Delivering Best Care and Maintaining Emotional Wellbeing in the Intensive Care Unit: the Perspective of Experienced Nurses

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Introduction

Critical care nursing has never been tougher, patient acuity is high, technology has exploded and increasingly, regulations and documentation requirements dominate practice (Moloney-Harmon, 2010). Repeated exposure to patients with life threatening illness or trauma, and sudden critical events can be difficult for nurses working in Intensive Care Units (ICU). There is a plethora of research confirming that ICU nurses globally experience prolonged stress culminating in burnout and disengagement from the workforce. For example, high levels of burnout were found in a survey of 80 critical care nurses working at five hospitals in Spain (Iglesias, Vallejo, & Fuentes, 2010). Overall, the Masloch Burnout Inventory revealed high levels of emotional exhaustion, moderate levels of depersonilation and low levels of accomplishment. Older nurses, those who had worked as a nurse for more than 10 years, and smokers had significantly higher levels of emotional exhaustion. These patterns were compared and found to be similar to the results from studies conducted in other countries using the same measure, including Canada, Norway, Hungary, France and the United States (US).

Feelings of suffering in ICU nurses were explored in a qualitative study with eight registered nurses who worked in a Spanish ICU (Martins & Robazzi, 2009). Most often reported as causing nurses to suffer were critically ill young patients with the effect being felt by the whole team. Nurses had trouble detaching from the suffering of young patients even when they were away from the workplace. Similarly, nurses suffered more when caring for long-term patients and those with whom they had formed a strong attachment.

Moral distress; painful feelings related to morally appropriate action constrained by institutional barriers (Jameton, 1984), has also been found in ICU nurses. McAndrew, Leske,

and Garcia (2011) measured moral distrees in 78 critical care nurses (excluding emergency department nurses) from a trauma centre in the US. Patterns of moral distress were found to be similar to patterns reported elsewhere. Factors in the work environment such as leadership, staffing levels, and relationships with other health professions were found to impact on moral distress. Other studies have also reported a link between moral distress and interpersonal issues between nurses and physicians (Wilson, Goetemoeller, Bevan & McCord, 2013; Karinikola, Papathanassoglou, Kalafati, et al., 2012).

More recently, compassion fatigue, another measure of distress has been identified in ICU nurses (Jenkins & Warren, 2012; Elkonin & van der Vyver, 2011). First described by Joinson (1992), compassion fatigue is a unique form of burnout which manifests as a gradual lessening of compassion in people who work directly with those who have experienced trauma and/or those who are suffering. Although described as a progressive and cumulative process, workers may experience it in response to repeated exposure to suffering, or a single event (Mason Leslie, Lyons, et al., 2014; Elkonin & van der Vyver, 2011). Compassion fatigue is compounded by feelings of moral distress (Mason, et al., 2014; Hamric & Blackhall, 2007; McLendon & Buckner, 2007).

There is evidence that pleasure is also associated with caring for patients in the ICU and this has been explored. Twenty six nurses and 96 nursing technicians employed at a hospital in Brazil were surveyed using the "Pleasure-Suffering at Work Scale". Pleasure with caring activities were found to be at satisfactory levels, however, level of emotional exhaustion and dissatisfaction, and lack of recognition were critically high (Shimizu, Couto & Merchan-Hamann, 2011).

Development of strategies to retain skilled and experienced nurses is essential within the current global nursing shortage (Kutney-Lee, Wu, Sloane, & Aiken, 2013, Oulton, 2006;

Buchan & Calman, 2004). The ability of nurses to maintain their emotional wellbeing and to work effectively within the ICU environment contributes to the retention of experienced staff. Studies investigating specific interventions or organizational strategies to prevent burnout are needed to address this problem (Epp, 2012).

This project sought to explore the perspective of experienced ICU nurses to reveal the strategies used by nurses who continue to nurse in ICU. While current literature expounds stressors experienced within this environment, it does not fully describe how ICU nurses maintain their wellbeing. Greater understanding of this phenomenon will assist in the creation of workplace environments which retain nurses in the critical care workforce. Retention of these highly skilled and experienced nurses is important within a climate of nursing shortages and an aging workforce.

Research Methods

Design and sample

The qualitative methodology grounded theory was used in this study (Glaser & Strauss, 1967) to explore and describe experienced ICU nurses' perceptions of emotional wellbeing in the ICU work environment. Experienced nurses were sampled because these nurses had demonstrated the desire and ability to remain working in this environment. Grounded theory has been recognized as a useful methodology when theory or explanation about a phenomenon does not exist (Stern, 1994). Developed from symbolic interactionism (Blumer, 1969), grounded theory discovers the meaning individuals derive from interactions whilst experiencing the phenomena of interest. The original grounded theory approach outlined by Glaser and Strauss's (1967) was used in this study. Data analysis was performed to a descriptive rather than theoretical level. The core category of *Nurse Distress* was identified during the analysis and relationships between categories were attempted and developed into a conceptual model, but theoretical abstraction was not achieved completely.

The setting for this study was an ICU in a Western Australian public hospital. The then 18-bed ICU accepted elective and emergency surgical, medical, neurological, trauma and cardiothoracic patients. At the time of this study, the unit employed over 100 full-time equivalent registered nurses.

Purposive sampling was used to select the first four participants. Following initial analysis of these data theoretical sampling (Glaser & Strauss, 1967) guided the invitation of further participants. Theoretical saturation was established by the identification of dense categories and the absence of new concepts in the data (Strauss & Corbin, 1990). Charmaz (2006) described the common understanding of saturation in grounded theory as "I kept finding the same pattern" (p. 113).

The sample consisted of 15 registered nurses who had a minimum of two years working in the study area. This period was considered to represent experienced ICU nurses. Ethical approval was obtained from the Human Research Ethics Committee of both the study hospital and administering university.

Procedures

Formal interviews were conducted with each participant and audio-recorded. Semi-structured questions were developed and referred to throughout the interview as a broad guide. The interview question guide was updated throughout the data collection period, to allow for exploration of emerging themes and ideas that arose from concurrent analysis.

Memos were written during the interviews to capture thoughts about the individual incidents in the data and prompt exploration of ideas introduced. These memos provided leads to pursue in subsequent interviews (Birks, Chapman, & Francis, 2008; Strauss & Corbin, 1998).

Data analysis

Recorded interviews were transcribed verbatim, then organised and managed for analysis using QSR NVivo (QSR International, Pty. Ltd. Version 7, 2006). Data were simultaneously collected, coded and analyzed using the constant comparative method as described by Glaser and Strauss (1967) to allow exploration and theory development.

Initially, open-coding was undertaken where all data (transcripts) were coded line by line to conceptualize all incidents that were present. The concepts were compared and grouped to find patterns and emergent categories. Axial coding was used to make connections between the major themes and core categories. The purpose of linking categories and subcategories was to begin reassembling the data to describe the phenomena under investigation more precisely (Strauss & Corbin, 1998). The data were constantly compared, some categories were subsumed into higher order categories and a higher level of conceptualization emerged.

The final stage of coding, known as Selective Coding was undertaken. The process of identification and integration of core categories or major themes expanded on the relationships between the categories, explored the dimensions and validated the connections (Strauss & Corbin, 1998).

Strategies were used to ensure rigor of the findings including independent member checks. Findings at different times throughout the analysis procedures were given to participants to confirm interpretation and meaning. An experienced grounded theorist also supervised coding procedures and analysis. Three of the participants were followed up informally after the interview to clarify information for emerging categories (Glaser, 1998) and one participant contacted the researcher via e-mail to provide some further details.

RESULTS

Fifteen registered nurses, with a mean age of 39.4 (26-50) years were interviewed. The length of time working in ICU ranged from 3 – 25 years with a mean of 13 years and most (n=12) were female. All 15 nurses indicated their intention to remain in ICU.

The basic psychosocial problem experienced by the nurses in this study was an *inability to protect self from distress.* Nurses who encountered this problem reported feelings of sadness, suffering, unhappiness, anguish, anxiety, fear, grief, frustration, disappointment and dissatisfaction. This was in contrast to the positive experience of emotional wellbeing, characterized by feelings of happiness, enjoyment and personal satisfaction. Emotional wellbeing was experienced when nurses felt that they had done their best working with critically ill patients and their families. The source of happiness and personal satisfaction for nurses was the successful delivery of best care to patients and their families. Nurses also stated that when they experienced feelings of happiness and personal satisfaction, they were motivated to continue working in the ICU.

It was evident that nurses sought to avoid the problem of their own distress and maintain their emotional well-being using a basic psychosocial process called "Protecting self from distress". This process involved three independent phases: *Delivering best care*, *Validating care episodes*, and *Distancing self from distress*.

Delivering best care described nursing in the ICU when the conditions enabled nurses to deliver best care to the patient and their family and facilitated nurses' consequent emotional wellbeing. The conditions that enabled nurses to achieve best care are the focus of this paper.

Validating care episodes describes strategies used by ICU nurses to promote the feeling of having achieved best care. Most commonly, nurses described reflecting either on their own or

with colleagues about ICU incidents and this helped them to validate their care and find meaning and perspective. Nurses actively sought validation from colleagues and patients' families. Additionally, sharing work experiences outside of the ICU with friends or family enabled nurses to place distressing emotions in perspective by looking at the big picture and justifying care.

Distancing self from distress describes strategies that created a physical or psychological barrier between the nurse and experiences at work that were actually or potentially distressing. This included strategies such as using distraction, listening to music on the way home, emotional barriers and self-caring activities. Nurses sometimes asked to select patients to avoid suffering when they felt they couldn't cope with it some days. In its extreme form, nurses left ICU nursing.

The phases identified were often used in combination depending on nurses' feelings of distress or emotional wellbeing. The need to protect themselves was variable and dependent on the conditions experienced. The data demonstrated that emotional wellbeing was most closely linked to the delivery of best care and therefore this paper describes the conditions which facilitated the delivery of best care and assisted nurses to maintain their emotional wellbeing.

Delivering best care and emotional wellbeing

When nurses in this study were asked the meaning of emotional wellbeing, they overwhelmingly described their feelings of happiness and satisfaction from caring for patients and their families, "I do enjoy it really. I mean … I come to work and I like what I do …" (N7); "I think emotional wellbeing of intensive care nurses is your mental health while you are at work, your mental stability. I suppose a lot of it comes down to your happiness like that plays … into your wellbeing …" (N4).

Delivering best care described nursing in the ICU when conditions facilitated emotional wellbeing by enabling ICU nurses to deliver best care to the patient and family. When this happened, nurses were happy and experienced personal satisfaction which had a positive impact on their emotional wellbeing. Five conditions were identified that facilitated nurses' happiness and satisfaction in the ICU and consequent emotional wellbeing: 'Achieving best care', 'Caring for the patient's family',' Autonomy within the ICU environment', 'Teamwork', and 'Previous nursing and life experience' (Figure 1).

Insert Figure 1 here

Achieving best care

Best care occurred when nurses determined that they had achieved holistic care that was driven by patient and family centered goals for critically ill patients. Best care meant that everything had been done for the patient and their family, and nurses believed the most appropriate care had been achieved. These experienced nurses set goals based on patient and family need. Best care was all-inclusive, integrating complex physiological care with comfort measures and emotional support of both patient and family: Nurses understood the impact of the ICU experience on relatives and derived a sense of satisfaction when able to improve outcomes for families in the face of medical futility for patients:

> … You look after people physically, mentally and spiritually and if you do the three, then you balance it out … Sometimes you can't do any more for the patient from the physical perspective, you can just tidy their hair or do something, because that is what the family remember, they are the small touches. (N6)

Conversely, failure to deliver best care resulted in nurses experiencing feelings of distress, which diminished emotional wellbeing. Failure to deliver best care was a complex phenomenon; a subjective determination of success or failure and consequent feelings of

personal dissatisfaction. Particular situations and patient characteristics were identified as impacting on nurses' perception of achieving best care or failure to deliver best care. Trauma patients, patients or families that reminded nurses of personal circumstances, aggressive, angry or abusive patients, and those who had self-harmed or preventable injuries, as well as long term patients, were given as examples.

Caring for the patient's family

Delivering best care to families was equally rewarding for nurses. Caring for families was explained as integral to caring for the patient and often, the focus of care became the families themselves:

> You can really give something to families as much as the patient, because their needs are so great. The patient is unconscious, I mean you do everything for them, but if they are really ill and they are not going to get better … in that situation, to be able to help the family, give them the explanations they need, get the people to talk to them that they need to talk to, and just help take that part of the anxiety. (N7)

Developing relationships with families was often how nurses came to know the patient and finding the connection through families was described. Nurses spoke about setting the scene for optimum care and wanting to create calm to decrease stress on patient and family members. For example when describing her experience of emotional wellbeing, one nurse remarked:

> [Emotional wellbeing] … means for me that I have looked after the family, they know everything that is going on, they have had tea, they've had coffee, they have seats, they've had the priest. The patient looks pristine in the bed, they have got their hair done, they have got clean clothes, teeth brushed, everything, the place is tidy and they [the relatives] can come in and just be with the patient … So that is big for me so my satisfaction is all of those things coming together. (N12)

The nurse-family relationship also provided nurses with the opportunity to receive feedback that validated patient care and this positively impacted emotional wellbeing, "I rate having a good day by not even making my patient better but by putting a smile on a relative's face" (N3); "And the families, families give you feedback and thank you, you're doing such a good job, just positive feedback" (N2).

Caring for families of critically-ill patients could also be very difficult for nurses personally. Tragedies were almost always difficult for nurses to manage and there were many examples in these data of situations where nurses experienced sadness and this was said to impact on their ability to provide best care. Nurses talked about crying and feeling powerless to help when families were pleading with them to keep the patient alive.

Autonomy within the ICU environment

Participants indicated that the ability to practice autonomously with support from the multidisciplinary team facilitated a sense of fulfillment in their role as ICU nurses. Autonomy was described as assessing patients, planning care and making decisions appropriate to advanced nursing practice within the ICU. A sense of satisfaction when able to contribute to clinical decision-making was evident:

> I was looking after a patient who I felt the treatment … was futile and discussed it with a senior consultant. I discussed it with a senior registrar and we came to the agreement that we would cap treatment where it was, we wouldn't offer any more treatment, we wouldn't withdraw treatment at that point, but we wouldn't offer any more. I felt pretty happy with that decision and the family were involved as well. (N11)

The meaning and importance of autonomy for nurses' emotional wellbeing became apparent when nurses described instances when they felt excluded from clinical decision-making. The

impact of not being involved in decision making or being able to achieve what they believed would be best care for the patient and family was summarized in the following exemplar:

> … Treatment had escalated when new consultants had come on. The patient, all I can say is that we basically flogged this guy for a week and then he died … I felt terrible, not only for the family who had to go through another week of absolute torture and an alien environment looking at their decaying relative on all this machinery, but also for the nurses who emotionally deal with that. (N11)

Threats to autonomous practice were identified as arising when their colleagues, in particular medical staff, did not support nurses. Nurses expressed frustration most commonly when they were challenged or not included in important decision-making and perceived that the quality of care was compromised.

Achieving goals

Autonomous nursing practice included setting patient care goals, and nurses described experiencing emotional wellbeing when those goals were achieved. Nurses assessed their own effectiveness through the impact of their clinical care:

> Well I feel like I have performed well, I have suctioned them out at the right time and I have turned them properly and their (blood) gases are good, they start the day a bit ahead of the eight ball … It just makes me feel good. (N5)

> … when I go home after most days when I know that I have been thorough and my work has been achieved and my goals have been achieved, I can go home and be completely relaxed. (N4)

When nursing care went to plan, nurses felt happy and satisfied, which promoted their emotional wellbeing. Nurses made comparisons between their experiences of ward nursing and believed that ICU nursing provided greater personal satisfaction through the achievement

of goals. Being able to give complete care was satisfying and contrasted with past experiences of frustration on busy wards, "I can always go home and not feel any guilt … I enjoy knowing everything has been done for my patient, no stone is left unturned, and I am thorough" (N4).

Teamwork

Another attribute of the ICU environment that had a positive impact on the emotional wellbeing of nurses was teamwork. Teamwork meant working closely with colleagues and having professional support constantly available:

> … Probably the support of everybody, normally it is not just you involved with someone's care, it's a lot of people. It's not just the doctors, it's the physios … I think the support really helps; I know that there is always someone there, someone who can go further. (N8)

> What teamwork means for me is looking out for everybody else that is round about me and if I see anybody struggling I will go in, I will ask them … if they need assistance … if you help them out when you are in the same situation one day it is normally reciprocated. (N11)

The attributes of someone who worked well in the team and maintained the teamwork environment were described:

> People that listen, that look out for each other and … anticipate other people's needs as well as their own ... People good at their job … listening … to what is going on in other bed areas ... You can be doing your work but you can be aware of what is going on somewhere else and you can go help that person if they are having a difficult time or if they are getting behind with something or getting a bit distressed. (N7)

Teamwork in the ICU was valued by nurses and contributed to their emotional wellbeing by the provision of educational opportunities, monitoring of standards, nurturing and social support:

> … Probably the support of everybody, normally it is not just you involved with someone's care, it's a lot of people … Normally the person next to you knows what is going on, you can talk to them. I think the support really helps, I know that there is always someone there. (N8)

In contrast, lack of teamwork was said to lead to feeling of anxiety, which were unsettling. When the team was perceived as dysfunctional, nurses were unhappy, "... The grumblings that are going on or the bitching and fighting … really unsettles me at work … I don't want to come to work, don't want to talk to anybody …" (N3).

Previous nursing and life experience

It was evident that nursing and life experience contributed to nurses' nurses' confidence and skills to manage emotionally challenging and/or complex care. Personal experience of overcoming adversity was valuable, such as:

> … years of experience really. Like work experience, life experience, probably gone through a traumatic family situation with my [relative] as well, makes you maybe a bit more aware … (N7)

Coupled with professional experience and education, this awareness enabled nurses to anticipate and manage challenge in clinical situations:

> Also I have done the critical care course so I know what I am talking about and I present myself to others I suppose, in an informed sort of manner, so I am saying to them, "I have seen this before, this is what we need to do". I suppose it is experience as well added in. (N12)

This study confirmed that longevity in the ICU environment increased nurses' ability to manage control the emotional fallout of caring for suffering patients and families:

> … I think that is something that comes with the knowledge and experience of being in that scenario … Experience definitely has a lot to do with it and I think seeing how other people handle situations. I haven't just got seven years of experience myself; I've got seven years of observing other people, which definitely contributes. (N4)

Personal experience was not always beneficial and there were examples of nurse distress that was attributed to their own personal life experience or situation such as identifying with some patients in a personal way. The extensive nursing experience of these participants could also impact negatively as they were allocated complex and difficult patients. These challenging patients with distressed families were sometimes allocated to the same nurse too often, resulting in exhaustion.

DISCUSSION

This study has explored how experienced ICU nurses seek to maintain their own emotional wellbeing. The results from this study build on previous research in this area, but from a different perspective. Previous studies have sought to understand stressors and their relationship to emotional exhaustion, burnout and the desire of ICU nurses to leave nursing (Bakker, Le Blanc & Schaufelli, 2005; Iglesias et al., 2010; Klopper, Coetzee, Pretorius, & Bester, 2012). The conditions related to delivering best care which assisted nurses to maintain their emotional wellbeing in ICU have been described in this current study. Positive and negative factors impacted on emotional wellbeing in an environment known to be stressful were identified.

Delivering best care emerged as central to emotional wellbeing. Nurses frequently focused on caring for patients, the happiness and satisfaction which promoted their emotional wellbeing. Morrison and Korol (2014) investigated actual and perceived caring roles of nurses in a grounded theory study of nine Canadian nurses. Overwhelmingly, nurses were focused on providing care that was "in the patients' best interest". The patients' families were also cared for as part of the caring role. Criticism from doctors, family and management whilst satisfying the needs of the patient, was also described. The purpose of Morrison and Korol's study was to compare the type of care nurses expect to provide, to identify when and whether disconnect in expectations led to compassion fatigue. The authors proposed a job satisfaction model where upon perceiving control and optimal challenge from a work environment, nurses derive reward, feel energetic and these feelings strengthen commitment to their job (Morrison & Korol, 2014). In contrast, the authors describe compassion fatigue, empathetically engaging with patients and integrating the emotions of fear, grief and loss, when nurses experience time/resource constraints and role conflict. This may lead to a desire to leave their job.

The relationship with the patient's family was paramount to achieving best care in this study which has also been identified by others (Agård & Maindal, 2009; Engström et al., 2011; Mitchell & Chaboyer, 2010). The importance of the relationship between nurses and the patients' family was important to support them in the caring relationship and ICU nurses sought to understand the patient's feelings, perceptions and beliefs in relation to their illness from the perspective of the family.

While ICU nurses may work in situations providing tailored care to a patient and family, the sense of teamwork was important to emotional wellbeing. Others studies have also referred to the importance of teamwork (Bach, Ploeg, & Black, 2009; Leon & Knapp, 2008). In the

current study, teamwork meant collaboration with working in cooperation with other health professions.

Consistent with other studies (Engström, Uusitalo, & Engström, 2011; Mitchell & Chaboyer, 2010; Ryan, 2004), ICU nurses looked for visible evidence of caring and sought to enhance feelings of reward and satisfaction, an integral part of emotional wellbeing. Satisfaction experienced by ICU nurses in relation to the care of patients and their families has been documented (Davidson, 2009; Davis, Ward, Woodall, et al., 2007). More recent studies have described compassion satisfaction and compassion fatigue and the potential for ICU nurses to experience either as moderate to high (Mason et al., 2014; Elkonin & van der Vyver, 2011). Factors that contributed to compassion satisfaction were linked to some of the factors identified in this study such as experience, collegiate relationships and participation with decision making (Wilson et al., 2014; Karanikola et al; 2014; Mason et al. 2014; Elkonin &van der Vyver, 2011).

Caring was central to feelings of reward; satisfaction and happiness in this study and has been described as the core of nursing (Dewar & Nolan, 2013; Watson, 1997). Caring was central to feelings of reward; satisfaction and happiness in this study and has been described as the core of nursing (Dewar & Nolan, 2013; Watson, 1997). The relationship between the quality of care delivered and the emotional wellbeing of ICU nurses is a finding that builds on other recent work in other areas of nursing. Maben et al (2012) found that the when well-being of staff caring for older people was diminished, then so was the quality of care experienced by the patients. Becket (2013) highlighted the challenges faced by nurses and physiotherapists to provide compassionate care to trauma patients within an environment not conducive to caring and the impact of this on the personal wellbeing of the nurse. Slatyer, Williams, and Michael (2014) found that nurses felt distressed when they cared for patients on medical and surgical

wards experiencing severe pain. When nurses found ways to empower themselves to facilitate patient comfort, their distress was diminished.

Understanding how to support nurses to achieve best care in the ICU is important to inform development of the practice environment. Enabling nurses to work with autonomy, within their scope of practice and in a teamwork environment was shown to support satisfaction and positive emotions such as happiness. The relationship between autonomy within the workplace and satisfaction, forms the underpinnings of occupational psychology enabling individual's to experience feelings of control and commitment (Laschinger, Finegan, Shamian, & Wilk, 2001; Tummers et al., 2002). Environments supportive of autonomous practice have also been reported as being associated with a better health status among nursing staff (Kramer & Schmalenberg, 2008).

Previous nursing and life experience was identified in this study as contributing to the competence and competence of the nurse and therefore relating to their emotional wellbeing in ICU. Satisfaction has also been described previously as being influenced by the personal characteristics and experience of the nurse (Burgess, Irvine, & Wallymahmed, 2010; Hays, All, Mannahan, Cuaderes, & Wallace, 2006).

CONCLUSION

This qualitative study has explored the perspective of experienced ICU nurses regarding the delivery of best care and maintenance of emotional wellbeing. Nurses in this study expressed the enjoyment they experienced working in ICU when they felt satisfied with the care that they delivered. This study has described the elements of the work environment which made nurses feel emotionally well and motivated them to want to remain working in the ICU.

The findings from this study are limited to the context of Western Australian; however, there was a great deal of support in the literature for the factors identified as impacting on the

emotional wellbeing of ICU nurses. This study was undertaken with a small group of experienced Australian ICU nurses in one clinical setting. Further insights into this phenomenon could be gained by exploring the perceptions of less experienced nurses, nurses from different cultural backgrounds, and a variety of ICU settings. The addition of field observations would also increase the strength of the results.

This study increases our understanding of the elements in the environment which optimize the emotional wellbeing of ICU nurses. Providing environments conducive to emotional wellbeing creates the incentive for nurses to remain nursing in the ICU. Supporting nurses to do their best, which includes recognizing factors such as nurse autonomy and teamwork may be useful strategies to consider for the retention of nurses. The development of policies and guidelines that encourage nurse autonomy and acknowledge the scope of practice of ICU nurses may be beneficial in this respect. Quantitative evaluation and exploration of the degree to which elements identified impact on ICU nurse emotional wellbeing and the development of measurement tools may be beneficial to managers. In addition, the findings from this work may have relevance to other nursing work environments such as ward areas, and further research is recommended.

There is a long standing worldwide shortage of nurses in conjunction with an ageing workforce. This study has demonstrated that despite the stresses associated with critical care nursing, many nurses deliver best care and maintain their emotional wellbeing.

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Figure 1. Delivering Best Care and Maintaining Emotional Wellbeing in the Intensive Care Unit: Conceptual model