of work-stress and coping by means of participant interview (Clinton et al., 1995) and focus groups (Edberg et al., 2008). Kokkonen et al. (2014) found that attachment insecurity, low self-efficacy and staff attitudes (pessimism) were associated with burnout and that a person centred approach was associated with a greater sense of achievement at work. Similarly, Margallo-Lana et al. (2001) found that positive coping strategies protected against psychological distress, with dementia care nurses being more likely to use positive coping strategies than care assistants. Rodney (2000) found that primary threat appraisal (perceiving the possibility of aggressive behaviour as a threat) was linked to increased stress. Using more qualitative approaches, Edberg et al. (2008) found that a primary driver among dementia care staff was 'a desire to do the best for the residents to alleviate their suffering and enhance their quality of life'. They describe this however as also the primary source of strain because nurses wanted to do much more than they actually could but were prevented by many factors including environment and challenges associated with caring for people with dementia. Clinton et al. (1995), using a repertory grid approach, found that nurses were aware of stressors in their work and had developed coping behaviours to respond to them. Factor analysis of 30 grids identified 92 stressors, of which client behaviours were the most frequently cited sources of stress with aspects of the organisation, work and the characteristics of clients next most frequent. Even the more qualitative approaches to this area have clearly been underpinned by a 'coping styles' approach based on socio-cognitive models. The present study similarly examines responses to work pressure but attempts to look at the data without assuming a coping styles model. In particular the analysis seeks to explore whether self-compassion and mindfulness can be observed in staff strategies for managing work pressure in dementia care and what factors appear to facilitate or hinder use of these techniques, since these strategies are likely to be required in order for nurses to maintain compassion towards patients (Raab, 2014).

Neff, Kirkpatrick & Rude (2007) argue that both self-compassion and mindfulness offer a buffer to the harmful effects of stress. Neff (2003) describes self-compassion as an emotionally positive self-attitude that should protect against the negative consequences of self-judgment, isolation and rumination; it is closely related to, and informed by the construct of mindfulness but also incorporates self-kindness and a sense of common humanity. Mindfulness is defined for present purposes as a "moment-to-moment, non-judgmental awareness, cultivated by paying attention in a specific way, that is, in the present moment, and as non-reactively, as non-judgmentally, and as openheartedly as possible" (Kabat-Zinn, 2005, p. 108). Working in a highly demanding occupational environment such as the current NHS, particularly in dementia wards, is likely to pose numerous barriers to self-compassion and mindfulness.

In spite of a wealth of evidence concerning the need for a whole system approach (see Crawford et al, 2014), nurses and health care workers are pressured to meet expectations of both the general public and other professionals to demonstrate compassion despite increasing work pressures (Ashker, Penprase & Salman, 2012). Different people, of course, respond differently to challenging work environments. There is evidence that training in managing work pressures using coping style approaches, as well as more contemporary mindfulness-based approaches, can reduce stress (Shapiro & Carlson, 2009). However, it is unclear whether staff intuitively use techniques akin to mindfulness or self-compassion to manage work pressures. With the current emphasis on recruiting

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staff with high levels of compassion or 'training' staff to be more compassionate, little focus has been placed on the structural and interpersonal barriers and facilitators to staff drawing upon their existing capacity for self-compassion, mindfulness and ultimately compassion to others. A focus on training compassion and Values Based Recruitment may therefore be misguided without a greater understanding of what may prevent or hinder the practices of self-compassion and mindfulness.

The study aimed to explore the experiences of managing work pressures in front-line NHS staff caring for older adults with dementia. One aspect of the analysis was to explore the factors that facilitate or hinder self-compassion and mindfulness, since these ways of responding to extreme pressure are likely to facilitate compassion towards others.

Methods
A constructivist grounded theory approach was followed, which acknowledges the subjective role of the researcher in the process of both generating and analysing the data (Charmaz, 2000).

Sample
Ward managers in five NHS Trust wards sent out study information by email; study posters were placed around the wards and the researcher (a professional doctorate trainee receiving research training and supervision) attended handover meetings to give information about the study. The final sample consisted of ten participants from three older adult dementia wards. Theoretical sampling is a key feature of grounded theory methodology and was used to guide recruitment of participants after having identified the first participant. All participants had a direct care role with older adults with dementia, worked in an inpatient environment, were aged over 18 and able to communicate verbally in English. Demographic information was provided by participants prior to being interviewed. This information is provided below in Table 1.

Table 1: Participant Demographics

Gender	Age group	Ethnicity	Job Role	Amount of time in current role (years)	Length of NHS service (years)
Male	30-40	White British	Charge Nurse	0-1	6-8
Female	30-40	White British	Charge Nurse	1-2	10-12
Female	30-40	White British	Staff Nurse	6-8	12-15
Male	40-50	White British	Staff Nurse	3-5	16-20
Female	20-30	White British	HCA	0-1	3-5
Female	20-30	White British	Staff Nurse	1-2	3-5
Female	50-60	White British	Charge Nurse	6-8	20-25
Female	20-30	White British	HCA	1-2	10-12
Male	30-40	White British	Staff Nurse	3-5	3-5
Female	20-30	White British	Staff Nurse	0-1	3-5

Procedure
Interviews using grounded theory methods are not designed to be overtly scripted or directive and should allow the researcher to be led by the participant (Pidgeon & Henwood, 1996). Charmaz (2006) proposes the development of an interview guide with an open first question (in this case "Can you tell me how you manage work pressure?") followed by a list of broad, provisional topics which would help to loosely 'guide' the interview process whilst also remaining informal and flexible. The topics broadly followed were about noticing emotions, noticing surroundings, reacting to emotions and tolerance or kindness. Questions in these topic areas were constructed *in situ* using participants' own words. Glaser and Strauss (1967) suggest that initial interviews are likely to be less directive, whereas subsequent interviews utilising theoretical sampling based upon the emerging theory are likely to bring a 'sharper focus'. Before commencing the interview, all participants were given time to read the information sheet, ask any questions and sign a consent form. Participants chose where to be interviewed; nine were by telephone and one at the participant's home. Interviews lasted between 35 and 78 minutes. After ten interviews, all authors agreed that "theoretical sufficiency" (Dey, 1999) appeared to have been reached. All interviews were carried out by [ZA], digitally recorded and transcribed verbatim.

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Analysis

Interviews were subjected to initial coding using MaxQDA by [ZA]. This involved attaching labels to segments of data to depict their content and enabled sorting and constant comparison with other segments of data. Coding progressed through three stages, initial, focused and theoretical (Charmaz, 2006). This method resulted in the formation of overarching categories which informed the theoretical model. All authors were involved in the latter stages of analysis.

Researcher Reflexivity

Charmaz (2006, p. 188-189) defines reflexivity as the researcher's ability to scrutinise their "research experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interest, position and assumptions influenced inquiry". Therefore, a reflective diary was used by the researcher to record her thoughts, feelings and opinions throughout the interviews and data analysis. The researcher had spent time on inpatient dementia wards as a trainee clinical psychologist prior to undertaking the research and had experienced this as both stressful and distressing. She was also aware of the extensive media coverage raising awareness of the serious consequences of poor care and neglect in hospitals and residential care homes. It was therefore acknowledged that the researcher began the research assuming that staff were likely to be working in the context of poor resources, little training and a high-pressure work environment and would likely feel uncared for themselves, both by their management and by society as a whole who adopt an increasingly negative view of them. These assumptions may have influenced the conduct of the interviews and subsequent processes of data analysis. To manage this impact, a reflective diary was used and all three authors (a trainee clinical psychologist, an experienced clinical psychologist working in older adult services and an academic psychologist with expertise in qualitative research) were directly involved in data analysis.

Results

Figure 1 provides an overall depiction of the categories and the theoretical model which emerged. The model indicates that there were two main types of work pressure experienced by participants which were either structural or interpersonal. These elicited a range of responses from participants, some of which appeared to be helpful and some unhelpful, described in detail below. There were some positive aspects of work as well and these appeared to be linked with eliciting the more helpful types of response to work pressure.

Figure 1: Emergent Model

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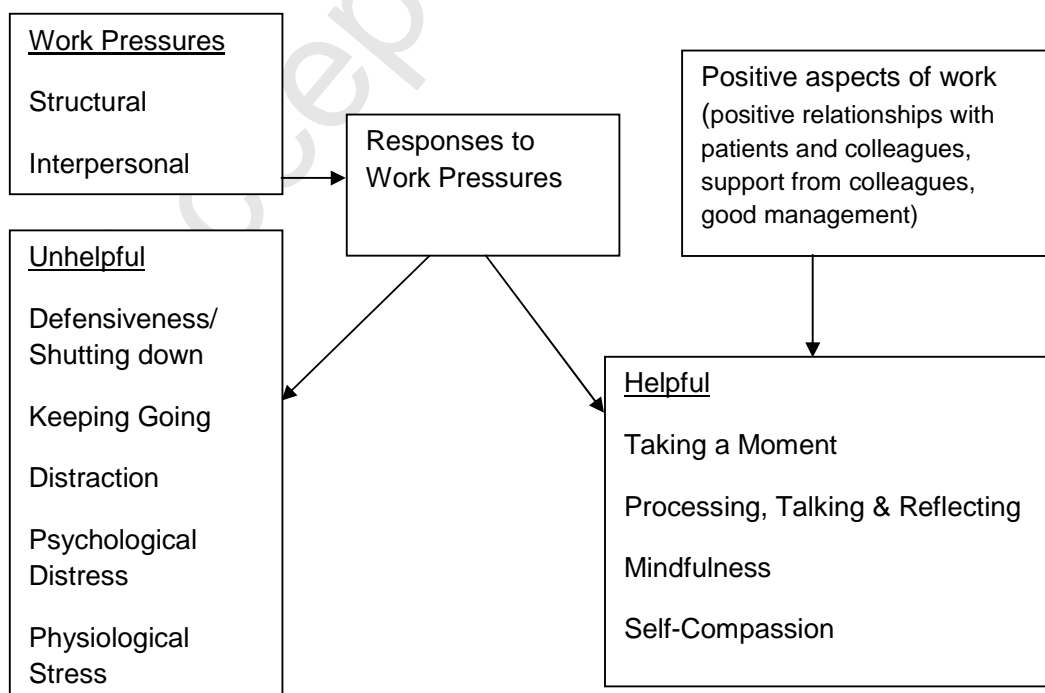
Work Pressures

Participants identified several elements of (or relating to) work that they experienced as demanding or difficult. These were grouped into structural and interpersonal aspects of work.

Structural factors (relating to physical, environmental and organisational elements) included shift work, the nature of the client group, lack of space, lack of autonomy, bureaucracy, lack of resources and high demands (which could be physically demanding, competing with each other and constantly changing). For example, illustrating how bureaucracy can make work feel particularly demanding:

> *I think what I find particularly stressful is that you spend more time writing about people than actually caring for them, you know, say somebody has a fall you have to do a physical observation but then you'd have to write an incident form, you have to inform the family, you have to document that you've informed the family, you have to do a falls analysis form, say you had an incident where a patient hit another patient again you have to do all of that but instead of a falls analysis form, along with an incident report form that goes to however many managers it also goes you know, there's a lot of repetitive tasks at the end of the day you do spend, if anything happens you write it down in four or five different places. (Participant 10)*

Interpersonal factors (relating to relationships or communication between individuals) included management styles, facing aggression, feeling undervalued, colleague behaviour and fears and worries. The following quote illustrates how patient aggression can be hard to experience:

> *If it's sort of aggression towards staff I think we react differently to that, I find that sometimes I can be quite sensitive and sometimes if there's a lot of comments from a patient, to me, I can sort of say they're ill but sometimes it will upset me as such.....you know, we had one patient who constantly called me fat which was......yeah, it was the other word that she used, I don't like to say the word she used to put after that…(Participant 5)*

Some work pressures identified involved both structural and interpersonal factors, such as a sense of professional responsibility which created an internal pressure to keep going and meet certain standards; similarly pressure appeared to arise out of there being a significant cross over between work and home life:

> *…the trouble is at the moment it has affected me now at home obviously and there are certain things I find quite difficult and doing activities with the kids is (pause) I love them, they're wonderful but you don't get the same enjoyment out of it when you're like this and you do sort of wish for that bed time to get closer because you've given so much already and sometimes I get quite agitated because you've sort of given yourself all day at work in that awful environment and you've had a really bad day, I guess yeah, so it does rollover there as well and you get quite agitated because they want you to do things and they might squabble and then you get irritable and you think 'for Christ's sake' I've given myself so much today to everybody, everybody wants a piece of me. (*Participant *2)*

Positive aspects of work

Although the weight of experiences seemed to be about how difficult work was, participants also sometimes identified positive aspects of work and these to an extent enabled the use of more helpful strategies for managing work pressure. Participants often valued positive relationships with patients, support from colleagues and also described some examples of good management and colleague relationships:

> *…even when it's crazy you find a way around it, you can't go and lock yourself in the cupboard but....normally you can grab yourself a sandwich or someone'll make everyone a cup of tea, it's not a written law but if someone's got a bit of free time they'll normally say 'who wants a cup of tea' and will make one for everyone. (Participant 10)*

> *I value the team I work with, I really do, I'm not just saying that… and our manager Sally, as I say, they're very supportive, Sally especially. We know that she'd have our back, if there's someone else petrified for whatever reason Sally will be the first one to jump for anything.*

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Obviously if we've done something wrong she'd be after us so to speak, but not in a negative way. She's very positive and I think overall the staff are… I value their regular support, their friendship if you like.(Participant 7)

Responses to Work Pressures

Participants described how they can respond to work pressures in a number of ways which may be best described as helpful versus unhelpful strategies. The latter were those which participants themselves indicated as being unhelpful in nature, but perhaps natural responses including defensiveness/shutting down, keeping going, distraction and psychological distress. Helpful strategies were those which participants indicated as being constructive or beneficial and included taking a moment, processing, talking and reflecting, mindfulness and self-compassion.

Defensiveness/Shutting down. Participants indicated that they sometimes responded to work pressure by becoming defensive and not wishing to talk to or engage with others. The example below highlights how this can negatively impact on personal relationships, since in this instance the shutting down occurred at home rather than at work:

Sometimes I just don't want to talk about it which is difficult because she would wanna talk about it if I'm a bit quiet or something you know, how was work, well I don't really wanna talk about it, so you know, I like to just switch off if I can but it's not always easy, I think people sometimes think I'm being a bit cold or hostile but I don't mean to be, it can affect others. (Participant 1)

Keeping Going. Many participants also suggested that they respond to pressures at work by going into a state of 'overdrive' or excessive activity, effort or work. The example below highlights how staff will 'keep going' when faced with work pressures, despite feeling that it may not be healthy or positive.

*...you sort of hit the floor running and don't really finish until you're sitting in your car, you have to do it but I don't think it's good for you. (*Participant *3)*

Distraction. All of the participants suggested that they often rely on distracting activities to take their mind away from work pressures or in an attempt to alter their emotional state. Once again, this appears to be a strategy utilised by staff more commonly at home rather than in the work-setting and often involved potentially unhealthy activities such as over-eating, smoking or drinking:

…coming home and if I've had a really bad shift just finding myself shovelling my mouth full of sweet things so that's, so those sort of coping things… if I think about it, the research, the talking but also… alcohol, food um… lots of crying, that, that helps sometimes, you know… it really gets unhealthy really… (Participant 2)

Psychological Distress. A number of participants talked about depression, anxiety, difficulty sleeping or stress resulting from work pressure and some had had periods of time off sick as a result of psychological distress, or were aware of colleagues who had:

I think the process of becoming overly anxious at work probably built up over a period of about two years. Before I went off sick for a month I was probably more aware of it myself within the last two or three months I suppose. Coming home, not being able to switch off. Thinking about things at home when really I should've been focussing on my children. So I guess there was a tiny element of guilt as well that here I am home and I'm still thinking about work. It took a while to build up I'd say, then two or three months before I became aware of it. I was off sick for about a month, which I think did me the world of good. I did actually seek some help, I went through the employee assistant programme and went for some sessions to chat about things, there was one every week and that was really helpful. It helped me to look at things differently.(Participant 3)

I woke up at about 1 o'clock in the morning and ran to the window, opened the window and I threw up out of the window, I couldn't make it to the bathroom it was too much… I got back into bed, had a drink of water…and I was shaking … I was on the brink, I was, I was a wreck,

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an absolute wreck and felt very small and pushed into a corner to make a decision, well I had pushed myself into a corner to make a decision and I was worried about the consequences I guess of the decision. (Participant 1)

Taking a Moment. Most participants made reference to the need to 'take a moment' and get away from the physical environment if they felt overwhelmed in order to relax and deal with difficult thoughts and emotions. Generally, taking a moment seemed to have a positive impact on participants' ability to manage work pressure:

I think just having the time off to have a quick breather, puts some perspective on it. If something's happened and you get frustrated and angry you need to get away from the situation for a few minutes, I'll feel a lot better. Have a cup of tea and forget about it for a few minutes. (Participant 9)

Processing, Talking and Reflecting. All of the participants indicated that processing, talking or reflecting are useful ways to manage work pressures and can help them to deal with challenges they face in the work environment. In some cases this was possible within the work context whereas for others this needed to happen at home instead or as well as at work. Some participants talked about writing things down instead of or as well as talking to people:

…my husband is very supportive and I've always been able to come home and talk to him about stuff. But I just find writing it down… Because you can't describe to other people what that is like for you, not only as a nurse but just as a human being. You know, being with someone... I started writing things down…, when I get time, I do, I think it's quite therapeutic because you do deal with a lot of situations that most people only deal with maybe once in their life if at all and you're sort of dealing with that every day. (Participant 8)

Mindfulness and Self-Compassion. While 'taking a moment' and 'processing, talking and reflecting' provide some of the necessary context for more formal mindfulness techniques, participants were prompted about whether they sometimes were able to accept a strong emotion and not try to change it. Although none of the ten participants specifically identified using this as a technique, some participants did seem to go a little beyond taking a moment and reflecting and seemed to be able to move towards something approaching mindfulness. For example, some participants described instances in which they had been aware of their emotional state and seemed to try to allow those feelings just to be experienced, rather than trying to immediately eradicate them:

If I'm really angry I don't say anything, I'm able to… I don't internalise anger if you see what I mean, I'm able to put it in a box. So I can think about it in a more rational way because I don't think we think rationally when we're angry. If somebody had done something at work that makes me angry I wouldn't call them on it at that time but I'd speak with them later, I'd be then to be able to speak with them and explain why I'd got angry at whatever the incident was. (Participant 7)

If I'm feeling strong, if I've got a strong emotion about something that doesn't tend to go away straight away almost, I would definitely let it run its course and take a few days sometimes, I find that helps. (Participant 2)

Others were less able to sit with a strong emotion:

I like to change how I feel, stressed out… I make the effort to stop feeling that, where possible (Participant 9)

Participants were also prompted about self-compassion in terms of whether and how they were able to be kind to themselves. A number of participants indicated that they were able to be kind and compassionate towards them self:

You're always trying to work towards it being better…but don't be too critical on yourself if it's not because if you are   then you won't be there to see the better days because you'll be off sick (Participant 6)

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…if I've had quite a busy week or whatever, busy shift, or I'm feeling particularly tired, I think that I'm not going to do housework. I'll go off and see a friend or see my daughter or something and I'll just sit and read a book just… chill out. My mum always said when my children we're small, stop fretting about the housework, it will still be there when I've got time to do it. Whereas then I couldn't take the advice, I find I am now (Participant 7)

Responses which approached mindfulness and self-compassion appeared to be more possible when staff could find time to 'take a moment'. However, there was an overwhelming sense that there was so little time to even eat, drink or go to the toilet during a shift that taking a moment was often impossible because of staffing ratios and ward structures:

Sometimes I think you need to just get off the wards… If there's another qualified on you might be able to say go and sort myself out. If you're the only qualified you don't like disappearing off for more than a few minutes in case something goes wrong and I'm responsible for it. (Participant 9)

At my previous job we were half hour and the manager was on the case if you hadn't taken your break. He'll be out saying 'you've got to have a break, go and have a break.' So aware of the fact about being rushed off my feet, take 5 minutes… it's just not possible where we are because of the setup really. Like I said there's only 4 staff in with the patients and you've got to have somebody in that dining area watching all the time and someone in the TV lounge the whole time. (Participant 8)

The sense of having no time may be self-perpetuating and could potentially be addressed with individual support offered by employers, which for one participant enabled them to grant themselves permission to take care of their own needs in the work environment:

When I was particularly stressed a couple of years ago I sort of went to occupational health… they said it was really important to, no matter how busy it was at work, to actually have something to eat and drink. Which sounds obvious, but actually, when you're really busy it does go completely out of your head so I do try to make sure I empty my bladder on time so I don't get a headache and make sure I'm having lots of fluids as well, yeah, that sounds like really simple things but that's what I try and do. (Participant 3)

However, this type of support seems only available once someone gets ill enough to seek it. Similarly, learning the importance of self-compassion can come about through an experience of having time off sick:

I was just so ill and I know it was because I just kept on going instead of dealing with what had happened in my personal life before going back to work...I'm not usually ill so for me to come in and get a cold and still go in to work, take a cold & flu capsule at work but I physically couldn't get out of bed I was that ill, I just felt awful and I know it's because I didn't take the time I should've taken when my uncle died I just kept working but you learn the hard way don't you? I know not to do that if I'm in that position again. (Participant 8)

Along with a sense of significant time pressure preventing self-compassion, there was also a general sense that professional conduct required one to alter one's emotional state in order to continue to work under some time pressure. In spite of strong emotions experienced in day-to-day work, often as a result of patient aggression or dealing with distressing situations including death, many participants felt they needed to repress their strong emotions, which in many ways is the opposite of mindfulness:

I was so aware that he was deliberately trying to wind me up and that made me all the more determined that I wasn't going to let him see how angry it was making me (Participant 7)

The frustration and anger, I sort of come home and do it there… I just think work's work. I do have trouble switching off from it and work people think that it's a weakness, but I actually think it's more of a strength because it makes me a better nurse. (Participant 8)

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…if you weren't in an environment where you have to be professional, you'd still feel angry out there but you'd do something about it out and about but in work you have to be professional and you can feel angry and there can be some people....not within our Trust but you see it on the television who fight back to the patients, they had a documentary on Panorama last year I believe it was and those people were hitting the patients and abusing the patients....I could never do that but you do still at the time feel quite threatened by them. (Participant 5)

Hence, it begins to appear that the unhelpful responses to pressure described above (defensiveness/ shutting down, keeping going, distraction, psychological distress, physiological stress) are in many ways the antithesis of mindfulness and self-compassion and result when mindfulness and self-compassion are hindered. Another barrier to self-compassion and mindfulness related to organisational factors. Feeling unsupported at a management and organisational level seemed to reflect a sense that neither compassion nor self-compassion is fully acknowledged or rewarded:

That's been very soul destroying because there's a lot of us that go the extra mile and the time owing thing was that if you sort of put in your seven hour....you know, you got the working day, you could negotiate a time to take it, see you're giving on a compassionate level but the small reward we would have, we could get it as time owing and the nurse in charge would sign and say yes you'd stayed on, you'd usually stay on to teach, to do paperwork or if the ward are short so basically, now you have to give compassion in your own time and don't even get paid for it, now I don't mind doing unconditional giving, I think that's something within your nature but there's something wrong there....work's work, you should be paid for it. (Participant 4)

Similarly, although training was thought to be useful to enhance compassionate care, there was also a sense that compassion was instinctive to people who go into the profession and that more important for facilitating staff compassion than training would be compassion demonstrated by the organisation:

... embrace it then [compassionate care] on a management level and show it in action… let's be honest about this, compassion comes from the heart, your staff should have that, if they need training they can do training which is wonderful, which will develop those skills but compassion is a human instinct… it comes from within, most people who are in care should have that, I think I have, that's why they should....they want to help people, to change people's lives in a positive way but the problem is, I think, if you look at the concept of where people get de-personalised if people are staring.....if people are spending prolonged periods of time on computers or at meetings and are devoid of contact with patients and their help and caring then they become a bit depersonalised. (Participant 4)

Discussion
The analysis suggests that multiple work pressures exist in these dementia care wards which may be viewed as either structural, interpersonal or a combination of both. In line with previous studies of staff experiences of working in dementia settings, there was an overwhelming sense of intense work pressure; examples of work enjoyment were limited. Several participants spoke about having had time off work for stress related issues and there was a very strong sense of the intensity of time pressure, the impossibility of taking breaks and the intense level of emotion that could be experienced on the ward often resulting from patient aggression or extremely distressing situations.

Although limited, positive aspects of work such as support from colleagues or managers could facilitate helpful strategies for managing work pressures. Helpful strategies included taking a moment, processing, talking and reflecting which all set the context for mindfulness and self-compassion but did not always reach the level of formal practise *per se.* Self-compassion was evident in some responses and some participants described a light mindfulness but there were significant barriers to more fully experiencing these states. These barriers included intense time pressure, a sense of professional responsibility not to express emotions at work and a lack of organisational modelling of compassion in action.

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The more reactive but less helpful strategies in response to pressure included defensiveness/shutting down, keeping going, distraction (through smoking, overeating or alcohol) and in more severe examples, depression, anxiety, stress, sleeplessness resulting from work pressure and ultimately illness needing time off work. These strategies appear to be particularly non-mindful and in a sense lacking in self-compassion, suggesting that they may be employed when self-compassionate and mindful responses are hindered.

There were a number of intuitively compassionate ways of handling extremely high pressures and these tended to be related to interpersonal factors (for example, the ability to relate well to colleagues, managers, clients, significant others and to the self in a reflective manner) which act as key natural protective factors in being able to deal with such pressures in this environment. However, it seems that these naturally compassionate strengths could potentially be enhanced through structural factors (such as regular breaks, adequate staffing and appropriate space away from the ward) to enable self-compassionate and mindful practices.

Mindfulness and self-compassion are potential ways of channelling emotions in a helpful way and are thus an important means of considering and conceptualising work stress. Participants often had an intuitive awareness of behaviour underpinning mindfulness and self-compassion such as feeling the need to take breaks, to reflect and process experiences. However it seems that a strong sense of professional responsibility not to show emotion combined with unhelpful organisational features that fail to model or reward compassion adequately may prevent staff fully engaging with self-compassionate and mindful practices.

In England, 42% of nurses report feeling burnt-out, second only to Greece (78%). The Netherlands had the lowest percentage (10%) and in the USA 34% of nurses reported burnout (Aiken et al, 2012). Burnout can result in high staff turnover and absenteeism and can result in significant financial costs to organisations (Kedem & Bagan, 2005). To manage employee stress and burnout, in many countries including UK, USA and Australia, health care employers provide access to Employee Assistance Programs which offer confidential advice, support and counselling for employees experiencing work or personal difficulties. In the UK, the Royal College of Nursing also provides its own counselling service for members and most professional nursing bodies internationally require practicing nurses to receive supervision or mentoring which can provide a further form of support for managing work pressure. As well as individual support, some healthcare employers internationally provide various forms of stress management training or organization-focused interventions to employees. However, these forms of support have historically been based on socio-cognitive models of stress and coping at the individual level and tend to be reactive in response to individuals not coping.

It may be beneficial to develop interventions which combine individual level training in facilitating existing mindful and self-compassionate skills which may have a more preventative focus, as opposed to traditional 'coping' skills, and to also make organizational level changes to tackle structural factors which may act as barriers to these ways of responding to work pressures. This might mean, for example, training in meditation which has been shown to be effective in encouraging stress control in one's day-to-day life (Patel et al., 1985) in combination with structural changes to allow time and space throughout the working day for individuals to practice this skill. Specific forms such as Mindful Self-Compassion Training (MSC: Neff & Germer, 2013) exist and have a small but growing evidence base in terms of reducing a range of psychological symptoms, including stress (Neff & Germer, 2013). Tharaldsen et al. (2011) argue that mindfulness can, through practice, become automatic and intuitive with time. Maintaining a consistent approach is likely to result in many physical and psychological benefits and further become a state of mind as opposed to a coping strategy to be employed when faced with adversity either at work or in any other environment. Encouraging the perception of situations as fluid and changeable (Wolever et al., 2012) is likely to be particularly helpful for workers in a challenging, fast-paced environment such as a dementia care ward.

Values-Based Recruitment may have merit. However, evidence (Chambers & Ryder, 2009) suggests that most staff entering the caring professions already hold high levels of compassion. Therefore structural responses to barriers that diminish existing compassionate capacities are called for. In terms of dementia care this could mean creating more opportunities for regular peer supervision and support; giving staff 'time owing'; access to a staff room or some kind of space where workers can go to take time away from the ward; to consider the physical environment of the ward and give staff

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appropriate office space away from patients to complete paperwork; providing additional staff when needed (for example in the early evening when patients are likely to become more restless); adequate and compulsory breaks for all staff at regular intervals; training or resources for all staff regardless of role or position; more access to and promotion of use of Employee Assistance Programs; access to staff in management or higher management positions; dedicated and protected time with clients focused on relationship building with them and their families; time given for reflection and emotional processing at work (which currently does exist in some locales). Finally some recognition or rewards-based system for practicing mindfulness and self-compassion could be introduced, with a focus on the quality of care for both self and other (Majernik & Patrnchak, 2014). This could compliment the understandable organisational drive to meet nationally imposed standards and targets.

Staff resilience might be further enhanced by ensuring an organisational culture exists of social safeness and mutual support, as opposed to one of fear and punishment avoidance (Cole-King & Gilbert, 2011). Goodrich (2012) suggests that organisations could facilitate this by providing staff with opportunities to reflect with trusted colleagues either in the form of case consultations, supervision or informal engagement. Establishing valued shared goals is also crucial and organisations could support employees by actively rewarding compassionate attributes and behaviours. For example, Gilbert (2009) proposes that staff could be exemplified for displaying sensitivity, warmth, resilience and respect rather than simply becoming more productive. On behalf of the NHS Leadership Academy, Storey and Holti (2013) reviewed the evidence concerning models and theories of leadership including transformational and post-transformational leadership as a basis for proposing a new model of NHS leadership. The model proposed incorporates notions of 'building a positive emotional climate', demonstrating compassion and modelling required behaviours. This model is very much in tune with the suggestions arising from this study, but may yet remain a challenge without adequate financial resourcing and active promotion at local levels.

Study limitations
A number of individual variables may be implicated in work stress including the age, personality, self-esteem, training background and profession of participants (Connor-Smith & Flachsbart, 2007) which have not been explicitly examined in the present study. Despite participants being recruited from three different wards, all sites were based in the same NHS Trust which may act to limit the transferability of our findings. With regard to this aspect (given the specialist nature and challenges encountered with such a client group) it may be that the findings are transferable to other staff populations caring for older adults with dementia in an inpatient environment. However, they may not generalise to staff working in different settings or with different client groups. We also acknowledge the lack of diversity within the sample. For example, all participants were Caucasian.

The study might have been subject to a selection bias as staff recruited were required to speak English and be able to express themselves during the interviews. Those taking part may also have been motivated to volunteer in terms of their attitudes towards work. Participants recruited were likely to be those who were actively working and were not on sick leave and were likely to have had experience of work pressure given the nature of the advertisement of the study and recruitment processes. Once again, these factors may represent a study bias. Further to this, all but one of the participant interviews took place via telephone which may have impacted on the quality of the interaction and thus the findings of the study, although there is evidence that telephone interviews are equally likely as face-to face interviews to elicit rich data (Novick, 2008).

Conclusion
The present study has elicited rich, personal descriptions whilst exploring the experiences of managing work pressures in front-line staff working in dementia wards in the UK. It is hoped that it will raise awareness of the challenges faced by this staff group but also to draw attention to their continuing hard work, courage, resilience and compassion. It is also hoped that this analysis will assist staff, managers and organisations to consider tangible ways in which such pressures can be mitigated in order to promote a felt sense of compassionate care.

We argue that neither Values Based Recruitment nor merely highlighting the importance of compassion will significantly improve compassionate care. Rather, organisations need to continually/consistently model and reward self-compassion and training should focus on the expression of self-compassion and mindfulness capacities, without which compassion to others is hindered. Strong professional values which embody stoicism need to be reconsidered carefully within

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professional groups in order to provide guidance from pre-qualification onwards about how to balance professional conduct with appropriate affect in response to extreme (and often chronic) situations.

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