Nurses' Experiences of Working During and After the COVID-19 Pandemic:

Views on Physical and Mental Wellbeing

Patience Domingos

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Faculty of Health, Education and Life Sciences, Birmingham City University

Copyright Statement

Declaration

Statement

I affirm that this thesis constitutes my original work and has not been presented, in whole or in part, for any other degree or qualification at this or any other institution.

All sources of information and help used to write this thesis have been properly cited and given credit. It has been made clear when the work of others has been used.

This research was executed in compliance with the ethical permission provided by Birmingham City University and all pertinent institutional and professional standards.

Abstract

Abstract

Nurses within the United Kingdom National Health Service faced persistent and heightened challenges throughout and after the COVID-19 pandemic, exacerbating existing workforce shortages and organizational strain. A sizeable portion of the current literature conceptualises wellbeing from the perspective of resilience, frequently attributing responsibility to individual capability rather than to the structural and ethical conditions of practice. This study examines nurses' lived experiences during and after the COVID-19 pandemic, reframing physical and mental well-being through the analytical perspective of endurance.

This Constructivist Grounded Theory research was conducted within a large NHS Trust in the West Midlands, United Kingdom. Data were collected from seventeen participants via eleven face-to-face semi-structured interviews and two focus groups comprising nurses from Bands 5 to 8. Recruitment, data gathering, and analysis were conducted iteratively through initial and focused coding, constant comparison, and continuous memo writing, underpinned by ongoing reflexivity in my capacity as a practitioner-researcher.

Four interrelated analytical categories were identified: Physical and Emotional Suppression and Delayed Processing; Physical and Psychological Trauma and Aftershocks; Organizational Dissonance and Fragmentation; and Moral Suffering and Ethical Erosion. These coalesced in the principal category of Institutional Betrayal and Organizational Abandonment. Two distinct analytic groupings emerged from the data: Surface Endurers and Fractured Endurers, which differentiate how nurses maintained professional functioning or encountered breakdown under extended organizational stress.

This study presents five principal theory-derived contributions. Conceptually, it positions endurance as a structural and moral process shaping nurses physical and mental wellbeing within ethically strained healthcare systems. Empirically, it captures the prolonged aftermath of COVID-19 on everyday professional life. Methodologically, it demonstrates a transparent and reflexive application of Constructivist Grounded Theory. Applied and in policy terms, it informs leadership, occupational health, and workforce governance by identifying organizational conditions that sustain, strain, or fracture professional endurance over time.

Dedication

I dedicate this thesis to my mother, Irene, whose courage, patience, unconditional love, support, and prayers have carried me through every step of this journey.

Acknowledgement

First and foremost, I give all glory, honour, and thanks to the Almighty God, my Heavenly Father, whose grace, guidance, and sustaining presence have carried me through every stage of this doctoral journey. As I reflect on this path, I remain in awe of how God sustained and provided for me throughout, shaping this work in ways that would not have been possible without His hand. What began as a long-held aspiration was brought to completion through His grace and provision.

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Abbreviations

BCU - Birmingham City University
BPS - British Psychological Society
CASP - Critical Appraisal Skills Programme
CDC - Centres for Disease Control and Prevention
CEL - Cumulative Endurance Load
CGT - Constructivist Grounded Theory
COVID-19 - Coronavirus Disease 2019
EOI - Expression of Interest
HRA - Health Research Authority
H1N1 - Influenza A (H1N1) Virus
ICN - International Council of Nurses
IDs - Identifiers
ILO - International Labour Organization
IPC - Infection Prevention and Control
MeSH - Medical Subject Headings
MERS - Middle East Respiratory Syndrome
NHS - National Health Service
NIHR - National Institute for Health and Care Research
OECD - Organization for Economic Co-operation and Development
OH - Occupational Health
ONS - Office for National Statistics
PO1, PO2 - Participant Identifiers
PARC Index - Professional Accountability and Responsibility Governance Index
PHE - Public Health England
PIS - Participant Information Sheet
PPE - Personal Protective Equipment
PTSD - Post-Traumatic Stress Disorder
RCN - Royal College of Nursing
SARS - Severe Acute Respiratory Syndrome
UK - United Kingdom
USA - United States of America
WHO - World Health Organization

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Chapter 1: INTRODUCTION

1.0 Introduction

The COVID-19 pandemic posed a lot of problems for healthcare systems around the world and put a lot of stress on healthcare workers, especially nurses. The National Health Service (NHS) in the United Kingdom was compelled to function under severe conditions that exacerbated enduring structural issues and revealed substantial weaknesses in workforce wellbeing, organizational readiness, and system flexibility. The World Health Organization (WHO) defines a pandemic as "the worldwide spread of a new illness across national boundaries, affecting a sizeable proportion of the population" (WHO, 2020); nonetheless, COVID-19 exceeded this epidemiological criteria. It fundamentally revolutionised the accessibility, delivery, and experience of healthcare, altering professional practices, organizational operations, and public expectations of care.

Nurses, the largest group of professionals in the global healthcare workforce (WHO, 2020b), were particularly important in the response to the pandemic. There is a lot of policy and empirical literature about their involvement in past outbreaks of infectious diseases, such as pandemic influenza, Ebola virus disease, and Zika virus (WHO, 2018; International Council of Nurses, 2019; Shultz et al., 2016; Wenham et al., 2016; Smith et al., 2017). Nurses have always been on the front lines of direct patient care, infection prevention and control, community involvement, and public health surveillance. Sometimes, they have had to do these things in dangerous situations without any help from their employers.

The COVID-19 pandemic exacerbated these roles, underscoring nurses' vital contributions to extensive public health crises while concurrently heightening the pressures on them. The pandemic intensified pre-existing systemic strains within the NHS, such as persistent staffing shortages, resource limitations, restricted access to mental health services, and increasing patient demand (Billings et al., 2021; The King's Fund, 2021). Nurses endured significant physical and psychological stress consequently. Extended utilisation of personal protection equipment (PPE) resulted in tiredness, thirst, heat exhaustion, dermal damage, and limited mobility (Mitchell et al., 2020). The physical demands were heightened by extended working hours, few rest breaks, and relentless workloads, which reduced recovery opportunities and resulted in cumulative weariness over time. For nurses, these demands were experienced not only during the height of the pandemic, but in its prolonged aftermath, as services adapted, workloads shifted, and expectations of recovery were unevenly realised. Understanding this context is essential, as it shaped the conditions within which nurses made sense of their wellbeing, their professional responsibilities, and their capacity to continue working.

In addition to these physical challenges, nurses faced constant physical, emotional, and psychological stress. The continual observation of patient decline, mortality, and distress, frequently without the

presence of family due to infection control protocols, resulted in cumulative trauma. Nurses expressed sentiments of guilt, ethical discomfort, powerlessness, and emotional fatigue (Maben and Bridges, 2020). These feelings were intensified by concerns around the transmission of the virus to loved ones, rapidly changing therapy guidelines, and increased mortality rates.

In this environment, inadequate organizational support and extended exposure to distressing circumstances led to heightened levels of anxiety, despair, concern, and psychological trauma (Billings et al., 2020; 2021). Despite extensive public acknowledgement and symbolic valuation of the NHS, nurses' interior experiences often disclosed a more intricate and concerning reality. Many described feeling abandoned, unsupported, and emotionally spent. Burnout, ethical distress, and difficulties in staff retention became increasingly evident, prompting urgent discussions about organizational accountability, workforce sustainability, and the adequacy of existing wellbeing frameworks for frontline healthcare workers (House of Commons Health and Social Care Committee, 2021; Buchan et al., 2022).

Although a growing body of research has examined nurses' experiences during the COVID-19 pandemic, much of this work has focused on acute stress, resilience, or immediate psychological impact. Less attention has been paid to how nurses described living with the longer-term consequences of sustained pressure once the emergency phase had passed, particularly in relation to organizational response and ethical responsibility. This study is grounded in that space, seeking to understand how physical and mental wellbeing were experienced, interpreted, and carried forward within everyday working life.

As a practitioner-researcher within the NHS, my professional experiences influenced both the study's emphasis and the interpretative framework employed in its execution. A comprehensive description of my positionality, along with the ramifications of insider research, is presented later in this chapter. This thesis employs a Constructivist Grounded Theory (CGT) methodology and is articulated in the first person. Charmaz (2014) asserts that researchers must "enter the scene" of their investigation, thereby clarifying their interpretive function (p. 27). She underscores that meaning is collaboratively created between the researcher and participants, necessitating reflexive, transparent, and contextually aware analysis (pp. 13, 161–162). Using the first-person perspective allows me to express analytical choices, exhibit reflexivity, and critically assess the impact of my professional background on the formulation and interpretation of the study's results. This method is consistent with the philosophical principles of CGT and improves the transparency and reliability of the research.

This study aims to investigate nurses' experiences during and after the COVID-19 pandemic, focussing on their perceptions of physical and mental wellbeing amidst ongoing uncertainty. While much attention has been directed toward immediate crisis response, this study is concerned with how nurses described continuing to work once the acute phase had passed, and how strain, responsibility,

and recovery were carried forward over time. Situated within a Constructivist Grounded Theory approach (Charmaz, 2014), the research seeks to develop an interpretive understanding of how endurance was produced, sustained, and, in some cases, exceeded within the contemporary healthcare organisation. Throughout the analysis, endurance emerged not simply as resilience or coping, but as the sustained continuation of nursing practice under prolonged physical, emotional, moral, and organizational strain. This introduction chapter lays the conceptual and contextual groundwork for subsequent chapters, encompassing a critical literature assessment, a description of the study strategy, presentation of findings, theoretical integration, and an examination of practical and policy implications.

1.1 Historical and Contemporary Context of the NHS

The National Health Service (NHS) was established in 1948 with the core premise of delivering comprehensive healthcare that is free at the point of access and financed by general taxation (Webster, 2002; Klein, 2019). It has evolved into one of the largest supported health systems worldwide, catering to a more diverse and ageing population with intricate and growing health requirements (Boyle, 2011; The King's Fund, 2020). In addition to these accomplishments, the NHS has had ongoing structural challenges, such as limited budget, increasing service demand, and enduring personnel deficits (Buchan et al., 2019; The Health Foundation, 2020).

In the ten years prior to the COVID-19 pandemic, these forces escalated. Austerity measures implemented in 2010 curtailed health funding growth, constraining worker expansion, and diminishing system capacity (Appleby, 2018; Health Select Committee, 2018). Nursing vacancy rates persisted at elevated levels in acute, community, and mental health services, resulting in heightened workloads, disparities in skill mix, and diminished possibilities for relational and patient-centred care (Royal College of Nursing, 2019; Ball et al., 2019; West et al., 2020).

Consequently, the NHS commenced the pandemic in a condition of increased organizational susceptibility. Persistent workforce and resource limitations hindered system adaptation and exacerbated the impacts of increasing demand, swift service reconfiguration, and heightened clinical acuity (The King's Fund, 2021; The Health Foundation, 2021). The conditions established the structural framework within which nurses had to function, influencing their experience of prolonged physical, mental, and ethical stress throughout the crisis and its subsequent aftermath (Ham et al., 2020; British Medical Association, 2021).

This historical and organizational framework positions nurses' physical and mental wellbeing not merely as a reaction to a singular crisis, but as a process integrated within a system marked by enduring stress, workforce volatility, and constrained organizational capacity. Comprehending the pre-

pandemic context is essential for understanding how nurses saw, coped with, and addressed the cumulative impacts of working during and after the COVID-19 pandemic.

1.2 Global and UK Effects of COVID-19 pandemic

The COVID-19 pandemic exerted significant pressure on global health systems, interrupting service provision, worker capacity, and organizational governance. Insufficient early clinical knowledge, ambiguity regarding transmission, and swiftly evolving guidelines created precarious and high-risk operating conditions inside healthcare contexts (Zhu et al., 2020; CDC, 2021). In the United Kingdom, increased hospital admissions and mortality necessitated the swift reorganization of clinical pathways within hospital and community services (ONS, 2021; Public Health England, 2020; Department of Health and Social Care, 2020). Regular modifications to national policies on infection control and personnel allocation led to persistent organizational ambiguity and operational instability (Greenhalgh et al., 2020).

Globally, shortages of personal protective equipment, staff illness, and rising demand for critical care hampered system response (Ranney et al., 2020; Cook et al., 2020). These problems made the NHS's already low staffing levels worse and made it harder to manage sudden increases in demand, which meant that staff had to work longer hours and be moved around more often (National Audit Office, 2020; The King's Fund, 2021). Repeated waves of infection prolonged these conditions, exposing nurses in acute, community, and primary care settings to ongoing clinical complexity, elevated mortality rates, and constant concerns about personal and familial risk (Billings et al., 2021; Kisely et al., 2020; Vindrola-Padros et al., 2020).

The dynamic characteristics of the pandemic, encompassing ongoing policy modifications and the introduction of virus variations, necessitated that healthcare organizations function in a perpetual state of adaptation (SAGE, 2021; GOV.UK, 2020). This resulted in nurses assuming broader duties, altered responsibilities, and extended involvement in high-stress settings with minimal chances for recuperation or organized psychological processing (Greenberg et al., 2020; Nyashanu et al., 2020). This context positions nurses' physical and emotional health within a framework of prolonged systemic pressure and governance instability, characterising wellbeing as a process influenced by constant organizational adaptation rather than a reaction to a specific crisis occurrence.

1.3 Effects of COVID-19 on Nurses' Physical and Mental Well-Being

UK and international studies indicate significant physical and psychological stress experienced by nurses during the COVID-19 pandemic. Prolonged shifts, elevated patient acuity, and ongoing staffing deficiencies have led to chronic weariness and constant physical strain, exacerbating current workforce challenges within the NHS (Duncan, 2020; Fernandez et al., 2020; Shaukat et al., 2020;

British Medical Association, 2021). Extended utilisation of personal protective equipment correlated with dehydration, hyperthermia, limited mobility, musculoskeletal discomfort, and dermal injury, thereby normalising physical distress as a regular aspect of daily practice instead of a transient crisis response (Lan et al., 2020; Ong et al., 2020; Stewart et al., 2021).

Redeployment into unfamiliar clinical environments, frequently with little preparation, heightened both physical and cognitive demands, while disrupted sleep and constant vigilance diminished opportunities for recuperation (Adams and Walls, 2020; Vindrola-Padros et al., 2020; Al Maqbali et al., 2021). Nurses experienced ongoing emotional and ethical stress due to rising mortality rates, restricted family participation during end-of-life scenarios, and ongoing concerns about personal and familial risk (Maben and Bridges, 2020; Kisely et al., 2020; Billings et al., 2021; Aughterson et al., 2021).

These interactions were also affected by the way the organizations were set up. Frequent changes to policies, poor communication, a lack of leadership, and continuing staffing shortages all made the workplace unstable and made it harder to get official psychological help (Shanafelt et al., 2020; West et al., 2020; Kinman et al., 2020). Peer support was an important informal resource, but emotional repression and long hours of labour were often seen as difficult to keep up with over time, which caused exhaustion and made it harder to manage emotions (Sun et al., 2020; Greenberg et al., 2020).

Despite an expanding body of research, a huge portion of the literature continues to be quantitatively focused, emphasising symptom prevalence rather than examining how nurses understand, manage organizational demands, and conceptualise wellbeing within their professional environments (Kisely et al., 2020; Al Maqbali et al., 2021). A significant deficiency persists in qualitative, theory-generating research that investigates the interplay between physical strain, emotional burden, and organizational conditions inside NHS environments during and post-pandemic (Hoernke et al., 2021; Aughterson et al., 2021).

1.4 Constructivist Grounded Theory: Methodological Framework

This research adopts Constructivist Grounded Theory (CGT) as defined by Charmaz to investigate how nurses derive meaning regarding their mental and physical well-being within certain organizational and social contexts (Charmaz, 2014; Bryant and Charmaz, 2019). CGT regards information as contextual and collaboratively generated through interaction, putting the researcher as an active participant in analytical interpretation rather than a dispassionate observer. Unlike objectivist grounded theory traditions, CGT acknowledges that data and theory are influenced by the researcher's posture, interpretive choices, and interaction with participants. My viewpoint is especially pertinent to my study, considering my position as a practitioner-researcher within the NHS, which influenced field access, participant engagement, and analytical acuity (Charmaz, 2014).

CGT highlights process, comparison, and reflexive analysis. Constant comparison, iterative coding, memo-writing, and theoretical integration were employed to formulate conceptually grounded categories that closely correspond with participants' narratives while facilitating analytic abstraction over time (Birks and Mills, 2015; Charmaz, 2014). This methodological approach is grounded in a relativist ontology and a subjectivist epistemology, wherein meaning is perceived as multifaceted, contextually dependent, and collaboratively generated between the researcher and participants. Throughout all phases of the study, CGT served as both an analytical tool and an interpretative framework, facilitating the formulation of a grounded theoretical explanation of nurses' experiences within the organizational and structural contexts influenced by the COVID-19 pandemic.

Ontological Position: Relativism

This study adopts a relativist ontological stance, viewing reality as multiple and contextually produced through social interaction and interpretation rather than as a single, objective condition (Guba and Lincoln, 1994; Charmaz, 2014). In keeping with Constructivist Grounded Theory, meaning is understood as generated within institutional and relational settings rather than discovered as a fixed truth. Nurses' physical and mental wellbeing is therefore conceptualised as a situated and variable process shaped by role, organizational support, workload, leadership practices, and access to recovery resources, with experiences differing across contexts and professional positions (Bryant and Charmaz, 2019; Mills et al., 2006).

As an NHS practitioner-researcher, my positionality is treated as an analytic condition rather than a source of bias to be removed. Access to the field, engagement with participants, and interpretive decisions are recognised as part of the knowledge-producing process, requiring ongoing reflexive scrutiny. This ontological stance provides a coherent philosophical foundation for the study's interpretive aims and directly informs the subjectivist epistemology through which meaning is examined as relational, contextual, and co-constructed.

Epistemological Position: Subjectivism / Constructivism

This study adopts a subjectivist epistemological stance, viewing knowledge as interpretive and co-constructed through interaction between the researcher and participants within specific social, historical, and organizational contexts (Guba and Lincoln, 1994; Charmaz, 2014). In line with Constructivist Grounded Theory (CGT), evidence, analysis, and theory are treated as contextual interpretations rather than objective representations of reality (Bryant and Charmaz, 2019; Mills et al., 2006).

Nurses' accounts of their physical and mental wellbeing are therefore understood as situated narratives shaped by professional roles, organizational cultures, and broader social conditions, rather than as fixed or quantifiable states (Charmaz, 2014). This orientation enables analysis of how participants interpret organizational responses, workplace demands, and wellbeing over time.

Reflexivity is integral to this stance. As a practitioner-researcher within the NHS, my positionality informs access to the field, engagement with participants, and analytic interpretation. Rather than bracketing this influence, a constructivist approach foregrounds transparency and critical self-awareness, recognising meaning as relational and contextually produced (Birks and Mills, 2015; Charmaz, 2014).

This epistemological position aligns with a relativist ontology, establishing a coherent philosophical framework in which theory is developed from the co-constructed experiences of nurses working during and after the COVID-19 pandemic (Bryant and Charmaz, 2019).

1.5 Researcher Positioning and Reflexivity

This study was conducted from the position of a practitioner-researcher with a professional background in nursing and clinical research within the NHS. In accordance with the interpretive tenets of Constructivist Grounded Theory (CGT), I acknowledge that researchers are not impartial observers but engaged contributors in the creation of knowledge. The experiences, values, and assumptions of researchers shape the questions they pose, their interactions with participants, and the interpretations they get from analysis (Charmaz, 2014).

My engagement with the research was therefore shaped by both insider familiarity with healthcare systems and an ongoing reflexive awareness of how this positioning influenced access, interpretation, and analytic judgement. Rather than seeking neutrality, I approached this study in line with constructivist grounded theory, recognising knowledge as co-constructed through interaction, context, and interpretation. As a practitioner-researcher this role influences both my motivation for this study and the perspective from which I approach the research process.

At the time of this study, I am employed by the NHS as a Projects and Research Associate in the Occupational Health and Wellbeing Service. I am a registered general nurse, and most of my professional experience has been in clinical research environments. Throughout the COVID-19 pandemic, I functioned as a clinical research practitioner and held the position of lead nurse for the SIREN public health study, which investigated SARS-CoV-2 infection and immunity in healthcare workers. This position offered constant insight into the challenges encountered by nurses during the pandemic and served as a primary impetus for pursuing this PhD thesis. This practitioner-researcher positioning shapes my analytical awareness, ethical framework, and interpretation of participants' narratives throughout the project.

Having insider knowledge of the NHS provides a profound comprehension of organizational frameworks, professional terminology, and the pressures influencing nurses' professional experiences. This familiarity facilitates rapport-building with participants, especially when addressing emotionally charged and ethically complicated experiences stemming from the COVID-19 pandemic. It also

facilitates awareness of the organizational settings and structural restrictions that shape participants' narratives. Nonetheless, insider research also has methodological hazards. Common professional backgrounds might create expectations of mutual understanding, promote implicit communication, or result in excessive identification with participants, thus constraining analytical depth if not critically assessed (Charmaz, 2014; Birks and Mills, 2015).

Reflexivity was employed constantly and iterative technique throughout the study process to tackle these problems. Reflexivity was considered not as a separate methodological phase but as an ongoing perspective that influenced data collection, analysis, and theory formulation. I conducted reflective memo-writing, kept a personal research diary, and engaged in regular analytical discussions with supervisors to critically assess how my positionality influenced interpretation. For instance, when participants mentioned experiences or organizational practices that aligned with my professional background, I deliberately sought clarification instead of presuming a shared understanding, thereby prioritising the participants' perceptions.

I meticulously considered power issues within the research interaction, even among collaborative professional societies. Although my NHS position enabled access and fostered trust, it also necessitated an awareness of participants' apprehensions about judgement, disclosure, or organizational consequences. I consequently sought to establish interview and focus group settings that emphasised psychological safety, transparency, and voluntary involvement. During the analysis, I prioritised the voices of participants and regarded meaning as co-constructed rather than imposed.

My insider status further influenced my interpretation of organizational narratives and systemic forces. My comprehension of the situations described by participants was shaped by my knowledge of NHS policy frameworks, workforce structures, and institutional responses. I acknowledged that my viewpoint was but one among many, and that nurses' experiences differed markedly based on their function, environment, seniority, and support systems. This knowledge fostered analytical transparency and mitigated the risk of over-generalization.

Engaging reflexively necessitated ongoing scrutiny of my interpretations, contemplation of alternate explanations, and receptiveness to complexity, especially when results contradicted my expectations or assumptions. This reflexive technique was crucial for maintaining the analysis in alignment with participants' meanings rather than being only interpreted via my professional perspective (Charmaz, 2014; Mills et al., 2006).

By clarifying my positionality and using reflexivity throughout the study, I sought to maintain the transparency, credibility, and ethical integrity essential to CGT. This methodology corresponds with a constructivist-interpretivist framework and facilitates the formulation of theory that is contextual, relational, and rooted in the actual experiences of nurses during and after the COVID-19 pandemic.

1.6 Local Context of the Research

This research was conducted within a comprehensive, integrated acute and community National Health Service (NHS) Trust located in the West Midlands region of England. The Trust provides an extensive array of services in both primary and secondary care, encompassing acute hospital services, district nursing, outpatient and intermediate care, community health clinics, and specialised provisions. It caters to a highly diversified population marked by ethnic heterogeneity, socioeconomic disparities, and persistent health inequalities (NHS England, 2021; The King's Fund, 2020).

These social and demographic attributes influence both the demand for healthcare services and the working conditions encountered by nurses. Communities with elevated deprivation and suboptimal baseline health were disproportionately impacted by COVID-19, amplifying the intensity, complexity, and emotional labour demanded from healthcare workers. Nurses operating in acute and community environments had constant engagement with high-risk clients, intricate care requirements, and increased clinical accountability. (Marmot et al., 2020; Office for National Statistics, 2021; The Health Foundation, 2021; Maben and Bridges, 2020; West et al., 2020).

Throughout the pandemic's peak periods, the Trust functioned across many hospital and community locations and was necessitated to swiftly adjust to changing circumstances. Services were rapidly restructured, elective procedures were diminished or suspended, and personnel from various departments were reassigned to areas of highest clinical demand. These modifications transcended acute hospital treatment. Community services faced considerable pressure in supporting vulnerable and isolated populations, providing in-home care, and adapting to constantly evolving infection prevention and control directives (Vindrola-Padros et al., 2020; Burton et al., 2020).

For nurses, these organizational conditions entailed functioning within an environment of perpetual operational change, frequently in unfamiliar roles or locales and amid enduring uncertainty. Nurses, regardless of their placement in acute wards, outpatient services, or community teams, adeptly managed evolving clinical priorities, increased workloads, and the psychological challenges associated with enduring a prolonged public health emergency. Significantly, these constraints persisted beyond the relaxation of pandemic limitations, continuing to influence nurses' experiences of recovery, reflection, and sustained wellbeing in the post-pandemic era (Maben and Bridges, 2020; Peters et al., 2020; Vindrola-Padros et al., 2020; NHS England, 2023; Morley et al., 2021; Billings et al., 2022).

Comprehending this organizational and local context is essential for interpreting participants' narratives within this study. The Trust's cohesive framework, workforce dynamics, and demographic attributes strongly affect nurses' perceptions of their physical and mental wellbeing during and post-COVID-19. The incorporation of both acute and community care offers a crucial analytical

perspective for examining the similarities and variations in nurses' experiences across various settings in subsequent chapters.

By contextualising the research within this NHS framework, the study remains cognisant of place, structure, and community as dynamic influences on experience. This framework facilitates a detailed and context-aware examination of nurses' health and establishes a basis for comprehending how organizational conditions influence the patterns, processes, and significances that arise throughout the study.

1.7 Research Aims and Objectives

The key objective of this study is to find out how nurses feel about and experience their mental and physical well-being while working during and after the COVID-19 pandemic. This objective underscores the study's foundation in Constructivist Grounded Theory (CGT), highlighting its focus on meaning-making, interpretation, and lived experiences within organizational and social contexts.

The study aims to comprehend how nurses interpret their feelings amid remarkable and prolonged demand, rather than viewing wellbeing as a quantifiable or static result. This encompasses their interpretation of physical, emotional, and organizational problems, the solutions they devise to manage persistent ambiguity, and their interactions with, responses to, or influences from organizational systems and support structures across time. Consistent with a constructivist grounded theory approach, this study was guided by a single overarching research question, supported by a set of analytic objectives that evolved as data collection and analysis progressed.

This study is directed by four interconnected research aims to accomplish its aim:

To investigate how nurses articulate and comprehend their physical and mental wellbeing during and after the COVID-19 pandemic.

To investigate the organizational, physical, emotional, and structural factors that influence nurses' sense of well-being.

To comprehend the tactics employed by nurses to manage workplace stress, uncertainty, and evolving clinical needs.

To develop a grounded theoretical interpretation of how nurses navigate and make sense of their wellbeing within the context of pandemic and post-pandemic nursing practice.

These objectives were pursued iteratively through data collection, constant comparison, and analytic memo-writing, and are carefully structured to facilitate theory development and interpretive exploration rather than simple description or evaluation. They offer a distinct analytical framework for the study by emphasising nurses' viewpoints while also considering the organizational and structural circumstances that shape those viewpoints. By doing so, they direct the analytical advancement of the

thesis and lay the foundation for the development of a robust grounded theory that can enhance comprehension, practice, and future organizational responses.

1.8 Chapter Summary

This introductory chapter has delineated the setting, justification, and underlying framework of the study. The research contextualises the global and national ramifications of the COVID-19 pandemic, emphasising the extraordinary pressures imposed on nurses and the broader National Health Service (NHS). This highlighted the necessity for a thorough investigation into nurses' physical and mental wellbeing, considering the emotional, organizational, and physical stresses inherent in nursing during and after the pandemic. The chapter additionally presented the setting of the local NHS Trust and highlighted deficiencies in the current literature, notably the prevalence of quantitative and symptom-centric research. Collectively, these components provide a definitive justification for the study and lay the foundation for the comprehensive literature review in Chapter 2.

The chapter delineated the conceptual and methodological foundations of the study, emphasising the utilisation of Constructivist Grounded Theory (CGT), first-person narrative, and reflexivity as essential components for analytic rigour and transparency (Charmaz, 2014). The research aims and objectives elucidated the study's concentration on nurses' experiences and perceptions of their wellbeing, the strategies employed to manage ongoing pressures, and their interaction with organizational responses. As the thesis progresses, the analysis moves from participants' accounts toward the development of a grounded theory of endurance and its wider organizational and ethical implications, which are explored in later chapters through integrative conceptual structures and governance-oriented interpretations. The analytic development of endurance mechanisms, and the theory-derived governance concepts introduced later in the thesis are not pre-specified at this stage but are progressively elaborated through constant comparison and theoretical integration and are formally developed in Chapters 6 to 8.

Thesis Structure

This thesis comprises eight chapters, each facilitating the formulation and synthesis of a grounded theoretical framework regarding nurses' health during and post-COVID-19 pandemic, in alignment with Constructivist Grounded Theory (CGT).

Chapter 2 situates the study within existing literature on nurses' wellbeing, organizational ethics, and moral dimensions of healthcare work, identifying conceptual spaces that inform the research focus. Chapter 3 outlines the methodological approach and analytic processes through which the data were generated and interpreted. Chapter 4 provides an account of the analytic pathway, demonstrating how codes, categories, and conceptual groupings were developed. Chapter 5 presents the findings through four interrelated categories, followed by Chapter 6, which integrates these into a grounded theory of endurance. Chapter 7 situates the theory in dialogue with existing scholarship and considers its

conceptual and applied implications. Finally, Chapter 8 draws together the study's contributions, boundaries, and next steps.

Chapter 2: Literature Review

2.1 Introduction to the Integrated Literature Review

This chapter examines the current evidence base to situate the study within established knowledge, ongoing debates, and areas that lack clarity. I present an Integrated Literature Review (ILR) as a strategic methodological decision due to the multifaceted nature of the phenomena under investigation, which encompasses nursing practice, workforce wellbeing, organizational behaviour, ethics, and health policy. An ILR facilitates the amalgamation of empirical research, theoretical frameworks, and reputable professional and policy sources into a unified, conceptually cohesive narrative, rather than considering these bodies of literature as separate or isolated (Whittemore and Knafl, 2005). In accordance with Constructivist Grounded Theory (CGT), the literature serves as a sensitising resource to augment theoretical sensitivity, without preordaining analytical results (Charmaz, 2006; Charmaz, 2014).

Grounded theory traditions differ in their approach to engaging with current literature. Glaser warned that premature absorption could limit analytical openness, but Strauss and Corbin highlighted the importance of literature in enhancing comparative analysis and theoretical understanding (Glaser, 1992; Strauss and Corbin, 1998). Charmaz's constructivist methodology presents a pragmatic stance, facilitating reflexive and iterative interaction with literature, provided that analytical choices are transparent and anchored in participants' narratives (Charmaz, 2006; Charmaz, 2014). I undertook a two-phase approach to the literature: first, a comprehensive overview of workforce wellbeing during and after COVID-19, followed by a more targeted re-engagement when analytical insights emerged through coding and memo-writing.

This chapter's focus encompasses more than just the acute periods of the pandemic. The research increasingly acknowledges that the effects on nurses persisted beyond the decline of infectious waves. Emerging post-pandemic evidence continues to demonstrate persistent physical and psychological after-effects, ongoing moral and ethical strain, and sustained workforce instability that continue to shape nurses' physical and mental wellbeing long after the acute phases of the pandemic had subsided (RCN, 2026a; RCN, 2026b; Billings et al., 2025).

constant

More recent workforce evidence suggests that the pressures experienced by nurses did not simply disappear with the reduction of infection waves. Across the NHS, concerns relating to exhaustion, burnout, workforce retention, and declining organizational trust continue to shape nurses' experiences of working in the post-pandemic period. Findings from the 2025 NHS Staff Survey, published in

2026, demonstrated continuing increases in work related stress and emotional exhaustion across the NHS workforce, reinforcing concerns that many nurses continue to work within systems still struggling to recover from the cumulative effects of the pandemic (NHS Employers, 2026; UCL, 2026; Nursing in Practice, 2026).

This framework is crucial to the current study, as it characterises wellbeing as a dynamic experience influenced by organizational conditions, professional responsibilities, and the way support and accountability were implemented over time.

This ILR thus fulfils a distinct role within the broader thesis narrative. This work consolidates current knowledge about nurses' wellbeing during and post-COVID-19, highlights conceptual and methodological shortcomings in prior studies, and underscores the necessity for an interpretive, theory-building methodology. This process reveals contradictions in the framing of wellbeing, especially with the emphasis on human responsibility over systemic organizational factors, without anticipating the categories derived from the study data. The chapter finishes by highlighting the gaps addressed by this research and transitions to Chapter 3, which outlines the methodological choices directing data creation and analysis.

2.2 Justification and Methodological Framework for the Integrated Literature Review

The literature review was integrated into the analytic process rather than being conducted as a discrete preliminary stage. This approach enabled me to identify conceptual gaps, dominant assumptions, and recurring patterns within existing research, particularly the limited attention given to organisational accountability and the ethical dimensions of sustained workforce strain (Maben et al., 2020; Billings et al., 2021). Engagement with the literature occurred iteratively alongside data collection and analysis, supporting theoretical sensitivity without directing category development, in keeping with Constructivist Grounded Theory principles (Charmaz, 2014).

The use of an Integrated Literature Review (ILR) also required ongoing reflexive awareness throughout the review process. Unlike systematic reviews, which often prioritise procedural standardisation and exhaustive retrieval, the ILR involves interpretive synthesis across diverse forms of evidence and therefore requires transparent analytical decision-making and critical engagement with conceptual relevance (Toronto and Remington, 2020). Within this study, reflexivity was essential in enabling me to engage critically with existing scholarship while remaining open to participants' meanings and the emergent direction of the analysis, consistent with Constructivist Grounded Theory principles (Charmaz, 2014).

A particular strength of the ILR was its ability to bring together empirical research, theoretical literature, professional discourse, and policy evidence to create a broader understanding of nurses' physical and mental wellbeing during and after the COVID-19 pandemic. This was especially

important given the complexity of wellbeing as a phenomenon shaped by physical demands, psychological experiences, ethical challenges, organisational conditions, leadership practices, and wider policy environments. Rather than limiting the review to a single form of evidence, the ILR enabled these different perspectives to be examined together, providing a richer and more contextually informed understanding of the issues under investigation (Whittemore and Knafl, 2005; Toronto and Remington, 2020).

The flexibility of the ILR also supported theoretical sensitivity by allowing iterative engagement with the literature as conceptual insights developed through coding, memo-writing, and ongoing reflexive analysis. This was particularly valuable within a rapidly evolving post-pandemic context, where emerging evidence continued to demonstrate that concerns relating to burnout, fatigue, workforce retention, and organisational pressures remained ongoing realities for many nurses rather than issues confined to the acute phases of the pandemic (NHS Employers, 2026; Hu et al., 2026; Felion et al., 2026). The ILR therefore provided a methodological framework capable of accommodating both established and emerging evidence while maintaining alignment with the interpretive aims of the study.

However, the interpretive flexibility that represents a strength of the ILR also introduces potential limitations. Unlike review approaches guided by highly prescriptive procedures, the ILR allows greater scope for analytical judgement, which may increase the potential for selective emphasis or interpretive influence by the researcher (Toronto and Remington, 2020). Recognising this possibility, I maintained transparency throughout the review process by documenting decisions relating to inclusion, synthesis, and conceptual relevance through memo-writing, supervisory discussion, and ongoing comparison with participants' accounts. This reflexive process supported analytical openness while ensuring that the literature informed, rather than predetermined, theoretical development.

Taken together, these strengths and limitations reflect the interpretive nature of the ILR and its compatibility with Constructivist Grounded Theory. Rather than seeking exhaustive coverage or definitive conclusions, the review provided a theoretically informed and contextually grounded foundation from which to explore nurses' experiences of physical and mental wellbeing during and after the COVID-19 pandemic.

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while ensuring that the literature informed, rather than predetermined, theoretical development. The following section outlines the search strategy and study identification procedures used to locate and select relevant literature.

2.3 Search Strategy and Study Identification

The search strategy for this Integrated Literature Review (ILR) was formulated to align with the study's emphasis on nurses' physical and mental wellbeing during and post-COVID-19 pandemic, adhering to the iterative and reflexive principles of Constructivist Grounded Theory (CGT) (Charmaz, 2014). The search highlighted literature that elucidates the experience, interpretation, and influence of wellbeing within clinical, organizational, and policy contexts, rather than seeking comprehensive numerical coverage.

A preliminary scoping phase was conducted to delineate the extent of pandemic-related nursing literature and to ascertain prevalent themes of physical fatigue, psychological discomfort, emotional labour, and wellbeing support. Consistent with CGT, the search method was iterative, involving more targeted searches as analysis advanced and new conceptual issues arose through coding and memo-writing (Charmaz, 2014).

Databases and Resources

Investigations were performed across the subsequent electronic databases: CINAHL Plus, MEDLINE, PsycINFO, PubMed, ScienceDirect, and Google Scholar. These databases were chosen for their pertinence to nursing, healthcare, psychology, and organizational study.

Alongside peer-reviewed academic literature, professional and policy sources were used to contextualise nurses' wellbeing within practical workforce environments. The sources comprised reports from the Royal College of Nursing (RCN, 2021; 2024), NHS England (2022; 2023), the World Health Organization (WHO, 2021), and submissions to the UK COVID-19 Inquiry (2024). The inclusion of these sources facilitated an analysis of the framing of nurses' physical and mental wellbeing within policy, professional discourse, and academic research (Grant and Booth, 2009; Snyder, 2019).

Search Terminology and Methodology

Search phrases were created iteratively and honed through preliminary searches, abstract evaluations, and analytical memo composition. Fundamental concepts centred on nursing, COVID-19, post-pandemic healthcare, and both physical and mental well-being. Relevant additional terms concerning moral distress, organizational support, leadership, and workforce policy were incorporated to elucidate the variables influencing wellbeing.

Boolean operators, truncation, phrase searching, and database-specific subject headings, such as MeSH words and CINAHL headings, were employed to improve precision. All searches, modifications, and decision-making processes were recorded utilising reference-management software to provide transparency and auditability (Whittemore and Knafl, 2005).

Identification, Screening, and Selection of Studies

The preliminary searches produced 632 records. After eliminating 294 duplicates, 338 titles and abstracts were evaluated for their relevance to nurses' experiences about physical and mental wellbeing during and post the COVID-19 pandemic.

Studies were not selected at the title and abstract stage if they concentrated on non-nursing populations, discussed COVID-19 without mentioning wellbeing, or presented prevalence data lacking interpretive or experiential analysis. This led to the evaluation of 20 full-text papers for eligibility.

Full-text screening emphasised conceptual contribution and interpretive depth, aligning with Integrated Literature Review technique and Constructivist Grounded Theory principles (Whittemore and Knafl, 2005; Charmaz, 2014). Ten studies were omitted due to the absence of nurse-specific analysis, primarily quantitative or prevalence-oriented designs, minimal focus on wellbeing as a core phenomenon, or inadequate analytical transparency. The last 10 qualitative studies constituted the empirical foundation of the Integrated Literature Review.

Table 2.1 below delineates the rationale for exclusion judgements, emphasising conceptual significance and interpretive depth, rather than solely relying on methodological hierarchy, to provide transparency following the full-text eligibility evaluation.

Table 2.1 Full-Text Articles Excluded Following Eligibility Assessment (n = 10)

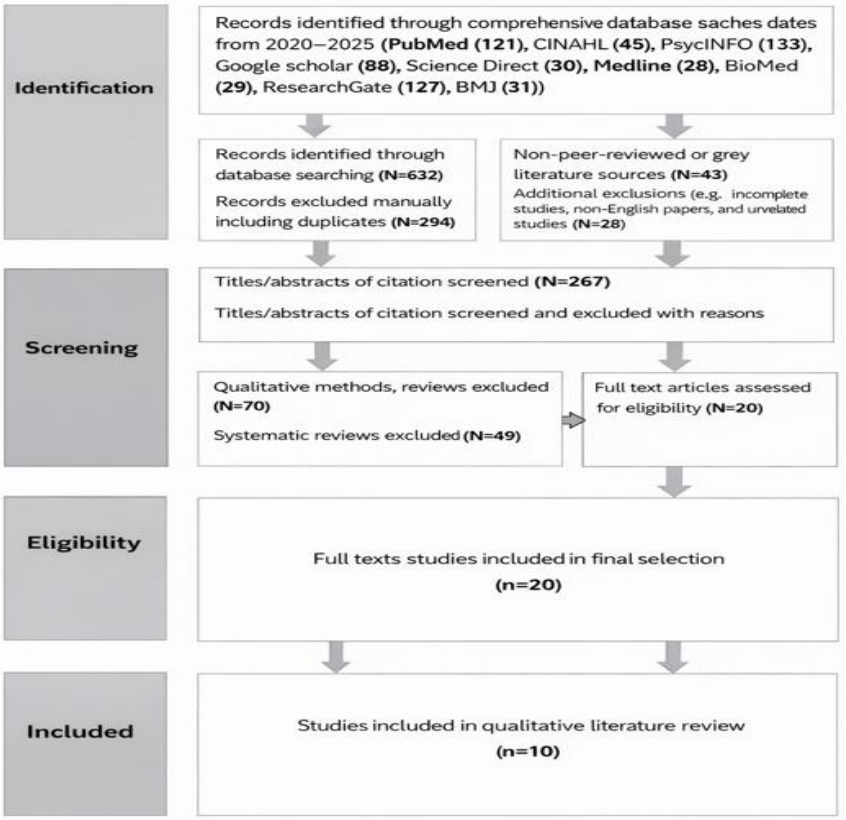
Reason for Exclusion	Rationale	Number of Studies (n)
Not nurse-specific	Findings were not disaggregated for nurses or focused on mixed healthcare populations	3
Quantitative / prevalence-focused only	Reported prevalence of distress or burnout without interpretive or experiential analysis	3
Wellbeing not central	Physical or mental wellbeing was not a primary analytic focus	2
Limited interpretive depth	Insufficient reflexivity, analytic transparency, or conceptual engagement	2

Total excluded at full-text stage		10

Figure 2.1 below provides a PRISMA flow diagram that delineates the processes of identification, screening, eligibility, and inclusion in the Integrated Literature Review, hence facilitating auditability in research identification and screening (Page et al., 2021). Although PRISMA is linked to systematic reviews, its application in this context facilitates transparent documentation of selection choices without undermining the iterative and reflective tenets of CGT (Charmaz, 2014).

Figure 2.1 PRISMA flow diagram illustrating the identification and selection of studies.

Analytical Examination of the Search Procedure



In accordance with Constructivist Grounded Theory, the search process served as an initial analytic site rather than a neutral preliminary phase (Charmaz, 2014). Reflexive memo-writing was employed consistently to record developing patterns, tensions, and conceptual gaps within the literature.

The findings consistently framed nurses' wellbeing in terms of psychological distress, exhaustion, burnout, and personal coping mechanisms. This work produced useful insights into rapid psychological responses but provided scant conceptual focus on protracted exposure, cumulative physical strain, and organizational accountability for sustained wellbeing (Traynor, 2018; Maben et

al., 2020; Billings et al., 2021). Physical wellbeing was frequently addressed implicitly or incorporated into broader conversations of stress rather than being analytically emphasised.

Contemporary workforce evidence suggests that these concerns continue to remain insufficiently resolved within the NHS workforce. Recent survey findings indicate that many nurses continue working despite physical exhaustion, emotional strain, and psychological distress because of ongoing staffing shortages, workload intensity, and operational pressures across healthcare services (RCN, 2025; NHS Employers, 2026). These findings further reinforce concerns that physical wellbeing often remains less visible within organizational and academic wellbeing discourse, despite its considerable influence on nurses' ability to function, recover, and remain within the profession over time. Recognising these patterns improved analytical sensitivity while allowing for unrestricted interpretation. Instead of creating rigid categories, the search process revealed conceptual gaps that drove subsequent research while maintaining receptiveness to nurses' narratives.

This technique ensured that the Integrated Literature Review upheld theoretical sensitivity while adhering to CGT principles. The subsequent section delineates the inclusion and exclusion criteria employed to improve the final corpus of literature.

2.4 Eligibility Criteria (Inclusion and Exclusion)

To guarantee that the literature incorporated in this Integrated Literature Review (ILR) offered analytically significant insights into nurses' experiences of physical and mental wellbeing during and post-COVID-19 pandemic, specific inclusion and exclusion criteria were implemented. The criteria were guided by integrative review methodology, which emphasises conceptual relevance and interpretive contribution rather than strict evidential hierarchies (Whittemore and Knafl, 2005; Torraco, 2005; Snyder, 2019) and were consistent with the theory-building focus of Constructivist Grounded Theory (CGT) (Charmaz, 2014).

In accordance with ILR methodology, the selection of studies was determined by conceptual relevance, interpretative depth, and the ability to enhance understanding of wellbeing as a contextual and relational phenomena. Inclusion decisions prioritised the ability of research to reveal how nurses encountered physical strain, psychological discomfort, and wellbeing issues in pandemic and post-pandemic healthcare settings, rather than only emphasising methodological design.

In accordance with CGT principles, the literature was used as a sensitising resource rather than a prescriptive framework (Charmaz, 2014). Consequently, studies were chosen that provided insights into meaning-making, organizational settings, and systemic implications on well-being. Literature that was solely descriptive or disconnected from organizational and contextual elements was deprioritized.

Inclusion Criteria

The review includes studies that satisfied the following criteria:

Demographic: Registered nurses or nursing associates employed in clinical, community, or managerial environments. Only studies using interdisciplinary populations were included if the perspectives of nurses were distinctly identifiable and presented separately.

Subject of inquiry: Analysis of nurses' physical and mental wellbeing, encompassing exhaustion, illness, psychological anguish, emotional strain, or recovery, as well as the investigation of organizational variables influencing these experiences during and after the COVID-19 pandemic.

Design and methodology: Qualitative research was emphasised for their ability to encapsulate lived experiences, interpretative significance, and contextual intricacies (Green and Thorogood, 2018). Mixed-methods studies were included when qualitative findings were distinctly described and demonstrated adequate analytical depth.

Priority was assigned to studies conducted in the UK to ensure relevance to the NHS and its accompanying policy framework. International research was incorporated that provided comparative insights or highlighted common worldwide patterns pertinent to nurse wellbeing.

Time-frame: Research published from January 2020 to May 2026, encompassing both acute pandemic phases and the prolonged effects on nurses' wellbeing.

Language and accessibility: Full-text, peer-reviewed studies in the English language are available.

Conceptual contribution: Research providing conceptual, theoretical, or interpretive insights on the wellbeing of nurses or organizational conditions, irrespective of sample size.

Exclusion Criteria

Studies were excluded if they:

Concentrated solely on nursing students, scholars, or other professional cohorts without specific delineation of nurses' experiences.

Consolidated several healthcare occupations without distinguishing nurse-specific observations.

Used exclusively quantitative methodologies that present prevalence or symptom scores devoid of interpretative analysis.

Prior to 2020 or pertaining to unrelated infectious illness situations.

Composed exclusively of editorials, opinion articles, or commentary lacking empirical or analytical substance, apart from a few high-quality policy reports used for contextual framing.

Were either inaccessible in their entirety or did not satisfy the basic quality criteria during evaluation (see Section 2.5).

Analytical Justification for Inclusion Determinations

Consistent with CGT, decisions about inclusion and exclusion were regarded as philosophically informed judgements rather than just procedural checkpoints (Charmaz, 2014). The screening revealed that the predominant focus of the existing literature was on individual coping, stress, or resilience, with insufficient emphasis on cumulative physical strain or organizational accountability. This pattern guided selection decisions by favouring research that defined wellbeing as relational, contextual, and integrated within organizational systems.

Quantitative studies that reported burnout or distress in isolation were eliminated unless they provided critical contextual insight. Conversely, smaller qualitative investigations were preserved as they highlighted nurses' embodied experiences, psychological burdens, and interactions with organizational settings. This methodology corresponds with Whittemore and Knafl's (2005) focus on conceptual depth and reinforces CGT's dedication to profundity, reflexivity, and the construction of meaning.

Table 2.2 delineates the eligibility criteria used in the review, elucidating how factors such as population, phenomena, design, context, and conceptual contribution influenced the selection of studies, so rendering inclusion and exclusion decisions transparent.

Table 2.2 Summary of the inclusion and exclusion criteria used in the Integrated Literature Review.

Criterion	Inclusion	Exclusion	Rationale
Population	Registered nurses or nursing associates	Students, faculty, mixed samples without nurse-specific data	To focus on practising nurses' professional experiences
Phenomenon	Physical and/or mental wellbeing; organizational context	Clinical outcomes without wellbeing focus	To maintain alignment with the study's research aims
Design	Qualitative or mixed-methods (with clear qualitative findings)	Purely quantitative studies	To support interpretive, theory-building analysis
Context	UK-based and selected international studies	Contexts lacking relevance to healthcare systems	To ensure policy and organizational relevance
Period	January 2020 – May 2026	Pre-2020 or unrelated contexts	To capture pandemic and post-pandemic impacts
Type	Peer-reviewed research; selected policy reports	Editorials or opinion pieces without data	To preserve analytic rigour

The eligibility criteria were established to harmonise scientific transparency with interpretive depth, ensuring that the resulting literature facilitated theory-building rather than just descriptive collection. This portion enhances the analytical foundation of the ILR by emphasising conceptual contribution and its significance to nurses' physical and mental well-being, hence facilitating quality appraisal.

Although additional post-pandemic studies published during late 2025 and early 2026 were reviewed as part of my ongoing engagement with the literature, they were not incorporated into the final data extraction or CASP appraisal process. As the study progressed, I continued to review emerging evidence to ensure that the literature remained current and responsive to developments within nursing and healthcare research. This included recent studies examining moral distress (Sydor et al., 2026; Orgambídez et al., 2025), burnout and quality of working life (Saleh et al., 2025; Catarelli et al., 2026), resilience and wellbeing (Lin et al., 2026; McKenna Lawson et al., 2026), post-pandemic working conditions (Sun et al., 2026), workforce resilience and work environments (Hu et al., 2026), organizational responses to moral injury (Sorina et al., 2025), the impact of long COVID on healthcare workers (Al-Oraibi et al., 2025), occupational fatigue (Pi et al., 2025), workforce retention and trust rebuilding (Felion et al., 2026), and nurses' experiences of redeployment and wellbeing following the pandemic (Dunning et al., 2024).

While these studies reinforced ongoing concerns regarding nurses' wellbeing, workforce instability, burnout, resilience, moral distress, and post-pandemic recovery, many continued to focus on individual psychological outcomes, workforce indicators, or broader healthcare populations. A substantial proportion employed cross-sectional, survey-based, systematic review, or quantitative approaches. Although valuable, these studies did not substantially extend the interpretive, constructivist, nurse-specific, and theory-generating focus that underpinned the final Integrated Literature Review sample. Their findings largely echoed concerns already identified within the reviewed literature rather than providing new conceptual insights aligned with the inclusion criteria and analytical aims of this study.

Consistent with Constructivist Grounded Theory principles, these more recent publications were therefore used as contextual and sensitising resources to maintain theoretical sensitivity and awareness of contemporary developments within the field, rather than retrospectively altering the established review framework, quality appraisal process, or final review corpus (Charmaz, 2014). This approach preserved methodological consistency while ensuring that the study remained informed by emerging post-pandemic evidence.

Section 2.5 delineates the methodology employed to evaluate the credibility, coherence, and analytical significance of the included research using the CASP qualitative checklist.

2.5 Quality Appraisal (CASP)

The Critical Appraisal Skills Programme (CASP) Qualitative Checklist was employed to evaluate the credibility, methodological coherence, ethical transparency, and analytic depth of all included studies, rather than to hierarchically rank evidence (CASP UK, 2018). In line with Constructivist Grounded Theory (CGT), appraisal was treated as a contextual and reflexive process that prioritised conceptual contribution and transparency over procedural uniformity (Charmaz, 2014).

Studies were retained where methodological quality supported interpretive synthesis, even where minor limitations were present. Appraisal focused on clarity of aims, coherence between design and methods, transparency of sampling and data collection, attention to reflexivity, ethical considerations, and the depth and clarity of analytic claims. Concise evaluation notes were recorded to inform subsequent comparison and synthesis.

Table 2.3 below summarises the appraisal outcomes for the ten included studies, highlighting overall methodological robustness and common limitations, particularly the variable reporting of researcher reflexivity and analytic transparency.

The appraisal process informed cautious interpretation of the literature but did not direct category development, maintaining the role of existing research as a sensitising resource rather than a source of analytic structure (Charmaz, 2014). This section outlines the approaches employed for data extraction and administration.

Table 2.3 Quality Appraisal Summary (CASP 2018)

Study	Clear Aims	Methodological Congruence	Sampling Appropriateness	Data Collection Transparency	Researcher Reflexivity	Ethical Considerations	Analytical Depth	Clarity of Findings	Conceptual Contribution	Overall Appraisal
Ball et al., 2023 (UK)	✓	✓	✓	✓	△	✓	✓	✓	✓	High
Billings et al., 2021 (UK)	✓	✓	✓	✓	△	✓	✓	✓	✓	High
Billings et al., 2022 (UK)	✓	✓	✓	✓	△	✓	✓	✓	✓	High
Clarkson et al., 2023 (Australia)	✓	✓	✓	✓	△	✓	✓	✓	✓	High

Dunning et al., 2024 (UK)	✓	✓	✓	✓	△	✓	✓	✓	✓	High
James et al., 2023 (UK)	✓	✓	✓	✓	△	✓	✓	✓	✓	High
Littzen-Brown et al., 2023 (USA)	✓	✓	✓	✓	△	✓	✓	✓	✓	Moderate – High
Greenberg et al., 2021 (UK)	✓	✓	✓	✓	△	✓	✓	✓	✓	High
McCallum et al., 2022 (Canada)	✓	✓	✓	✓	△	✓	✓	✓	✓	High
Benedict et al., 2022 (Germany)	✓	✓	✓	✓	△	✓	✓	✓	✓	High

Key: ✓ = Criterion met; △ = Partially met or unreported

Note: All included studies met the minimum CASP quality threshold. The most common limitation was incomplete or absent reflexivity, particularly in terms of researcher positionality and analytic transparency.

Data Extraction Process

Data were extracted from each included study using a structured framework to support transparent and comparative synthesis. Extraction focused on study context, methodological approach, and key analytic claims relating to nurses' physical and mental wellbeing, organizational conditions, and ethical or structural influences.

Concise evaluation notes were recorded to capture methodological strengths, limitations, and areas requiring cautious interpretation. These notes informed cross-study comparison and synthesis but did not direct category development, maintaining the role of the literature as a sensitising resource rather than an analytic driver, in keeping with Constructivist Grounded Theory principles (Charmaz, 2014).

2.6 Data Extraction and Administration

Following quality appraisal, data were extracted using a structured and transparent framework to support comparative synthesis. Extraction focused on four domains: study context and sample characteristics, the framing of nurses' physical and mental wellbeing, key analytic claims, and conceptual emphases or omissions within each study.

In keeping with Constructivist Grounded Theory, the literature was treated as a sensitising resource rather than a source of analytic categories. Cross-study comparison was used to identify areas of convergence and divergence, particularly the tendency to privilege psychological coping over cumulative physical strain and organizational conditions (Billings et al., 2021; West et al., 2020; Traynor, 2018).

Targeted memo-writing supported awareness of conceptual gaps without directing theory development. The extracted material provided the basis for subsequent synthesis, enabling examination of dominant framings and under-theorised dimensions of nurses' wellbeing across organizational and policy contexts (Maben et al., 2020). The following section outlines the approach used to integrate these findings and examine patterns and tensions within the reviewed literature.

2.7 Data Synthesis and Integration

The final phase of the Integrated Literature Review moved from descriptive comparison to analytic synthesis, integrating patterns and conceptual gaps across the reviewed literature. In line with Whittemore and Knafl's (2005) integrative approach and Constructivist Grounded Theory, synthesis was treated as an interpretive and reflexive process that enhanced theoretical sensitivity rather than producing analytic categories (Charmaz, 2014; Dixon-Woods et al., 2006).

Cross-study comparison focused on how nurses' physical and mental wellbeing was framed within academic, professional, and policy sources, with attention to areas of convergence, divergence, and omission. This process highlighted a recurring emphasis on individual coping and psychological adaptation, alongside more limited theorisation of cumulative physical strain and organizational responsibility (Traynor, 2018; West et al., 2020; Maben et al., 2020).

Comparative analysis across national and organizational contexts indicated that governance arrangements, leadership practices, and policy environments shaped whether wellbeing was positioned as an individual concern or an organizational obligation (Clarkson et al., 2023; Billings et al., 2025). More recent workforce analyses suggest that many of the pressures experienced during the pandemic have not simply disappeared with the end of the public health emergency. Instead, they continue to influence nurses' working lives through ongoing workforce shortages, fatigue, burnout, moral distress, retention challenges, and concerns about organizational support and trust (Hu et al., 2026; Felion et al., 2026; McKenna Lawson et al., 2026; Sun et al., 2026). National workforce

reporting identifies ongoing concerns relating to staffing instability, emotional exhaustion, burnout, and declining morale across NHS services, raising broader questions regarding organizational recovery and the sustainability of the nursing workforce moving forward (UCL, 2026; NHS Staff Survey, 2026). These findings reinforce the growing recognition that wellbeing cannot be separated from the organizational conditions within which nurses continue to practise.

From this synthesis, three sensitising insights informed subsequent empirical analysis without directing category development: an individualisation bias in wellbeing framings, an epistemic imbalance privileging psychological distress over physical strain, and a recurrent entanglement of moral strain with organizational ambiguity (Morley et al., 2021; James et al., 2023; Benedict et al., 2022). This synthesis functioned as an analytic support rather than a theory-generating process, maintaining the role of the literature as a contextual and sensitising resource within the Constructivist Grounded Theory framework (Charmaz, 2014).

2.8 Pre-Pandemic Context and Systemic Pressures

Before the onset of COVID-19, nurses were already operating inside healthcare systems marked by persistent structural stress. Persistent difficulties, such as chronic workforce shortages, escalating workload intensity, and disjointed policy solutions, have exerted considerable pressure on nurses' physical and mental well-being within the NHS and similar worldwide systems. Prior to the pandemic, research on moral distress emphasised the conflicts faced by nurses when institutional limitations hindered their ability to adhere to professional principles (Jameton, 1984; Rushton et al., 2017). Subsequent research corroborated these apprehensions, illustrating how chronic underfunding and staffing volatility were undermining nurses' professional integrity and moral purpose prior to the onset of the pandemic (Maben et al., 2018; Bridges et al., 2019).

In addition to practical demands, the pre-pandemic literature indicated considerable conceptual inconsistencies in the understanding and articulation of nurses' health. Moral distress, burnout, and wellbeing are frequently conflated, but they represent different feelings and processes. Austin et al. (2019) emphasised that this deficiency in conceptual clarity jeopardised the understanding of the origins and nature of nurses' distress. Recent evaluations affirm that this ambiguity endures, especially in the ongoing conflation of moral distress and moral damage (Houle et al., 2024). This conceptual ambiguity has hindered efforts to differentiate between emotional tiredness, ethical discomfort, and experiences associated with organizational failure or insufficient institutional support.

From a Constructivist Grounded Theory viewpoint, these ambiguities hold analytical significance rather than being merely problematic. Charmaz (2014) asserts that sensitising notions should guide inquiry while preserving analytical flexibility. I regarded pre-pandemic literature as reflective of enduring exposure to strain rather than as offering definitive explanatory frameworks. This corpus of

work heightened the understanding of the historical and organizational variables influencing nurses' experiences, while underscoring the necessity for reflexivity and prudence in applying established conceptions to pandemic and post-pandemic contexts.

Collectively, pre-pandemic research indicates that nurses commenced the COVID-19 pandemic while functioning inside systems characterised by workforce volatility, ethical dilemmas, and conceptual ambiguity. The research indicates a disjointed domain where psychological explanations frequently prevail, whilst physical strain and organizational accountability garner relatively less analytical focus. This backdrop is essential for comprehending how nurses subsequently encountered the pandemic and why prevailing frameworks frequently fell short in encapsulating the profundity and duration of their encounters. These discoveries enhanced theoretical sensitivity without predefining analytical results, so facilitating the emergence of novel interpretations through interaction with empirical evidence in the following chapters.

2.9 Effects of the COVID-19 Pandemic on Nurses' Wellbeing

As the COVID-19 pandemic progressed, the challenges faced by nurses prior to 2020 significantly escalated. Initial pandemic studies recorded significant psychological, physical, and ethical stressors experienced by nurses in both hospital and community environments, encompassing fears of infection, continual exposure to mortality, ethical dilemmas, and swiftly changing organizational requirements (Billings et al., 2021; Greenberg et al., 2021; Maben et al., 2020). Subsequent evidence, however, indicates that these effects extended beyond the acute crisis phase.

Recent post-pandemic research reveals that distress has continued, especially concerning moral injury, fatigue, disengagement, and workforce attrition in various nursing environments, including mental health, community, and long-term care settings (Vanderloo et al., 2025; Heitzmann et al., 2025). This latter body of work indicates a significant tonal shift, transitioning from initial narratives of unity and emergency reaction to reports defined by fatigue, disillusionment, and a perception of lack of support. The physical and mental wellbeing of nurses is increasingly viewed as the aggregate result of extended exposure to stress within systems that have unable to recuperate or mend after consecutive pandemic waves.

The physical consequences of remote labour during the pandemic have been increasingly evident in recent academic research. Research indicates that organizational problems, such as insufficient rota planning, prolonged shifts, and persistent understaffing, were primary contributors to physical fatigue and sleep disturbances (Pi et al., 2025; James et al., 2023). These findings corroborate previous observations that physical strain and exhaustion are often normalised within nursing environments and regarded as unavoidable aspects of professional dedication (Maben et al., 2022). Consequently,

physical wellbeing was frequently eclipsed by psychological interpretations, making embodied suffering less apparent and recasting organizational failure as individual deficiency.

The pandemic literature conceptually emphasises psychological coping and recovery, frequently neglecting the organizational factors that caused harm. Longitudinal evaluations delineate a trajectory from rapid crisis response to enduring exhaustion, disengagement, and attrition (Billings et al., 2021; Vanderloo et al., 2025). Emerging workforce evidence suggests that these patterns have continued beyond the immediate aftermath of the pandemic, with nurses reporting ongoing challenges related to workforce pressures, burnout, fatigue, moral distress, retention, and changing working conditions (Felion et al., 2026; Hu et al., 2026; McKenna Lawson et al., 2026; Sun et al., 2026). Findings from the 2025 NHS Staff Survey demonstrated increasing levels of work-related stress, emotional exhaustion, and concerns regarding workload intensity across NHS staff groups, with many staff continuing to report insufficient staffing levels to safely manage the demands of their roles (NHS Employers, 2026; Picker, 2026). Additional workforce analyses further suggest that poor mental wellbeing, emotional fatigue, and limited opportunities for professional progression continue to contribute to nurses leaving the NHS workforce in the post-pandemic period (Nuffield Trust, 2026; Nursing in Practice, 2026). Although these studies yield significant insights into mental health outcomes, they provide less elucidation into how nurses persisted in their roles within environments marked by persistent staffing deficiencies, ethical dilemmas, and constant uncertainty. Professional and policy evidence reflects these scholarly apprehensions. The Royal College of Nursing's report, Building a Better Future for Nursing (RCN, 2021), based on comments from over 10,000 nurses, showed that many nurses were unhappy and felt neglected and unsupported by their organizations. Later briefings showed that the risk of burnout and attrition was growing, calling it a "second pandemic" that was impacting the nursing profession (RCN, 2022). Collectively, these sources illustrate that the concerns to nurses' wellbeing were universally acknowledged but inadequately managed at a systemic level.

2.10 Organizational and Policy Responses

Despite ongoing focus on the wellbeing of healthcare personnel post-COVID-19 pandemic, organizational and policy responses have predominantly emphasised individual psychological assistance rather than tackling the structural factors affecting nurses' physical and mental wellbeing. A growing body of scholarly discourse contests this disparity, highlighting that post-pandemic initiatives frequently emphasised resilience, emotional coping, and the enhancement of well-being, while overlooking the systemic factors that contribute to suffering (Billings et al., 2022; Maben et al., 2023; West et al., 2020).

Numerous studies characterise these responses as reactive and temporally constrained, providing apparent reassurance without accompanying organizational reform. Billings et al. (2022) observe that

various wellbeing measures were implemented swiftly during crisis periods but were deficient in continuity, assessment, or incorporation into long-term workforce planning. Maben et al. (2023) delineate a phenomenon of "support without repair," wherein psychological services proliferated despite ongoing staffing shortages, heightened task intensity, and fragmented leadership.

Although wellbeing initiatives expanded following the pandemic, more recent workforce evidence suggests that many nurses continue to work within environments characterised by unresolved staffing shortages, sustained workload pressures, emotional exhaustion, and continuing concerns about workforce retention, organizational trust, and working conditions (Felion et al., 2026; Hu et al., 2026; McKenna Lawson et al., 2026; Sun et al., 2026). Contemporary NHS workforce reports continue to identify growing concerns relating to burnout, stress related sickness absence, and declining morale across healthcare settings, raising questions regarding whether organizational recovery has been fully realised within the nursing workforce (NHS Employers, 2026; UCL, 2026).

Economic and workforce modelling further undermines the viability of this method. Lasater et al. (2025) illustrate that rectifying nurse understaffing via structural investment is ethically imperative and economically beneficial, resulting in decreased burnout, patient mortality, and staff turnover. These findings reframe wellbeing as an organizational obligation and a matter of systemic performance rather than a voluntary ethical consideration. Nonetheless, this data has not been regularly converted into policy implementation.

National policy texts persistently underscore resilience, recovery, and compassion, frequently lacking explicit procedures for accountability or enforcement (NHS England, 2023; RCN, 2024). Compassionate leadership initiatives and wellbeing toolkits were extensively advocated (Abrams et al., 2024; Elfiana et al., 2024), although qualitative evidence indicates that these interventions often lacked the power to affect resource distribution, staffing choices, or ethical escalation. Consequently, compassion was framed as a personal leadership trait instead of a governance philosophy capable of transforming organizational conditions.

Data from senior nursing leaders substantiates this tension. Dunning et al. (2024) indicate that nurse leaders frequently encounter moral constraints inside bureaucratic frameworks, bearing the responsibility for staff wellbeing while lacking the authority to implement meaningful change. The discord between duty and power led to ethical stagnation, resulting in the absorption rather than resolution of suffering. The UK COVID-19 Inquiry (2024) highlighted fragmented leadership, inconsistent workforce protection, and inadequate personnel safeguards as predictable factors contributing to staff injury, attributable to governmental decisions rather than inevitable crisis circumstances.

This literature suggests that organizational and policy approaches to nurses' wellbeing have been marked by rhetorical acknowledgement rather than substantive change. Although psychological

support and empathetic leadership are beneficial, evidence indicates that in the absence of structural reform, these approaches may become compensatory rather than remedial. This analysis highlights a constant disparity between wellbeing discourse and organizational practice by placing individual support within the framework of policy stagnation and systemic limitations.

From a constructivist viewpoint, these patterns demonstrate that wellbeing is influenced not alone by personal experience but also by institutional aims and limitations (Charmaz, 2014). When organizational accountability is shifted to individual resilience, the structural origins of harm remain hidden and may become normalised (Traynor, 2018; West et al., 2020). The disparity between articulated values and actual experiences serves as a crucial context for comprehending the long-term implications of pandemic work, a topic that will be explored further in the next section.

2.11 Long-Term Effects on Physical and Mental Wellbeing

As the acute phase of the COVID-19 pandemic diminished, a growing collection of information started to reveal the prolonged effects on nurses' physical and mental wellbeing. Instead of dissipating after acute demands subsided, various adverse effects linked to pandemic labour endured and, in certain instances, exacerbated. This literature emphasises that the effects of COVID-19 on nurses should not be perceived as a temporary crisis response, but rather as a persistent condition with lasting physical, psychological, and ethical ramifications (Billings et al., 2025; Maben et al., 2024; Dunning et al., 2024).

Nurses reported enduring weariness, sleep disturbances, musculoskeletal pain, and diminished functional performance long after the initial waves of illness. James et al. (2023) elucidate how weariness became normalised during peak periods and largely neglected after the withdrawal of emergency staffing measures. Likewise, Pi et al. (2025) recognise organizational variables including rota instability, chronic understaffing, and extended shift patterns as significant contributors to cumulative physical depletion. These findings contest narratives that depict weariness as an unavoidable or temporary aspect of crisis employment, instead framing it as a foreseeable consequence of prolonged structural stress.

National survey statistics corroborate these reports. The Royal College of Nursing’s Survey of Members with Long-COVID (RCN, 2024) indicated that 72% of impacted nurses experienced persistent exhaustion, while 51% reported cognitive impairments, with several individuals expressing diminished confidence in their capacity to practise safely. NHS workforce surveys published in 2026 identified ongoing increases in work related stress, emotional exhaustion, presenteeism, and burnout across NHS staff groups, alongside growing reports of healthcare staff continuing to work despite physical and psychological ill health because of workforce shortages and operational demands (NHS Employers, 2026; UNISON, 2026). Rather than representing a period of recovery, these findings

suggest that many nurses continue to work within conditions where the demands associated with the pandemic have become embedded within everyday practice, limiting opportunities for physical and psychological restoration.

The qualitative research conducted by Al-Oraibi et al. (2025) enhances these figures, demonstrating how enduring physical symptoms undermined nurses' professional identities, career paths, and sense of efficacy. Organizational answers were often regarded as rigid or inadequate, intensifying emotions of neglect and exasperation. In addition to physical symptoms, enduring mental health consequences were regularly documented. Initial pandemic research concentrated on acute anxiety, dread, and trauma, whereas subsequent studies depict a more protracted and intricate psychological pattern. Billings et al. (2025) observe that nurses commenced processing their experiences only after the immediacy of the crisis diminished, resulting in what they characterise as an extended phase of emotional reckoning. Maben et al. (2023) similarly report on postponed psychological processing, indicating that nurses who maintained functionality during the emergency period thereafter encountered emotional tiredness, disengagement, and diminished morale.

The ethical aspects of wellbeing were intricately linked to these psychological consequences. Continual exposure to ethically demanding circumstances, along with insufficient organizational reform, led to sustained moral discomfort and a decline in trust. The UK COVID-19 Inquiry (2024) findings highlight that harms were predictable and avoidable, associated with shortcomings in workforce protection, inconsistent leadership, and insufficient personnel safeguards. This underscores the notion that long-term mental wellbeing effects are not merely individual reactions to trauma, but rather responses influenced by systemic factors.

Data from professional organizations corroborate these apprehensions. The RCN's Rebuilding Nursing survey (2024) revealed that 57% of participants felt that organizational conditions had not improved since 2021, with individuals expressing decreased trust in employers and a perception that lessons had not been assimilated. These opinions strongly correspond with qualitative findings from Dunning et al. (2024), in which nurses reported experiencing emotional exhaustion and professional undervaluation due to the lack of significant post-pandemic reform.

Significantly, these enduring effects are not limited to the UK setting. Global research indicates remarkably analogous trends. Research conducted in Canada (McCallum et al., 2022), Germany (Benedict et al., 2022), Australia (Clarkson et al., 2023), and the United States (Littzen-Brown et al., 2023) consistently indicates ongoing fatigue, emotional exhaustion, and moral distress among nurses in diverse healthcare systems. Meta-analytic data substantiates the worldwide prevalence of these patterns, associating moral distress with increased rates of depression, anxiety, and diminished quality of life among healthcare professionals (Jafari et al., 2025).

This literature indicates that the long-term physical and mental wellbeing effects of the pandemic are cumulative, interconnected, and significantly influenced by organizational environment. Emotional support measures alone seem inadequate when physical fatigue, ethical turmoil, and systemic instability persist unaddressed. According to Lasater et al. (2025), sustainable recovery relies on improving staffing, workload, and leadership conditions rather than only facilitating individual coping mechanisms. From a Constructivist Grounded Theory perspective, these findings underscore the need of focussing on what endures beyond the crisis moment (Charmaz, 2014). The examined research consistently indicates that nurses' wellbeing is influenced by extended exposure to challenging situations, postponed recuperation opportunities, and insufficient organizational support. Physical fatigue, mental exhaustion, and ethical strain persisted beyond the cessation of emergency measures; rather, they remained ingrained in routine professional existence.

This body of evidence highlighted the temporal aspect of wellbeing harm, emphasising the progression of cumulative strain over time and the impact of institutional responses on the alleviation or entrenchment of distress. The literature indicates that post-pandemic wellbeing concerns should not be regarded as residual or anomalous, but rather as a continuation of persistent systemic stresses. Extensive evidence indicates that the physical and mental wellbeing of nurses has been profoundly and persistently impacted by the working environment throughout the pandemic. Chronic weariness, protracted psychological processing, and ethical anguish are routinely documented across many national contexts and professional environments. These effects are intricately associated with organizational variables, notably personnel, leadership, and the lack of enduring structural reform. The subsequent section elaborates on this study by examining the impact of organizational and cultural narratives on perceptions of wellbeing in the post-pandemic context (Kisely et al., 2020; Billings et al., 2021; Morley et al., 2021; Shanafelt et al., 2020; West et al., 2020; Maben et al., 2023; WHO, 2022; Carlie et al, 2025;Yun Hu et al, 2026).

2.12 Conceptual Tensions in Contemporary Wellbeing Discourse

This chapter reveals a persistent tension in the conceptualisation and management of nurses' physical and emotional wellbeing across the studied literature. The number of research on wellbeing has greatly increased before, during, and after the COVID-19 pandemic, however the foundational explanatory frameworks have remained relatively limited. A sizeable portion of the literature has focused on psychologically orientated constructs emphasising individual coping, emotional regulation, and adaptive capacity, frequently neglecting the organizational and structural determinants (Billings et al., 2021; Maben et al., 2023; West et al., 2020).

Before the pandemic, wellbeing was frequently regarded as a professional attribute that could be augmented through personal resilience, occupational commitment, and emotional intelligence (Jackson et al., 2007; Foster et al., 2019). During the COVID-19 pandemic, this framing intensified,

with resilience being a central theme in academic literature, policy documents, and organizational communications (Cooper et al., 2020; NHS England, 2022). Nurses were encouraged to adapt, persevere, and recover during exceptional stress, often bolstered by symbolic gestures of appreciation and temporary psychological support initiatives.

Nonetheless, as the literature advanced into the post-pandemic age, the shortcomings of this methodology became more apparent. Numerous studies have started to challenge the sufficiency of individualised frameworks in elucidating persistent physical fatigue, protracted psychological processing, and enduring moral distress in environments where staffing levels, workloads, and organizational cultures have remained relatively stable (Maben et al., 2024; Dunning et al., 2024; Vanderloo et al., 2025). Instead of illustrating recovery or resolution, various testimonies recorded ongoing strain and disengagement, indicating a disparity between prevailing wellbeing narratives and actual professional experiences.

Recent post-pandemic studies and workforce reporting continue to show that many of the challenges exposed during the COVID-19 pandemic remain evident within contemporary healthcare organisations (Felion et al., 2026; Hu et al., 2026; McKenna Lawson et al., 2026; Sun et al., 2026). Rather than being resolved through the transition to recovery, concerns relating to burnout, emotional exhaustion, declining morale, workforce retention, and organizational trust continue to be associated with persistent staffing shortages, workload pressures, and unstable working conditions (NHS Employers, 2026; The King's Fund, 2025; UCL, 2026). These findings suggest that nurses' wellbeing cannot be fully understood through individual coping or resilience alone. Instead, they highlight the continuing influence of organizational and structural conditions in shaping how wellbeing is experienced, sustained, and challenged in the post-pandemic healthcare environment.

A further conceptual tension pertains to the relative emphasis of mental wellbeing over physical wellbeing. Psychological outcomes, including anxiety, stress, burnout, and trauma, are thoroughly theorised, whereas physical consequences such as chronic fatigue, pain, sleep disruption, and somatic depletion often regarded as secondary or presumed aspects of crisis work (James et al., 2023; Pi et al., 2025). This disparity maintains an implicit hierarchy wherein wellbeing is perceived as a mental or emotional condition, despite increasing evidence that physical exhaustion influences nurses' ability to perform, recuperate, and sustain their presence in the profession (RCN, 2024; Al-Oraibi et al., 2025).

The moral aspects of wellbeing further complicate this scenario. Moral anguish and moral harm are increasingly acknowledged; however, they are frequently characterised as personal ethical dilemmas instead of consequences of organizational decision-making, lack of leadership, or structural limitations (Morley et al., 2021; Rushton et al., 2017). This perspective risks attributing ethical pressure solely to the individual nurse, rather than examining the institutional settings that foster recurrent moral compromise.

Collectively, these bodies of literature illustrate a conceptual domain marked by fragmentation. The psychological, physical, moral, and organizational aspects of wellbeing often analysed separately, with minimal integration across analytical levels. Consequently, current paradigms fail to address how nurses operate under sustained pressure, how cumulative effects persist over time, and how institutional contexts influence both distress and resilience.

From a Constructivist Grounded Theory viewpoint, these conceptual tensions are analytically beneficial rather than detrimental (Charmaz, 2014). They emphasise the limitations of prevailing explanations and the necessity for alternative interpretive methodologies. This chapter addresses these tensions as sensitising concerns that inform, but do not dictate, the future empirical research, rather than resolving them during the literature review stage.

The literature informed the study about issues of temporality, embodiment, and organizational accountability. It highlighted the maintenance or deterioration of wellbeing over time, the interconnection of physical and mental events, and the influence of institutional environments on nurses' reactions to hardship. Significantly, these discoveries guided the analytical framework of the investigation without imposing predetermined categories or explanatory frameworks.

2.13 Summary of the Integrated Literature Review and Identified Gaps

This Integrated Literature Review examined how nurses' physical and mental wellbeing has been understood across pre-pandemic, pandemic, and post-pandemic literature. Drawing together empirical research, theoretical scholarship, professional discourse, and policy evidence, the review demonstrated that concerns surrounding nurses' wellbeing existed long before the emergence of COVID-19 and were intensified rather than created by the pandemic itself. Chronic understaffing, ethical tension, workforce instability, and organizational fragmentation had already become embedded features of nursing practice, creating conditions of sustained pressure before the pandemic unfolded (Bridges et al., 2019; Maben et al., 2018; RCN, 2019).

As the pandemic progressed, the literature expanded rapidly to document escalating psychological distress, emotional exhaustion, physical fatigue, ethical conflict, and organizational disruption experienced by nurses across healthcare settings (Billings et al., 2021; Greenberg et al., 2021; Clarkson et al., 2023). This body of work was important in bringing visibility to nurses' experiences and validating the realities of frontline practice during COVID-19. However, much of the literature continued to rely on psychologically orientated frameworks that positioned coping, resilience, and emotional adaptation primarily at the level of the individual nurse. While these approaches offered valuable insight into immediate responses to crisis and uncertainty, they provided a more limited understanding of how prolonged strain became embedded within organizational systems and everyday professional practice over time.

As the literature developed into the post-pandemic period, evidence increasingly suggested that these pressures did not simply disappear with the reduction of infection waves. Instead, many nurses continued to describe enduring physical exhaustion, delayed emotional processing, moral distress, disengagement, and diminished trust in organizational structures long after the acute phases of the crisis had passed (Maben et al., 2024; Dunning et al., 2024; Vanderloo et al., 2025; RCN, 2024). More recent studies published during 2025 and 2026 have reported similar concerns, including persistent occupational fatigue, burnout, moral distress, workforce instability, and difficulties rebuilding organizational trust in the post-pandemic environment (Pi et al., 2025; Sydor et al., 2026; Felion et al., 2026; Hu et al., 2026). Collectively, this evidence suggests that the effects of the pandemic have become woven into many nurses' everyday working lives rather than remaining confined to a distinct period of crisis.

Across all phases of the literature, several interconnected patterns became increasingly visible. Wellbeing was frequently framed through individualised concepts such as resilience, coping, and burnout, often positioning responsibility for adaptation and recovery primarily with nurses themselves (Traynor, 2018; West et al., 2020). Although more recent literature has increasingly acknowledged organizational influences on wellbeing, resilience-based and burnout-focused explanations continue to dominate much of the post-pandemic evidence base (Lin et al., 2026; Catarelli et al., 2026; McKenna Lawson et al., 2026). Psychological wellbeing also received considerably greater analytical attention than physical wellbeing, despite growing evidence that chronic fatigue, bodily exhaustion, sleep disruption, illness, and functional decline continue to affect nurses' ability to recover and remain within the profession (James et al., 2023; Al-Oraibi et al., 2025; Pi et al., 2025). Moral distress and ethical strain were widely acknowledged but were often detached from leadership practices, institutional accountability, and structural conditions, resulting in ethical suffering frequently being understood as an individual burden rather than a systemic issue (Morley et al., 2021; Rushton et al., 2017; Sydor et al., 2026).

The literature review also highlighted a fragmented conceptual landscape in which physical, psychological, moral, and organizational dimensions of wellbeing were often explored separately rather than understood as interconnected experiences unfolding across time. Professional and policy responses reflected many of the concerns raised within the academic literature, yet these responses frequently prioritised short term psychological support and resilience-based interventions over sustained structural reform (NHS England, 2023; RCN, 2024). Recent workforce evidence similarly suggests that staffing shortages, workload pressures, burnout, retention concerns, and organizational instability remain prominent despite increased attention to staff wellbeing and workforce recovery (Felion et al., 2026; Hu et al., 2026; The King's Fund, 2025). Consequently, a recurring tension emerged between organizational wellbeing discourse and nurses' lived experiences of ongoing strain, fatigue, and organizational disconnection.

From a Constructivist Grounded Theory perspective, these tensions are analytically significant because they reveal not only gaps within the existing evidence base, but also limitations in how nurses' wellbeing has been conceptualised and understood. Existing literature provides important insight into distress, coping, and workforce pressures, yet offers a more limited understanding of how nurses made sense of prolonged exposure to strain, how physical and mental wellbeing became intertwined over time, and how organizational conditions shaped experiences, fragmentation, and recovery within everyday professional life. This remains evident within recent studies, which continue to focus predominantly on burnout, resilience, stress perception, or workforce outcomes rather than the interpretive processes through which nurses understand and navigate these experiences (Saleh et al., 2025; Lin et al., 2026; Catarelli et al., 2026; Sydor et al., 2026). These limitations reinforced the need for a theory-generating approach capable of exploring how nurses interpreted and navigated their experiences within the wider organizational context.

While the Integrated Literature Review enabled a broad and conceptually informed synthesis across empirical, professional, and policy literature, the interpretive nature of the approach also required ongoing reflexive awareness regarding analytical emphasis, conceptual relevance, and the evolving nature of post-pandemic scholarship. Consistent with Constructivist Grounded Theory, literature was used to support theoretical sensitivity and contextual understanding rather than to predetermine analytical interpretation (Charmaz, 2014; Toronto and Remington, 2020).

This review therefore identified four key gaps that provided the rationale for the current study:

Conceptual gap: Existing frameworks frequently prioritise resilience and burnout while offering a more limited understanding of prolonged exposure to strain within largely unchanged organizational systems.

Integrative gap: Physical and mental wellbeing are often explored separately, with insufficient attention given to how they interact, accumulate, and shape one another over time.

Organizational gap: Moral and psychological distress are frequently detached from leadership practices, organizational accountability, and wider structural conditions.

Methodological gap: There remains limited constructivist, reflexive, theory-generating qualitative research that explores how nurses themselves interpret and make sense of wellbeing during and after the COVID-19 pandemic.

To address these gaps, this study employs Constructivist Grounded Theory to explore nurses' experiences during and after the COVID-19 pandemic, focusing on how physical and mental wellbeing were understood, negotiated, and sustained within conditions of prolonged organizational pressure and uncertainty. The following chapter therefore moves from reviewing existing knowledge

to outlining the philosophical, methodological, and reflexive foundations that guided the generation and analysis of participants' experiences throughout this study.

Chapter 3: Methodology

3.1 Introduction

This chapter delineates the methodological foundations of this study, which use a Constructivist Grounded Theory (CGT) methodology to investigate nurses' experiences during and after the COVID-19 pandemic, focussing specifically on their perceptions of physical and mental wellbeing. In qualitative research, methodology encompasses more than just technical procedures; it embodies fundamental assumptions regarding the comprehension of reality, the generation of knowledge, and the interpretation of meaning within particular social and organizational settings (Denzin and Lincoln, 2011; Maxwell, 2013). This chapter delineates the philosophical framework, methodological approach, and analytical rationale that underpin the study's design and execution.

This research does not concentrate on quantifying wellbeing as a predetermined outcome, nor on assessing nurses' experiences in relation to established psychological or organizational frameworks. Instead, it aims to comprehend how nurses evaluated and understood their professional experiences during and after the pandemic. From this viewpoint, physical and mental wellbeing are perceived as contextual and relational, influenced by professional positions, organizational situations, and the chronological framework of COVID-19. Addressing these elements necessitates a methodical approach that is attuned to meaning-making, context, and the processes defined by participants. Constructivist Grounded Theory offers a suitable methodological framework for this objective. Charmaz (2014, p. 15) characterises grounded theory as “a systematic, yet flexible set of guidelines for collecting and analysing qualitative data to construct theories rooted in the data themselves.” This equilibrium between analytical rigour and interpretive flexibility is especially appropriate for research aimed at comprehending experience rather than validating predetermined explanations (Charmaz, 2014; Bryant and Charmaz, 2007). CGT facilitates transparent analytical processes while being attuned to participants' narratives, perceptions, and reflections regarding their professional experiences during and after the pandemic.

The research is framed within a constructivist-interpretivist framework, acknowledging that realities are diverse, socially created, and contextually dependent (Denzin and Lincoln, 2011). From this perspective, knowledge is perceived as arising from the interaction between the researcher and participants, rather than as an objective depiction of an external reality. This epistemological stance corresponds with the study's objective to investigate how nurses interpret their experiences, rather than to determine causal linkages or universal metrics of wellbeing (Maxwell, 2013; Charmaz, 2014).

My research strategy is influenced by my role as a practitioner-researcher inside the NHS. This professional experience offers insight into organizational structures, terminology, and practices, facilitating the interpretation of participants' narratives. This intimacy requires meticulous reflexive

involvement to prevent the assumption of similar meanings or experiences. In accordance with CGT, this positionality is recognised and scrutinised throughout the research process, with reflexivity regarded as a fundamental methodological practice rather than a supplementary concern (Mills et al., 2006; Berger, 2015; Charmaz, 2014).

This chapter elucidates the establishment of methodological conditions for theory formation. The text delineates the formulation of the research aim, objectives, and question to ensure they are open and exploratory; illustrates how Constructivist Grounded Theory offers a consistent philosophical and methodological alignment; and describes how the study design facilitates iterative progression between data collection and analysis. This chapter establishes a basis for comprehending how the analytical work in later chapters is rooted in participants' narratives and influenced by reflective interpretation.

Research Aim

This study aims to investigate nurses' perspectives on their experiences during and after the COVID-19 pandemic, emphasising their understanding, navigation, and management of physical and mental wellbeing within an NHS organizational framework. The research aims to cultivate an interpretive comprehension of how nurses perceive these experiences concerning professional expectations, organizational needs, and personal capabilities (Charmaz, 2014).

Research Objectives

The research is directed by the subsequent objectives:

To investigate nurses' lived experiences during and following the COVID-19 pandemic and their views of physical and mental well-being.

To investigate the organizational, ethical, and systemic factors influencing nurses' wellbeing and coping mechanisms.

To examine how nurses balanced professional obligations with personal constraints in the wake of the pandemic.

To construct a theoretically informed analysis of nurses' experiences based on their narratives (Charmaz, 2014; Maxwell, 2013).

Research Question

What are nurses' experiences of working during and after the COVID-19 pandemic, views on physical and mental well-being?

Analytical Positioning of the Aim and Objectives

In accordance with Constructivist Grounded Theory, the study aim, objectives, and question are designed to be exploratory and conceptually generative rather than prescriptive (Charmaz, 2014).

Grounded theory research questions are constructed to elicit narratives of meaning and process, rather than to limit investigation through pre-established variables or results. In this study, the objectives serve as analytical signposts rather than definitive endpoints, permitting the conceptual directions that arise throughout data collection and analysis to guide the constant evolution of the research (Maxwell, 2013).

I approached the research question as a point of entry into nurses' experiences rather than as a boundary around what could be explored. As the analysis progressed, patterns began to form around how organizational conditions, embodied strain, and moral meaning were intertwined in participants' accounts. These patterns gradually shaped a set of more focused questions that helped me look more closely at various aspects of the same underlying concern: how nurses continued to work, care, and make sense of their roles under sustained pressure. This development reflects a deepening of attention rather than a change in direction, and the way these questions informed the construction of the categories and the grounded theory is taken up again in Chapter 6.

This transparency fosters methodological consistency and analytical integrity by guaranteeing that conceptual growth is anchored in participants' interpretations rather than influenced by preconceived notions. Reflexivity, theoretical sensitivity, and iterative engagement with the data thus establish coherence among the study's objectives, methodological framework, and analytical choices throughout the research process (Charmaz, 2014; Mills et al., 2006).

In keeping with Constructivist Grounded Theory (Charmaz, 2014), I did not treat the research question as a fixed or static instrument, but as an analytic starting point that was progressively elaborated through constant comparison, memo writing, and theoretical integration. While the study was initiated with a single overarching research question to preserve openness and conceptual sensitivity, this question was analytically refined into a set of subsidiary questions as categories began to stabilise and relationships between organizational conditions, embodied strain, and moral meaning became clearer. This evolution did not represent a shift in research intent, but rather a sharpening of analytic focus as the theory developed in interaction with the data. The relationship between the overarching research question and its subsequent analytic elaboration is revisited in Chapter 6, where I demonstrate how these subsidiary questions contributed to the construction of the categories, core category, and grounded theory.

Table 3.1 below depicts the correlation among the research aim, objectives, research question, and methodological framework supporting this study. It shows how the open and exploratory framing of the research design guides the choice of Constructivist Grounded Theory, ensuring alignment among philosophical stance, analytical approach, and the study's emphasis on nurses' interpretation of physical and mental wellbeing. By clarifying this alignment, the figure establishes a guiding

framework for the methodological choices outlined in Chapter 3 and enhances clarity regarding the study's progression from research design to data analysis.

Table 3.1: Alignment of Research Aim, Objectives, and Methodological Approach

Study Element	Description	Methodological Alignment
Research Aim	To explore nurses' perspectives of their experiences of working during and after the COVID-19 pandemic, with a focus on physical and mental wellbeing.	Establishes an interpretive focus consistent with Constructivist Grounded Theory (Charmaz, 2014).
Research Objectives	Explore nurses' lived experiences. Examine organizational, moral, and systemic conditions shaping wellbeing. Consider how nurses negotiated professional demands alongside personal limitations. Develop a theoretically informed interpretation grounded in participants' accounts.	Guides iterative data collection and analysis without constraining conceptual development.
Research Question	What are nurses' perspectives of their experiences of working during and after the COVID-19 pandemic: views on physical and mental wellbeing?	Open, exploratory question aligned with CGT's emphasis on meaning-making and process (Charmaz, 2014).
Methodological Approach	Constructivist Grounded Theory	Supports inductive, iterative analysis and co-construction of meaning between researcher and participants.
Philosophical Positioning	Constructivist–interpretivist paradigm recognising multiple, context-dependent realities.	Ensures coherence between ontological and epistemological assumptions and analytic strategy (Denzin and Lincoln, 2011).
Analytic Orientation	Iterative engagement with data using constant comparison, reflexive memo-writing, and theoretical sensitivity.	Enables transparent movement between data generation and analysis, supporting conceptual development.
Anticipated Contribution	An interpretive, data-grounded understanding of nurses' experiences of physical and mental wellbeing during and after the pandemic.	Grounds later analytic chapters without pre-empting theory development.

This chapter's methodological selections indicate that a qualitative approach, specifically Constructivist Grounded Theory, is particularly effective for examining the emotional, moral, relational, and organizational aspects of nurses' experiences (Denzin and Lincoln, 2011; Green and Thorogood, 2018). Quantitative methods, although beneficial for exploring various research enquiries, are constrained in their ability to elucidate the interpretive processes by which nurses comprehend their wellbeing and manage professional duties amid persistent organizational stress (Charmaz, 2014).

This chapter establishes a methodological framework that underpins the subsequent analysis and elucidates the alignment of methodological choices with the study's objectives, philosophical stance, and the intricacies of nurses' experiences during and after the COVID-19 pandemic.

3.2 Selection of a Qualitative Research Methodology

Choosing a suitable methodological approach necessitated meticulous alignment among the study's objectives, its philosophical framework, and the characteristics of the phenomenon being investigated. This research aims to investigate the opinions of nurses and nursing associates regarding physical and mental wellbeing during and after the COVID-19 pandemic. While a considerable amount of literature has recorded nurses' anguish during the acute phases of the pandemic, there is a paucity of studies investigating how these experiences were interpreted, mediated, and integrated into routine organizational contexts, especially in the post-pandemic era. Addressing these complex and dynamic experiences necessitated an approach adept at dealing with meaning, process, and context rather than just measurement or prediction.

Qualitative inquiry is particularly effective for examining lived experiences, subjective meanings, and social processes, which are key to this study's focus (Denzin and Lincoln, 2013; Creswell, 2013). A qualitative method facilitated the exploration of nurses' perceptions of their wellbeing, their interpretations of organizational and professional expectations, and the evolution of these interpretations over time. The study necessitated an approach that transcended mere descriptive accounts of distress to cultivate an interpretive comprehension of how experiences were sustained, managed, and rendered meaningful within intricate NHS environments.

Grounded theory is recognised as a paradigm for analysing social processes in healthcare settings (Bryant and Charmaz, 2007; Birks and Mills, 2015). Current studies on nurses' health during COVID-19 have highlighted many stresses, such as trauma exposure, staffing demands, bereavement, and moral distress (Maben and Bridges, 2020; Billings et al., 2021; Clarkson et al., 2023). Nevertheless, most of this research fails to theorise how these issues are comprehended and navigated over time inside institutional cultures. A grounded theory method was deemed especially suitable for cultivating a process-oriented and theoretically informed comprehension of these events.

This study employs Constructivist Grounded Theory (CGT), which openly recognises the interpretive function of the researcher and perceives data as co-constructed rather than merely uncovered (Charmaz, 2006, 2014). This attitude strongly coincides with the study's objectives, wherein nurses' narratives are influenced not just by events but also by organizational conditions, professional expectations, and personal interpretations within the NHS setting. As a practitioner-researcher within this system, I analysed participants' narratives while maintaining reflexive awareness of how my

professional experience and placement could influence interpretation (Mills et al., 2006; Berger, 2015).

Philosophical Orientation and Rationale

The research is set within a constructivist-interpretivist framework, which perceives reality as multifaceted, contextually determined, and influenced by social interactions (Guba and Lincoln, 1994; Crotty, 1998; Denzin and Lincoln, 2013). From this viewpoint, perceptions of physical and mental wellbeing are regarded not as static states but as meanings shaped by interactions with organizational, relational, and structural contexts. Constructivist Grounded Theory operates under this paradigm, highlighting that knowledge is produced through the interaction between researcher and participants rather than being obtained as an objective truth (Charmaz, 2014).

This study conceptualises knowledge as arising via discussion, interpretation, and reflexive analysis. Charmaz (2014) asserts that facts do not offer a direct insight into reality; instead, meaning is generated through the research process itself. Reflexivity is regarded as a fundamental methodological practice, necessitating constant consideration of how researcher positioning, assumptions, and emotional reactions influence analytical choices (Finlay, 2002; Berger, 2015). This reflexive position enhances analytical rigour rather than detracting from it.

A constructivist–interpretivist approach emphasises meaning-making, process, and conceptual development rather than prediction or measurement. This viewpoint is especially crucial for comprehending how nurses managed moral dilemmas, organizational demands, and wellbeing throughout various stages of the pandemic. Constructivist grounded theory offers analytical methods that effectively capture these processes and formulate conceptual categories based on participants' judgements (Charmaz, 2014).

Consideration of Quantitative Approaches

Quantitative approaches were evaluated in the study's design but were inadequately aligned with the research objectives. Survey-based methodologies and standardised metrics can yield significant insights into the prevalence and distribution of distress; however, they are constrained in their ability to examine how experiences are interpreted, negotiated, and comprehended over time (Creswell, 2013; Parahoo, 2014). Such methodologies generally depend on predetermined factors and may limit the examination of emotional intricacy, ethical conflict, and organizational sense-making.
Due to the study's emphasis on comprehending processes and interpretations rather than measurement or prediction, a qualitative method was deemed more suitable. Constructivist grounded theory facilitates the investigation of action, interaction, and consequence, enabling conceptual comprehension to evolve inductively through prolonged engagement with participants' narratives (Charmaz, 2014).

Analytical Logic, Rigour, and Reflexivity

This study's analysis adheres to Constructivist Grounded Theory, employing inductive and abductive reasoning within an iterative analytical framework (Charmaz, 2014; Bryant and Charmaz, 2007). Induction aided in the formulation of analytic categories based on participants' narratives, whereas abduction enabled more profound theorisation when evidence contradicted original assumptions or unveiled unforeseen patterns (Dey, 2003). Iteration entailed constant engagement with data, evolving notions, and pertinent literature to facilitate conceptual refinement.

Rigour was ensured through reflexive memo-writing, frequent comparison, and clear documenting of analytical judgements (Charmaz, 2014; Lincoln and Guba, 1985). Sampling aimed to capture diversity across roles, contexts, and experiences to facilitate conceptual growth rather than ensure representativeness. The constant supervisory dialogue facilitated a thorough examination of developing interpretations, with reflexivity being paramount, so guaranteeing that analytical assertions were based on participants' narratives rather than presupposed professional expertise.

This section outlines the evolution of grounded theory and elucidates the justification for employing a constructivist approach in this study.

3.3 Research Questions

This study seeks to understand how nurses experienced working during and after the COVID-19 pandemic, and how their physical and mental wellbeing was shaped within organizational and professional contexts. In keeping with a Constructivist Grounded Theory approach, the research questions are framed to remain open and responsive to participants' accounts, allowing patterns and processes to emerge from the data rather than testing predetermined assumptions (Charmaz, 2014).

The study is guided by the following five research questions:

1. How do nurses describe their experiences of working during and after the COVID-19 pandemic within an NHS Trust?
2. How do nurses understand the impact of these experiences on their physical and mental wellbeing during and after the pandemic?
3. How do nurses describe the ways they sustained professional functioning under prolonged organizational and clinical pressure?
4. How do nurses experience and interpret organizational support, leadership, and workplace change during and after the pandemic?
5. How do nurses' experiences and interpretations vary across different clinical settings, roles, and care contexts within the NHS Trust?

Collectively, these questions indicate a focus on nurses' living experiences, organizational contexts, and discrepancies among environments. The existing literature elucidates the extensive challenges faced by nurses during the COVID-19 pandemic, encompassing increased workload, uncertainty, ethical dilemmas, and disrupted support systems (Maben and Bridges, 2020; Billings et al., 2021; Morley et al., 2021; WHO, 2022). The questions remain open and exploratory, encouraging participants to articulate their understanding and navigation of these conditions in their own terms. By doing so, they facilitate the formulation of a substantive, explanatory narrative that can enhance considerations regarding future pandemic preparedness and the ways NHS organization can more effectively support nurses' physical and mental wellbeing during and after prolonged crises (Charmaz, 2014; UK COVID-19 Inquiry, 2024; RCN, 2024).

3.4 The Development of Grounded Theory

Grounded theory (GT) originated in the late 1960s through the efforts of Barney Glaser and Anselm Strauss, who aimed to contest prevailing positivist paradigms by formulating an inductive methodology for theory development based on empirical data. Their foundational work, The Discovery of Grounded Theory (Glaser and Strauss, 1967), introduced systematic yet adaptable analytical methods that facilitated the development of theory based on participants' experiences rather than through pre-established hypotheses. Charmaz (2014, p. 1) defined grounded theory as "systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories grounded in the data themselves."

Grounded theory is philosophically motivated by symbolic interactionism, which posits that meaning arises through social interaction and interpretive processes (Blumer, 1969). From this viewpoint, individuals actively create meaning, identities are shaped through interaction, and experiences are situated within relational and organizational contexts. This attitude has rendered grounded theory especially impactful in nursing and healthcare research, since comprehending practice necessitates consideration of context, emotion, professional responsibilities, and organizational dynamics (Ralph et al., 2015).

After their first partnership, Glaser and Strauss established divergent methodological stances. Glaserian grounded theory prioritises emergence and the reduction of researcher interpretation, positing theory as a construct to be uncovered from evidence (Glaser, 1992). Straussian grounded theory, by contrast, implemented more systematic analytical methods, such as axial coding and defined analytical frameworks (Strauss and Corbin, 1990, 1998). Notwithstanding these distinctions, grounded theory traditions maintain fundamental commitments to iterative interaction between data collection and analysis, constant comparison, theoretical sensitivity, and the formulation of explanatory frameworks rooted in empirical evidence (Morse, 2001; Birks and Mills, 2015).

The methodological disagreements established the basis for Charmaz's formulation of Constructivist Grounded Theory (CGT), which redefined grounded theory as a distinctly interpretive and reflective approach congruent with modern qualitative research (Charmaz, 2006, 2014). Instead of viewing theory as an objective finding, Charmaz perceives it as formed through the interaction between the researcher and participants, influenced by context, perspective, and analytical choices. She contends that researchers "formulate our grounded theories through our historical and current engagements and interactions with individuals, viewpoints, and research methodologies" (Charmaz, 2014, p. 17). This role emphasises reflexivity and acknowledges the researcher's impact as essential to the analytical process.

Within grounded theory traditions, various analytical approaches are fundamental, including the simultaneous collecting and processing of data, constant comparison, memo-writing to facilitate conceptual growth, theoretical sampling, and progression from descriptive narratives to conceptual abstraction. This study employed these concepts to guide an iterative analytical process, wherein data collection, coding, and interpretation occurred in mutual discourse. Reflexive memo-writing and supervisory discussions enhanced analytical depth and transparency, ensuring that conceptual growth was anchored in participants' narratives rather than influenced by unexamined preconceptions.

Before choosing grounded theory, several qualitative techniques were evaluated based on their analytical emphasis and theoretical capacity (Creswell, 2013). Case study methodologies provide an in-depth analysis of confined systems but are inadequate for theorising social processes across varied experiences. Ethnography facilitates profound cultural immersion; yet it proved unfeasible due to the dispersed and dynamic character of nursing work during and after the pandemic. Phenomenology offers profound understanding of lived experience while putting less attention on organizational and structural processes. Narrative inquiry emphasises individual trajectories but does not easily facilitate the formulation of explanatory theories. Conversely, grounded theory provided the necessary flexibility, methodological rigour, and conceptual emphasis to investigate how wellbeing experiences were perceived and navigated within intricate organizational settings.

In the context of grounded theory, Constructivist Grounded Theory provided the most suitable epistemological and methodological alignment for this research. CGT acknowledges that data and meaning are collaboratively created through the interaction between researchers and participants, consistent with a relativist ontology and a constructivist epistemology that identify multiple, context-dependent realities (Charmaz, 2014; Mills et al., 2006). This interpretive perspective was especially pertinent considering my role as a practitioner-researcher inside the NHS. Following Charmaz’s (2014) recommendations, interviews and focus groups were conducted as relational interactions, employing iterative cycles of constant comparison, memo-writing, and theoretical sampling to enhance analytic categories until theoretical sufficiency was achieved.

Recent nursing research illustrates the efficacy of Constructivist Grounded Theory in analysing emotionally intricate, ethically significant, and organizationally integrated experiences, such as moral distress, institutional pressure, and post-pandemic workforce wellbeing (Clarke et al., 2022; Ballantyne et al., 2023; Gul et al., 2022). These studies demonstrate CGT's ability to clarify both personal meaning-making and the structural factors influencing professional experience.

Charmaz (2014, p. 239) notes that “the power of grounded theory lies in its capacity to move beyond surface meanings to interpretive understanding.” This principle informs the methodological decisions in this study, emphasising an approach that considers not only the experiences of nurses but also their interpretations and understandings of those experiences within moral, organizational, and emotional contexts. This section elaborates on the philosophical assumptions that support Constructivist Grounded Theory and their significance to the current study.

3.5 Constructivist Grounded Theory (CGT)

Constructivist Grounded Theory (CGT) serves as the comprehensive methodological and conceptual basis for this research. CGT, based on the foundational work of Glaser and Strauss (1967), reinterprets grounded theory through a constructivist–interpretivist perspective that emphasises interpretation, context, and reflexivity (Charmaz, 2006, 2014). Charmaz (2014, p. 1) posits that grounded theory provides “systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories grounded in the data themselves.” This equilibrium between analytical rigour and interpretive flexibility closely aligns with the objectives of this study, which aims to investigate how nurses comprehended and interpreted their experiences during and after the COVID-19 pandemic, particularly concerning physical and mental wellbeing.

CGT operates within a relativist ontology and an interpretivist epistemology, acknowledging that realities are diverse, contextually contingent, and constructed through interaction, language, and interpretation (Bryant and Charmaz, 2007; Mills et al., 2006). Knowledge is thus perceived not as a neutral depiction of an external reality, but as co-constructed through the interaction between the researcher and participants within organizational, professional, and historical settings (Charmaz, 2014; Denzin and Lincoln, 2011). This perspective is particularly pertinent in a research of wellbeing, since individuals may perceive analogous employment conditions in significantly diverse manners based on their function, environment, experience, and context (Killam, 2013).

A key characteristic of CGT is the clear recognition of the researcher’s interpretative role. Charmaz (2014, p. 17) asserts that researchers "construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices." This principle is especially pertinent in this study, as I engage in research as a practitioner-researcher within the NHS. My professional history equips me with an understanding of organizational structures, terminology,

and practices, so augmenting my analytical awareness. This proximity necessitates constant reflexive awareness to guarantee that interpretation is anchored in participants' narratives rather than influenced by familiarity or presumption (Mills et al., 2006; Berger, 2015).

Reflexivity is regarded as an essential methodological practice throughout the investigation, enhancing transparency and analytical integrity rather than serving as an ancillary or distinct element (Finlay, 2002; Charmaz, 2014). Reflexivity is operationalised through constant memo-writing and methodical documentation of analytical choices, arising enquiries, and interpretative ambiguities (Charmaz, 2014). Consistent supervisory dialogue enhanced analytical rigour, facilitating the critical evaluation of assumptions and interpretations throughout time. Collectively, these methodologies establish a clear audit trail of analytical progression and conform to overarching qualitative standards of dependability and rigour (Lincoln and Guba, 1985; Gentles et al., 2014).

The Co-construction of meaning is fundamental to CGT. This study treated data creation as an interpretative engagement, wherein participants' narratives were constructed through discussion, clarification, and reflection throughout interviews and focus groups (Charmaz, 2014, 2016). Transcripts were seen as interpretive narratives rather than impartial documents. The method of constant comparison facilitated an examination of both similarities and differences in participants' narratives, aiding in the formation of conceptual categories that were rooted in participants' language while transcending just superficial description (Charmaz, 2014; Bryant and Charmaz, 2007).

Charmaz's Constructivist Grounded Theory states that meaning is co-created by researchers and participants throughout data collection and analysis (Charmaz, 2006; 2014; 2016). Mutual presence, debate, and the social situations in which participants' narratives are formed shape the research interaction. The substance, style of expression, and analytical visibility of data come from moments of connection, reflection, and joint sense-making during the research interaction, according to this approach. A constructivist and interpretative research paradigm views meaning as a construct negotiated through interaction rather than a static or individual interpretation (Bryant and Charmaz, 2007; Creswell, 2013; Charmaz, 2016).

To find patterns of meaning and action across settings, the study prioritised in-depth, contextual narratives over breadth or measurement (Blaxter et al., 2010; Collis and Hussey, 2014). This flexible design allowed for iterative data generation, question and prompt refinement based on emerging insights, and participant engagement until new accounts stopped contributing meaningfully to the evolving comprehension. Grounded theory holds that human experience is social, generated by encounter and negotiation in specific cultural and organizational contexts (Chenitz and Swanson, 1996). Constructivist grounded theory helped create an abstract, integrated narrative around a primary category and connected categories, transcending individual narratives to explain systematic processes.

Emergent theory is a conceptual framework that may be assessed, updated, and used in numerous healthcare situations (Charmaz, 2006).

Understanding how nurses interpreted and valued their COVID-19 pandemic experiences improves our understanding of nursing as a socially and culturally contextualised profession. Professional standards, organizational expectations, and sociocultural discourses shape participants' narratives (Garro and Mattingly, 2000; Maynes et al., 2012). Nurses' intimate and ongoing interaction with patients and crucial role in public health emergencies provide them a unique perspective on policy, leadership, and organizational frameworks at the point of care (Hughes, 2006).

The study highlights nurses' knowledge building experiences to improve organizational learning and policy considerations. Nurses are vital to service delivery and innovation, but their experiential knowledge is often turned into formal research and organizational change (Bortini et al., 2018). A constructivist, co-constructed methodology helps translate lived experiences into conceptual and theoretical frameworks, improving practice, comprehension, and healthcare system adaptation.

To enhance the alignment between philosophical perspective and analytical methodology, Charmaz's constructivist concepts were used through the study's analytical processes. The process involved repeated movement between data collection and analysis, constant comparison, memo-writing to facilitate conceptual growth, and sample decisions that adapted to developing analytic approaches (Charmaz, 2014; Birks and Mills, 2015). These activities were regarded as interconnected rather than sequential phases, facilitating conceptual advancement while ensuring methodological clarity. **Table 3.2** below encapsulates the implementation of selected constructivist ideas within this study.

Table 3.2 Application of Charmaz's Constructivist Principles

Charmaz's principle	Application in this study
"We construct our grounded theories through our past and present involvements and interactions…" (Charmaz, 2014, p. 17)	My practitioner-researcher positioning informs analytic sensitivity; reflexive memo-writing and supervisory discussion support ongoing interrogation of assumptions (Berger, 2015; Mills et al., 2006).
"Grounded theory consists of systematic, yet flexible guidelines…" (Charmaz, 2014, p. 1)	Data generation and analysis proceed iteratively; constant comparison and memo-writing guide conceptual development (Charmaz, 2014).
Reflexivity is integral to constructivist inquiry (Charmaz, 2014)	Reflexive journalling and analytic memos document interpretive decisions and emerging questions; supervision supports analytic challenge and transparency (Finlay, 2002; Gentles et al., 2014).
Conceptual development moves beyond surface description (Charmaz, 2014)	Coding and comparison support movement from descriptive accounts to more conceptual interpretation of how experiences of wellbeing are understood and negotiated in context.

Charmaz's Principle: Application in This Study

The positioning of practitioner-researcher enhanced analytic sensitivity; reflexive memo-writing and supervisory dialogue facilitated constant examination of assumptions (Mills et al., 2006; Berger, 2015). Grounded theory encompasses systematic, albeit adaptable, rules (Charmaz, 2014, p. 1). “We develop our grounded theories based on our historical and current engagements and interactions…” (Charmaz, 2014, p. 17). Data collection and analysis occurred iteratively, with constant comparison and memo-writing directing conceptual advancement. Reflexivity is essential to constructivist research (Charmaz, 2014). Reflexive journaling and analytical memos recorded interpretive choices and developing enquiries; supervision facilitated analytical rigour and transparency (Finlay, 2002; Gentles et al., 2014). Conceptual growth transcends superficial description (Charmaz, 2014). Coding and comparison facilitated the transition from descriptive narratives to conceptual interpretations of how wellbeing was comprehended and negotiated within context.

Constructivist Grounded Theory offers a philosophically consistent and methodologically suitable paradigm for this research. The interpretivist attitude and focus on co-construction correspond with the objective of examining nurses' perspectives on physical and mental wellbeing during and after the COVID-19 pandemic, while its analytical procedures facilitate conceptual formation based on participants' narratives. This section elucidates the implementation of this methodological approach within the study context, ethical protocols, recruitment strategies, and access procedures.

3.6 Research Setting and Access

This research was performed within a substantial, integrated National Health Service (NHS) organization in the West Midlands. The setting was intentionally chosen since it embodied the organizational framework that influenced nurses' experiences during and after the COVID-19 pandemic. The study concentrated not only on individual experiences but also on the ways in which physical and mental wellbeing were experienced, interpreted, and navigated within an organizational structure that both supported nurses and imposed constant demands on them. In alignment with Charmaz’s constructivist perspective, the research environment was regarded not as a neutral context but as a social realm where meaning is perpetually constructed through organizational frameworks, professional interactions, and quotidian practices (Charmaz, 2014, pp. 27–30; Charmaz, 2016).

The organization caters to an extremely diversified demographic, including populations facing considerable socioeconomic disadvantage. National indices reveal that deprivation levels in the area are among the greatest in England, characterised by persistent inequalities in income, housing, and health outcomes (Ministry of Housing, Communities and Local Government, 2020; Office for National Statistics, 2021). Evidence consistently associates these structural problems with elevated service demand, intensified workload, and persistent organizational strain in healthcare environments

(Public Health England, 2022; NHS England, 2022). In nursing practice, these pressures have been demonstrated to exacerbate emotional labour, moral obligation, and exposure to distress, especially in contexts of unmet needs, resource limitations, and recurrent contacts with suffering (Traynor, 2017; Maben and Bridges, 2020; Banks et al., 2022).

In this study, these structural conditions were not regarded solely as contextual background. Instead, they constituted the conditions under which nurses understood professional duty, boundaries of care, and experiences of physical and mental well-being. From a constructivist grounded theory viewpoint, meaning is perceived as arising from the interactions between persons and their organizational and social environments (Charmaz, 2014). Positioning the study inside a socioeconomically disadvantaged context thus offered a pertinent framework for analysing how nurses interpreted persistent workload pressure, ethical responsibility, and resilience within limited systems.

My justification for conducting the study within this organization was also influenced by my role as a practitioner-researcher in this setting. Professional experience inside the organization offered insight into how structural variables contributed to professional fatigue and systemic stress in daily practice. Now, these contextual elements are delineated as a component of the methodological rationale for the study environment. The analysis chapters analyse and substantiate the linkages participants explicitly made between deprivation, organizational pressure, or structural constraints and their feelings of physical and mental wellbeing.

Negotiating Access and Positionality

Access to the research environment required both formal authorisation procedures and relational negotiations. Access was obtained through ethical approval from the University, the Health Research Authority, and the Research and Development section of the organization. These approvals granted official authorisation to undertake the study. Nonetheless, in accordance with Constructivist Grounded Theory, access was not regarded only as an administrative procedure. Charmaz (2014, pp. 30–31) asserts that access entails negotiating trust, connections, and role boundaries within the social context being examined.

As an employee of the organization, I held an insider role within the research environment (Bonner and Tolhurst, 2002; Costley, 2010). This role provided insight into organizational frameworks, professional standards, and the quotidian aspects of nursing, encompassing informal practices and emotional labour that may seem obscure to outsiders. This familiarity enhanced access and fostered rapport with participants. Simultaneously, insider research entails acknowledged methodological hazards, such as presumed shared understanding, excessive familiarity, and the possibility of neglecting implicit meanings (Hewitt-Taylor, 2002; Berger, 2015).

To mitigate these concerns, reflexivity was integrated across the access and recruitment stages. I consistently wrote memos to record assumptions, emotional reactions, and developing analytical

enquiries, facilitating a critical analysis of how my professional identity and organizational expertise could influence interactions and interpretations (Charmaz, 2014). Reflexive memoing served not to alienate me from the field, but to make my perspective transparent and analytically justifiable.

Transparency was emphasised in the communication of my role to participants. Insider status facilitated access to the concealed curriculum of practice, encompassing informal norms, ethical dilemmas, and emotional labour; nonetheless, it necessitated careful management of boundaries between colleague and researcher. I maintained vigilance regarding instances where collegial familiarity could affect the narration or reception of experiences, as well as how these dynamics might influence meaning-making within the research engagement.

In alignment with Charmaz's constructivist perspective, I did not regard myself as an external spectator but rather as an active participant in the collaborative creation of understanding (Charmaz, 2016). Instead of attempting to negate my positionality, I acknowledged it clearly. Recognising that a common professional culture and organizational proximity influenced access and interaction enhanced the transparency and credibility of the research process, ensuring that access was regarded as a constant, reflexive, and relational achievement rather than a singular procedural occurrence.

3.7 Sampling Strategy

Recruitment unfolded as an extension of the same attentiveness and care that participants described within their professional lives. When nurses expressed interest, I treated this as the beginning of a conversation rather than as a commitment to take part. Some asked for time to reflect, others needed to check their shift patterns, and a few returned after stepping back during particularly demanding periods at work. I followed their pace rather than setting one of my own, making it clear that participation was optional, revisable, and separate from their role within the organization.

At the point of interview and focus group entry, I revisited the purpose of the study, my role as a practitioner-researcher, and the voluntary nature of involvement, and invited participants to decide what they felt able to share. I remained attentive to moments of hesitation, emotional weight, or fatigue, and used these as cues to slow the conversation, offer pauses, or move away from lines of discussion. Alongside this, I kept reflexive memos that recorded how these encounters shaped both my understanding of participants' experiences and my own position within the research relationship. In this way, recruitment and early engagement became part of the analytic process itself, grounded in responsiveness, trust, and ethical care rather than in procedural exchange alone.

Sample Size and Theoretical Sufficiency

A total of 55 nurses and nursing associates submitted the Expression of Interest form, demonstrating significant readiness to participate in the study. Subsequent communication, amid workload constraints and restricted availability, resulted in the participation of 17 individuals. This consisted of

11 individual interviews and two focus groups, one with four participants and the other with two people, although the initial design permitted up to six individuals per group.

In grounded theory, adequacy is assessed not by numerical sample size but by theoretical sufficiency, which is the juncture at which further data enhance depth and precision without modifying the fundamental features or linkages among analytic categories (Charmaz, 2014, p. 200; Morse, 2015). Through simultaneous data collection and analysis, constant comparison, memo writing, and supervisory dialogue, I noted that supplementary data were enhancing existing categories rather than producing fundamentally new conceptual avenues. Theoretical sufficiency was deemed to have been achieved based on this criterion.

The demographic composition of the sample was analytically significant rather than merely descriptive. Differences in gender, professional seniority, ethnicity, career stage, and care setting facilitated ongoing comparison during the analysis. In accordance with Constructivist Grounded Theory, these features were regarded not as variables to be manipulated but as contextual aspects that influenced organizational experience and meaning-making (Charmaz, 2014). **Table 3.3** below delineates participant characteristics and offers an overview of the sample to enhance transparency. The following sections delineate how essential sample traits enhanced analytic sensitivity and comparison, without considering them as definitive explanations. The findings chapters analyse and substantiate the connections participants made between these traits and their experiences of physical and mental wellbeing.

Ethnicity, Gender, and Professional Seniority

The sample was primarily female, mirroring the gender distribution of the nursing workforce in England (NHS Digital, 2023). The professional seniority of participants varied from Band 5 to Band 8a, facilitating comparison among frontline, specialised, and leadership positions.
This scope for the examination of how nurses perceived and interpreted responsibility, visibility, and organizational expectations across various roles within the company. In accordance with Constructivist Grounded Theory, role and seniority were regarded as analytically pertinent settings for negotiating meanings rather than as explanatory variables in isolation (Charmaz, 2014).

Participants identified themselves across many ethnic backgrounds, including White British, Black British, Asian, and Mixed Heritage categories. Ethnicity was not regarded as a definitive explanatory variable, nor was it presumed to yield homogeneous experiences. Rather, it was examined as a singular dimension through which organizational practices such as inclusion, recognition, and access to support might be perceived and experienced.

National research indicates that nurses from marginalised ethnic backgrounds may encounter disparate organizational treatment and heightened exposure to workplace stresses (NHS Race and Health Observatory, 2022; Royal College of Nursing, 2023). These findings guided analytic

sensitivity without predefining assumptions. Accounts where participants clearly linked ethnicity to feelings of unequal support or marginalisation are analysed and substantiated in the findings chapters.

Profile of Nurses

Participants indicated had professional experience ranging from 5 to 40 years. This scope encompassed reports from pre-pandemic work settings, the acute pandemic phase, and the post-pandemic era, facilitating comparisons across various career phases and temporal contexts.
This variation emphasised analytic attention to nurses' interpretations of change over time, particularly about their experiences of working conditions as worsening, persisting, or normalising throughout the pandemic and thereafter, rather than merely presenting tenure as a contextual detail. The thesis later examines and evidence how participants linked their job stage or tenure to their understanding and management of physical and mental wellbeing.

Consistent with Constructivist Grounded Theory, the table is not intended to assert representativeness but to illustrate the variety of situations in which meanings were generated and analysed (Charmaz, 2014). This facilitates the audit trail connecting recruiting and sampling choices to subsequent conceptual development via constant comparison and memo-writing. **Table 3.3** below summarises participant characteristics, encompassing role, band, setting, and years of qualification. The table is provided to enhance transparency and to illustrate the extent of the sample used for analytical comparison.

Table 3.3: Profile of Nurses

Participant ID	Band	Gender	Ethnicity (Self-reported)	Years Qualified	Setting
P01	6	Female	Asian Indian	25	Secondary
P02	5	Female	Black British	20	Secondary
P03	8a	Male	British Asian Pakistani	22	Cross-site
P04	6	Female	British Pakistani	10	Secondary
P05	7	Female	White British	33	Community
P06	7	Female	White British	23	Cross-site
P07	6	Female	White British	12	Secondary
P08	7	Female	Mixed White Asian	15	Secondary
P09	8	Female	Mixed White Afro-Caribbean	20	Cross-site
P10	7	Female	Mixed	30	Secondary
P11	7	Female	White British	38	Secondary
P12	7	Female	British/Indian	16	Community
P13	7	Male	White British	29	Cross-site
P14	6	Female	Black British	25	Secondary
P15	7	Female	White British	35	Community
P16	8a	Female	Black British (multiple heritage)	33	Cross-site
P17	6	Female	White British	17	Secondary

NOTE: Departmental identifiers have been removed to protect participant anonymity.

Participants were selected from secondary care, community services, and cross-site positions. The care setting was regarded as analytically significant rather than merely a contextual backdrop. Nurses

in acute secondary care reported more frequent experiences of prolonged trauma exposure, physical fatigue, and ethical distress, corroborating current findings regarding the physical and mental ramifications of frontline COVID-19 care (Maben and Bridges, 2020).

In contrast, those engaged in community and cross-site positions frequently highlighted problems of professional isolation, disjointed communication, and unacknowledged labour. These accounts reflected broader depictions of community nursing practice marked by heightened demand, diminished visibility, and restricted organizational integration (Iacobucci, 2021). Comparing perspectives across care settings facilitated an analysis of how organizational location influenced access to support, perceptions of value, and interpretations of professional duty.

Sampling across care settings facilitated constant comparison and enhanced analytical development by emphasising how experiences of physical and mental well-being were influenced not only by role or seniority but also by organizational positioning within the healthcare system. This method corresponds with Charmaz's (2014) focus on formulating grounded theory that is cognisant of context, structure, and social dynamics.

The final sample consisted of 17 nurses employed in NHS Bands 5–8a, encompassing frontline clinical positions, specialised practice, and senior operational leadership. This range facilitated comparisons across various levels of organizational responsibility, visibility, and proximity to decision-making, which was analytically pertinent when assessing how participants perceived workload pressure, organizational support, and their physical and mental wellbeing.

The sample was primarily female, mirroring the gender distribution of the nursing workforce in England (NHS Digital, 2023). Incorporating participants from Bands 5–8a facilitated the analysis of differences among workers providing direct care, individuals in advanced or specialist roles, and those in leadership positions. These contrasts guided the investigation of how organizational expectations, accountability, and role demands influenced wellbeing experiences across professional hierarchies, rather than presuming a homogeneous nursing experience (Charmaz, 2014).

Participants identified themselves across several ethnic backgrounds, broadly mirroring the demographic mix of the local nursing workforce (ONS, 2021). Ethnicity was examined with analytical prudence to prevent tokenistic interpretations or hasty causal attributions. At this methodological stage, ethnic diversity significantly improved theoretical sensitivity, guaranteeing that emergent categories were not generated from a homogeneous professional cohort.

The years of qualification varied from 5 to 40, facilitating a comparison across early, mid, and late career stages. This temporal distribution facilitated an investigation of how participants contextualised their COVID-19 experiences with previous working circumstances and ensuing organizational changes. Variations in tenure shaped the comprehension of how professional identity, expectations, and perceptions of wellbeing developed over time, rather than serving as fixed background traits.

Participants were selected from secondary care, community services, and cross-site jobs, enabling comparison across organizational settings distinguished by varying patterns of exposure, visibility, and support. The setting-based differences were analytically relevant, rather than incidental, thereby facilitating an analysis of how organizational environment influenced sensations of pressure, isolation, and moral obligation.

The sample's composition offered adequate conceptual diversity to facilitate constant comparison across roles, settings, seniority, and experience. This guaranteed that developing analytic categories were anchored in many organizational contexts instead of merely representing the experiences of a singular minority, thereby enhancing the coherence, credibility, and methodological rigour of the study (Charmaz, 2014; Morse, 2015).

Despite significant initial enthusiasm, evidenced by around 55 Expressions of Interest, participation was limited due to persistent task pressures, staffing deficiencies, and professional fatigue. Several nurses who first indicated interest later retracted their participation upon realising that it would take place outside of contracted working hours. This pattern echoes broader UK evidence of time scarcity, exhaustion, and diminished ability for voluntary participation among nurses post-COVID-19 pandemic (Buchanan et al., 2022; Royal College of Nursing, 2023).

I saw these dynamics as analytically informative rather than as a methodological restriction. The circumstances that rendered participation challenging illuminated the organizational context influencing nurses' experiences, characterised by ongoing task pressure, restricted flexibility, and limited opportunity for reflection or recuperation. In accordance with Constructivist Grounded Theory, these factors were not excluded but acknowledged as influencing both involvement and the construction of meaning (Charmaz, 2014).

Reflexivity and Insider Perspective

As an insider researcher within the same NHS organization, I possessed contextual awareness of organizational culture, professional norms, and the emotional landscape of pandemic work. Insider posture can improve rapport and access (Bonner and Tolhurst, 2002), but it also entails risks of excessive familiarity and uncritical assumptions (Berger, 2013). In alignment with Charmaz's focus on reflexivity as methodological awareness, I maintained constant reflexive practices during recruiting and sampling. Reflexive memo-writing served as a crucial analytical instrument, facilitating the emergence and modification of assumptions.

For instance:
"*I initially anticipated that senior nurses would be more reserved, yet they exhibited greater vulnerability than certain junior colleagues*." Reflexive memorandum, March 2024.

This challenged my idea that hierarchy constrains openness and reminded me that power dynamics can suppress certain voices while amplifying others. Engaging reflexively with these situations enhanced analytical sensitivity and averted premature closure regarding hierarchical assumptions. These procedures enhanced the study's credibility and corresponded with Lincoln and Guba's (1985) standards for dependability and confirmability.

As a practitioner-researcher, I approached the study with my own emotional and experiential background from that period. Emotional resonance with the participants' narratives was thus probable. While reflexive and supervisory procedures facilitated the establishment of analytic distance, complete detachment was neither feasible nor suitable within a constructivist framework. Charmaz observes that researchers operating in trauma-imbued environments cannot detach themselves from the subjects they investigate (Charmaz, 2014, p. 288). In this investigation, emotional vulnerability served as both a limitation and an analytical asset. It enhanced my awareness of emotional subtleties, such as pauses, tonal shifts, and the significance of participants' metaphors, while concurrently necessitating vigilant attention to the danger of over-identification. I regarded this as an analytical vulnerability: a circumstance that could limit interpretation if unexplored yet could enhance analysis when actively addressed through memo-writing and supervision.

The location is significant for the interpretation of the theory. The analysis was not conducted from an objective perspective. It was designed from a practitioner-researcher perspective, somewhat intertwined with the organizational settings indicated by the participants. Emotionality is thus shown not as a flaw to be hidden, but as a barrier necessitating rigorous reflective practice to ensure that the theory is anchored on the participants' interpretations rather than my own.

In this Constructivist Grounded Theory study, reflexivity was not a supplementary portion added at the conclusion of the research procedure. It influenced my methodology in data collection, analysis, and theoretical integration consistently. Charmaz underscores that the researcher is an integral component of the researched universe, and that interpretations are collaboratively developed through perspective, interaction, and analytical choices (Charmaz, 2014, pp. 161–166). Reflexivity thus served as an ongoing methodological approach, enhancing credibility and ensuring that the analysis stayed closely matched with participants' narratives.

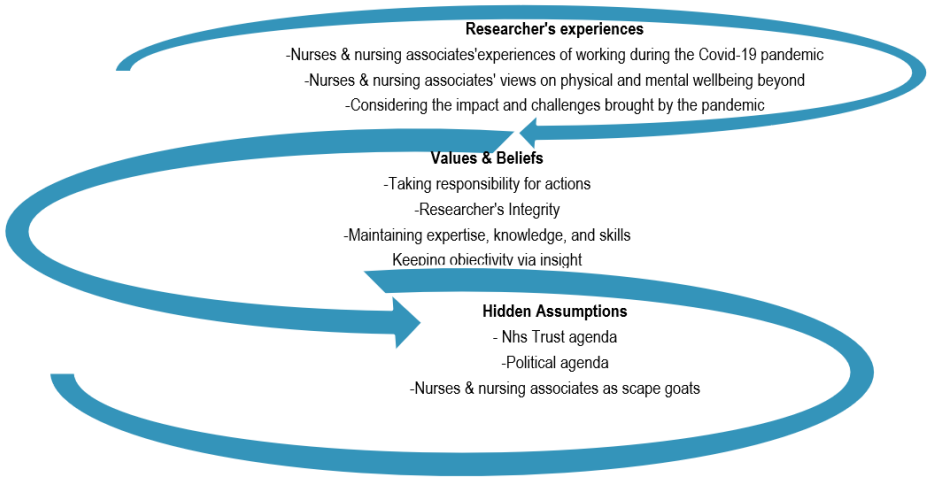
I was an NHS practitioner-researcher and doctorate researcher in this study. I worked in the NHS during the pandemic and researched nurses' experiences during and after COVID-19. This dual positioning placed me both within and adjacent to the organizational framework under examination. I conveyed my exposure to the structural pressures, moral dilemmas, and emotional demands articulated by participants, while also analytically engaging with the interpretation, negotiation, and evolution of those experiences across time. In accordance with a Constructivist Grounded Theory

approach, this viewpoint was regarded not as a contaminant to be eradicated, but as a condition necessitating deliberate reflexive consideration (Charmaz, 2014).

Assuming the practitioner-researcher role improved analytic sensitivity by fostering familiarity with NHS systems, professional terminology, and the pragmatic aspects of worker wellbeing, especially during and after the pandemic. Simultaneously, it necessitated constant reflective discipline to guarantee that interpretations were anchored in participants' narratives rather than influenced by professional closeness or presumed mutual comprehension. Reflexivity served as a methodological shield, allowing me to operate effectively in this dual capacity while preserving analytical honesty and transparency. Unlike previous grounded theory traditions that prioritised the perspective of a detached or "impartial observer," Constructivist Grounded Theory situates the researcher within the inquiry, acknowledging their involvement in the interpretative process (Charmaz, 2016; Singh and Estefan, 2018).

Figure 3.1 below depicts how the researcher's previous experiences, beliefs, and professional ideals were regarded as reflexive resources instead of concealed influences, hence altering the enquiries posed, the moments engaged in dialogue, and the meanings constructed through contact with participants.

Figure 3.1 Researcher's Constant Reflexive Process



Drawing on my previous and current professional position within an NHS Trust, I adopted a Constructivist Grounded Theory approach to explore how my practitioner-researcher positioning shaped the study and influenced the direction of the research process (Charmaz, 2016; Heringa, 2005). As the study progressed, I became increasingly aware of the importance of recognising my own subjective perspective and the relational dynamics that developed between myself and participants throughout data collection and analysis. Rather than attempting to position myself as detached from the research, I acknowledged that my role within the inquiry was inherently interpretive. In keeping with Constructivist Grounded Theory, knowledge was understood as being co-constructed through interaction, dialogue, and shared meaning-making between myself and participants, shaped by both their experiences and my own professional and relational understanding of the healthcare environment (Charmaz, 2016).

A fundamental tenet of Constructivist Grounded Theory is the embrace of a reflexive, self-aware approach to scrutinise how the researcher's presence and viewpoints affect the research process and the insights that arise. The study employed reflexive memoranda and a research diary to record how the researcher's background, professional expertise, and evolving theoretical awareness influenced decisions in data collection, analysis, and writing (Charmaz, 2014; 2016). This constant reflexive practice enhanced openness and dependability in the study, elucidating how the research topic, design decisions, and participant interactions shaped both the developing analysis and the researcher's comprehension of the phenomenon under investigation (Gentles et al., 2014).

Insider research carries recognised challenges, including familiarity, blurred boundaries, and assumptions of shared understanding between the researcher and participants (Asselin, 2003; Chavez, 2008). However, when approached reflexively and with ongoing critical awareness, insider positioning can also deepen theoretical sensitivity and strengthen interpretive understanding. My professional background enabled me to recognise cultural cues within participants' accounts, including the use of humour to soften distress, brief references to organizational pressures, and the normalisation of silence, endurance, and emotional suppression within nursing practice. At the same time, familiarity was not treated as understanding in itself. I returned repeatedly to participants' words, meanings, and explanations to ensure that analytical interpretations remained grounded in their accounts rather than shaped by my own organizational knowledge or assumptions.

Emotional proximity was a primary reflexive difficulty in this investigation. Participants articulated feelings of fatigue, ethical distress, and perceptions of institutional neglect that echoed elements of my own professional views. Charmaz contends that reflexive responsibility necessitates consideration of how emotions, values, and positionality influence analytical decisions (Charmaz, 2014, p. 170). I used reflective writing after interviews and focus groups to record emotional reactions in conjunction with developing analytical enquiries. This exercise facilitated the distinction between participants' experiences and my personal feelings, so averting empathy from leading to interpretative closure.

Emotional resonance did not facilitate category construction; rather, it incited a more meticulous examination of the existing data and the necessity for more comparison.

Reflexivity was crucial in addressing power dynamics and relational ethics during the research interaction. The distinctions between insider and outsider roles were regarded as fluid rather than rigid, with participants occasionally perceiving the researcher as someone who comprehended the environment without need further clarification (Dwyer and Buckle, 2009). To prevent presuming common interpretations, the researcher employed open-ended prompts and requested clarification, even when professional jargon or organizational allusions were recognised. At the beginning of each interview , the researcher explicitly defined their role and limitations, encompassing confidentiality, voluntary involvement, and autonomy from management. This method fostered trust while preserving analytical integrity, especially when participants discussed experiences of stress and distress associated with organizational contexts.

By means of regular comparison and analytical memo composition, the researcher assessed interpretations across various contexts and narratives. When a developing interpretation threatened to mirror organizational familiarity instead of the participants' facts, the researcher revisited the transcripts to verify how nurses articulated their experiences in their own terms. This introspective discipline was crucial in establishing the analytical differentiation between Surface Endurers and Fractured Endurers. While these classifications may initially seem akin to patterns of presenteeism or absenteeism, their development arose from a thorough comparison of moral strain, embodied depletion, organizational dissonance, and limited recovery opportunities, rather than from assumptions based on occupational health frameworks.

Reflexivity also served as a means of containment during the analysis. Engaging with narratives of mortality, interrupted mourning, solitude, trepidation, and persistent exhaustion necessitated emotional effort. Memo-writing and supervisory discussion were employed to manage the material's significance without succumbing to avoidance or excessive identification. This illustrates Charmaz’s focus on reflexivity as a form of conscious self-awareness that enhances analytic rigour rather than detracts from it (Charmaz, 2014, p. 159).

Ultimately, reflexivity facilitated theoretical integration. Charmaz defines integration as illustrating the coherence of categories inside a process, rather than allowing them to exist as parallel themes (Charmaz, 2014, p. 262). Reflexive engagement enabled me to identify how emotional suppression, aftershocks, organizational dissonance, and moral injury operated as interconnected dynamics within endurance. Insider information facilitated the identification of organizational inconsistencies; however, these insights were regarded as tentative and were substantiated through constant comparison and the pursuit of disconfirming instances. Consequently, integration was predominantly guided by facts rather than by familiarity.

Reflexivity served as the mechanism for upholding ethical and analytical integrity. It safeguarded the analysis against excessive familiarity, rendered emotional proximity apparent as a limit, and facilitated interpretative prudence with conceptual advancement. According to Charmaz's quality criteria, reflexivity enhanced credibility, and resonance by anchoring the theory in participants' interpretations, while simultaneously fostering creativity and utility through meticulous theoretical integration (Charmaz, 2014, p. 337).

In Constructivist Grounded Theory, recruiting is a morally contextualised and relational practice rather than a neutral or merely procedural activity. In accordance with Charmaz's exposition of situated and relational ethics (2014, pp. 30–32), recruitment for this study was conducted with careful consideration of professional vulnerability, emotional exposure, and the organizational factors influencing participants' ability to engage.

Encouraging nurses to contemplate their experiences during and after the COVID-19 pandemic could potentially resurface traumatic memories, such as loss, moral anguish, and fatigue. Recruitment discussions were thus executed with diligence, mindfulness, and adaptability. This involved adjusting interactions based on participants' readiness, revisiting information when ambiguity arose, and overtly normalising reluctance or withdrawal without justification.

Ethical mindfulness, as articulated by Guillemin and Gillam (2004), guided real-time decisions during the recruitment process. Instead, than viewing ethics as a singular approval or consent milestone, ethical sensitivity was manifested through constant reactivity to emotional signals, workload demands, and indications of exhaustion. This guaranteed that recruitment processes emphasised participant wellbeing in conjunction with methodological rigour, aligning with the interpretative and relational principles of Constructivist Grounded Theory.

Inclusion Criteria

In Constructivist Grounded Theory, inclusion requirements serve as methodological tools rather than administrative barriers. They assess if participants are situated to elucidate the issue under examination in conceptually significant manners (Charmaz, 2014, pp. 18–22; Corbin and Strauss, 2015). This study's inclusion criteria were established to guarantee analytical relevance, conceptual depth, and epistemological coherence with the constructivist objective of examining nurses' interpretations and experiences of their physical and mental wellbeing during and after the COVID-19 pandemic.

Participants were eligible for inclusion if they were:

Registered Nurses working at NHS Bands 4–8a.

Employed on a substantive (permanent) contract within the organization during and after the COVID-19 pandemic.

The criteria were chosen to guarantee that participants had prolonged organizational immersion and direct engagement with the structures, expectations, and pressures influencing nursing practice during the pandemic. In accordance with Charmaz's (2014, p. 199) focus on choosing data sources that might elucidate evolving categories, participation was limited to practitioners with sustained experience rather than those with intermittent or temporary involvement.

Incorporating nurses and nursing associates from Bands 4 to 8a facilitated an analytical comparison of varying levels of organizational responsibility, professional visibility, and closeness to decision-making. This facilitated the investigation of how organizational position influenced perceptions of effort, responsibility, and wellbeing, aligning with Patton's (2002) recommendation for maximal variety to enrich conceptual depth rather than representativeness.

Limiting eligibility to substantially employed nurses allowed participants to contemplate organizational conditions before, during, and after the pandemic within the same institutional framework. This continuity was crucial for ongoing comparison and for analysing the evolution of meanings over time, aligning with Morse's (2015) assertion that conceptual adequacy relies on the depth and duration of participants' experiential knowledge.

Exclusion Criteria

Exclusion criteria were intentionally implemented to preserve analytical emphasis and conceptual coherence, rather than to restrict participation based on procedural considerations. In Constructivist Grounded Theory, exclusion boundaries serve to refine the analytical focus by averting the dilution of the phenomenon being studied and preserving conceptual integrity (Charmaz, 2016).

The following groups were excluded:

Agency nurses, bank staff, retired nurses, and casual workers

Student nurses and trainees on clinical placement

Healthcare staff outside nursing (e.g. allied health professionals, support workers)

Staff employed on temporary, fixed-term, or external secondment contracts.

Agency and temporary nurses were excluded because their employment patterns typically involve movement across multiple organizations, limiting sustained exposure to a single organizational culture, leadership structure, or wellbeing system. Including such participants would have weakened analytic sensitivity to institutional processes by introducing fragmented organizational perspectives (Glaser, 1978; Charmaz, 2016).

Student nurses were excluded due to their failure to satisfy the inclusion requirements of substantial employment and organizational continuity.

Limiting participation to actively engaged nurses guaranteed that all participants had encountered pre-pandemic work conditions, acute pandemic challenges, and post-pandemic organizational circumstances within the same NHS Trust. This continuity facilitated longitudinal analysis and ongoing comparison across time, roles, and contexts, in accordance with Charmaz's (2014, pp. 136–140) recommendations for formulating grounded theoretical explanations of processes.

Reflexive Review of Inclusion and Exclusion Boundaries

In accordance with constructivist grounded theory principles, the inclusion and exclusion criteria were reflexively evaluated during data collection and analysis. Reflexive decisions concerning sampling boundaries were recorded through analytic memos and supervisory discussions, both of which are incorporated in the methodological audit trail.

As analytical categories evolved, I considered if broadening participant groups might facilitate conceptual advancement. Through constant reflexive evaluation, I concluded that the current sample remained adequate for theoretical sufficiency, and that expanding eligibility would result in conceptual dispersion rather than analytical enhancement (Charmaz, 2014; Thornberg and Charmaz, 2014).

Upholding these boundaries ensured methodological consistency and transparency, in accordance with Lincoln and Guba's (1985) standards of credibility, dependability, confirmability, and transferability. Consequently, inclusion and exclusion decisions were regarded as methodological and epistemological actions that influenced the study's integrity, rather than simply impartial logistical selections.

Consent Procedures

In Constructivist Grounded Theory, informed consent is perceived not as a singular administrative occurrence but as a relational, iterative, and ethically integrated process that develops through constant interaction between the researcher and the participant (Charmaz, 2014, pp. 27–31; Guillemin and Gillam, 2004). This study conceptualises consent as an ongoing and dialogic practice, aligned with an interpretivist perspective wherein understanding and meaning are collaboratively formed through relationships, trust, and reciprocity.

Participants were invited to contemplate challenging professional experiences during and after the COVID-19 pandemic, encompassing aspects of physical and mental wellbeing within a high-pressure organizational context. Consequently, the consent process was structured to emphasise clarity, voluntariness, and reflexive sensitivity throughout the engagement.

Consent processes were grounded in known ethical principles of respect for persons, beneficence, and justice (Beauchamp and Childress, 2019), in conjunction with the Declaration of Helsinki (World Medical Association, 2013) and NIHR Good Clinical Practice guidelines (2022). Formal ethical

approval for the study was obtained from the Birmingham City University Faculty of Health, Education and Life Sciences Research Ethics Committee and the NHS Health Research Authority, with all relevant documentation included in the Appendices.

It was crucial to ensure that participants comprehended the study's objective, scope, expectations, and protections, especially considering the convergence of professional responsibilities, organizational affiliation, and personal experience.

In alignment with the principles of Constructivist Grounded Theory regarding relational ethics, consent was defined as a collaboratively established agreement that acknowledged participants' professional expertise, autonomy, and their right to dictate the scope and nature of their involvement, rather than merely as procedural adherence see **Table 3.4** below (Charmaz, 2014; Denzin and Lincoln, 2013).

Table 3.4: Summary of Consent Process

Stage	Purpose	Ethical Principle	Constructivist Alignment
Information sharing	Provide full study details	Respect for autonomy	Enables informed decision-making
Reflection period	Allow time to consider participation	Beneficence and voluntariness	Encourages ethical agency
Written consent	Formalise agreement	Justice and transparency	Establishes shared understanding
Time-limited withdrawal	Protect autonomy while maintaining analytic integrity	Relational ethics	Reflects concurrent analysis in CGT
Ongoing consent	Reaffirm permission throughout	Ethical responsiveness	Consent is negotiated and dynamic
Data protection	Secure and anonymise data	Non-maleficence	Protects professional and emotional wellbeing

In this study, consent was enacted as a dynamic, relational, and ethically reflexive process consistent with the interpretivist foundations of Constructivist Grounded Theory. By embedding consent within ongoing dialogue, transparency about analytic timing, and sustained attentiveness to participant comfort, the research upheld dignity, autonomy, and methodological integrity throughout.

Before participation, all prospective participants received a detailed Participant Information Sheet that delineated the study's objectives and design, the requirements of participation, confidentiality and anonymity measures, data management and storage protocols, the voluntary aspect of participation, and the right to withdraw. A copy of the Participant Information Sheet is included in (**Appendices)**. Participants were allotted ample time to examine the information and were urged to enquire or seek clarification before to deciding regarding their participation. This intentional hiatus was incorporated throughout the procedure to guarantee that consent was informed, voluntary, and contemplative.

Prior to any interview or focus group, formal written consent was secured using an authorised consent form (**Appendices**). Participants were invited to select their own pseudonym, which was documented

on the consent form. This methodology emphasised participant autonomy and confidentiality from the beginning. Upon obtaining consent, I allocated participant identifiers (e.g., P01, P02) for analytical tracking and data management objectives. These IDs were used by me as the researcher and served exclusively as internal analytical instruments in conjunction with pseudonyms selected by participants.

At the commencement of each interview and focus group, consent was reiterated verbally. I reintroduced myself as a doctoral researcher, clarified the study's goal, reiterated essential details from the Participant Information Sheet (PIS), and confirmed participants' ongoing willingness to participate. The topic guides for interviews and focus groups used throughout data collection are presented in Appendices section.

Withdrawal, Ongoing Consent, and Analytic Timing

Participants were notified that they maintained the opportunity to withdraw from the study within seven days after their interview or focus group. The timeline was clearly specified in the Participant Information Sheet, reiterated during the consent process, and orally restated at the end of participation.

Following this seven-day interval, data were deemed to have commenced active analysis and could no longer be entirely retracted. The restricted withdrawal period aligns with the methodological principles of Constructivist Grounded Theory, wherein data collection and analysis transpire simultaneously rather than in a linear fashion (Charmaz, 2014). Charmaz observes that grounded theorists examine data concurrently with its collection, using initial interviews to guide subsequent classification, comparison, memo-writing, and theoretical orientation (Charmaz, 2014, p. 124).

Participants were thus advised that departure at this stage could jeopardise analytic integrity, since individual narratives may have already influenced coded segments, analytic memo writing.

Within this context, people preserved the right to:

Refuse to respond to any enquiries during interviews or focus groups.

Cease or discontinue participation at any moment.

Solicit a partial withdrawal, such as refraining from utilising direct quotations, within the specified term.

This strategy corresponds with Charmaz’s (2014, pp. 30–32) focus on maintaining methodological rigour alongside relational and ethical awareness in constructivist research.

Relational Ethics and Reflexive Practice

Ethical practice in Constructivist Grounded Theory encompasses not only documentation but also reflexive knowledge of power, positionality, and interactional dynamics (Finlay, 2012; Ellis, 2007). As

a practitioner-researcher inside the same NHS organization, I remained cognisant of the potential for participants to detect implicit hierarchies, professional sensitivities, or organizational risks when recounting their experiences.

I continually emphasised that participation or non-participation would not affect employment, evaluation, or professional status, and that the NHS group operated only as a recruitment and data collection entity. It was clearly stated that all data transport, storage, transcription, and analysis were conducted using Birmingham City University systems instead of Trust infrastructure. This distinction was conveyed both verbally and in writing to ensure transparency and provide reassurance (**Appendices**).

Ethical attentiveness, as defined by Guillemin and Gillam (2004), informed every contact. Consideration was given to tempo, tone, and participant comfort, with consent regarded as actively upheld rather than fixed. This method acknowledged that participants' emotional preparedness and ability to engage may vary, especially when discussing events associated with sorrow, loss, or moral conflict.

Reflexive memorandum, August 2024:
"*When participants exhibited emotional distress while recounting experiences, I paused the interview and reaffirmed their option to continue, pause, or terminate*."

These instances underscored that consent must be dynamic; it must be active and responsive throughout the engagement.

All interviews and focus groups were audio-recorded via an Olympus DS-700 digital recorder owned by Birmingham City University (BCU). Recordings were swiftly transmitted to Birmingham City University OneDrive, a secure, password-protected cloud storage system, and subsequently erased from the recording device upon confirmation of successful transfer. The recording and data management techniques are specified in the sanctioned study protocol.

The transcription was executed using a blend of manual efforts by the researcher and a transcribing service recommended by Birmingham City University. All transcripts were securely stored on BCU OneDrive in compliance with the Data Protection Act (2018) and the UK General Data Protection Regulation. Access to audio files, transcripts, consent papers, and analytical materials was limited only to the doctoral researcher and the supervision team. All potentially identifying information was eliminated or generalised during transcription and processing to reduce the danger of indirect identification within a singular organizational context. Kaiser (2009) contends that anonymisation transcends a mere technological process; it becomes a moral need, especially in workplace research where professional reputation, relational trust, and psychological safety are potentially compromised.

3.8 Ethical and Regulatory Considerations

Ethical and regulatory issues are fundamental at every phase of qualitative research, especially in Constructivist Grounded Theory (CGT), because knowledge is collaboratively created through the relational interaction between researcher and participant (Charmaz, 2014, pp. 27–33; Denzin and Lincoln, 2013). This study regarded ethics not as a separate procedural obligation but as a constant, reflective, and relational duty integrated throughout the research process. Participants were regarded not merely as data providers but as informed practitioners whose emotional wellbeing, professional identity, and lived experiences necessitated meticulous ethical consideration.

Thus, ethical conduct transcends mere adherence to formal governance structures, incorporating a reflexive awareness of power dynamics, vulnerability, and contextual factors. This section delineates the ethical principles, regulatory clearances, and governance mechanisms that framed the study, contextualising these within a constructivist perspective of ethics as manifested via practice rather than imposed mechanically.

The research was executed in alignment with the four fundamental principles of research ethics: respect for autonomy, beneficence, non-maleficence, and fairness (Beauchamp and Childress, 2019). These principles guided decisions across all phases of the research, encompassing recruiting, consent, data management, participant withdrawal, and dissemination.

Formal approval was secured via a triadic ethical and regulatory governance procedure:

Approval from the Birmingham City University Research Ethics Committee, granting academic ethical clearance (**Appendices**)

Approval by the Health Research Authority, consistent with the UK Policy Framework for Health and Social Care Research (HRA, 2022)

Confirmation of NHS Research and Development capacity and capability, authorising the institution to undertake the study inside the Trust

The hierarchical governance framework guaranteed compliance with institutional, regulatory, and national ethical norms for the study. All materials intended for participants, encompassing the study protocol, Participant Information Sheet, permission form, recruitment materials, interview and focus group guides, and Expression of Interest documentation, underwent review and received approval as part of this process (**Appendices**).

Throughout the study, slight modifications were implemented to the research materials, including alterations to interview prompts to align with the evolving analytical focus. The modifications were executed using formal amendment protocols in compliance with University and HRA directives and are recorded to ensure a transparent audit trail. This procedure guaranteed constant ethical supervision and conformity with Good Clinical Practice criteria (NIHR, 2022).

The regulatory framework established a supervised and accountable mechanism for the ethical conduct of the study. This was especially significant due to the study's emphasis on nurses' experiences during and after COVID-19, encompassing exposure to trauma, ethical distress, and organizational pressure. Ethical governance served not merely as procedural protection but as a fundamental basis for ethically attuned interaction with participants during the investigation.

Confidentiality, Anonymity, and Data Protection

Confidentiality, anonymity, and data security were regarded as constant ethical obligations during both the analytical and reporting phases of this investigation, rather than merely procedural mandates limited to data collection. This was especially significant due to the sensitive nature of participants' narratives, the workplace environment of the research, and the relationship dynamics intrinsic to Constructivist Grounded Theory. Participants provided comprehensive perspectives on organizational pressures, ethical dilemmas, and personal vulnerabilities experienced during and following the COVID-19 pandemic. Safeguarding participants' identities, professional reputations, and emotional wellbeing remained paramount during analysis, interpretation, and dissemination.

All analytical materials were managed in compliance with the Data Protection Act (2018) and the UK General Data Protection Regulation. Participant identities (e.g., P03, P14) were uniformly employed across transcripts, analytic notes, diagrams, and written outputs to ensure anonymity while upholding analytic traceability. This methodology facilitated constant comparison and theoretical synthesis while maintaining participant confidentially, consistent with constructivist ethical norms and collaborative meaning-making (Charmaz, 2014).

Consideration was given to the possibility of indirect identification, which is exacerbated in single-organization research where jobs, seniority, and contextual details may make persons identifiable even without names (Kaiser, 2009). Throughout the investigation, all potentially identifying information, such as ward names, service titles, administrative roles, and specific contextual references, was eliminated or intentionally generalised. When contextual material was analytically significant, meticulous judgement was applied to equilibrate conceptual profundity with ethical safeguarding. The decisions were recorded via reflexive memo-writing to guarantee transparency and accountability.

Conducting insider research within the same NHS organization presented heightened ethical sensitivity (Bonner and Tolhurst, 2002; Berger, 2015). During analysis and reporting, I was cognisant of how organizational familiarity could affect both the interpretation and presentation of findings. Reflexive memos were employed to scrutinise assumptions regarding the definition of “common knowledge” inside the Trust and to prevent the unintended disclosure of identifying information through excessive specificity. This reflexive approach upheld ethical rigour while maintaining analytical honesty.

The selection and presentation of participant quotations were influenced by both analytical significance and ethical obligation. Following Charmaz's (2014, pp. 161–175) recommendations, extracts were selected to emphasise participants' voices and conceptual contributions while reducing the likelihood of identification. Quotations were modified just to eliminate identifying identifiers or to improve clarity, without changing their content. Decisions about the utilisation of quotations were regarded as ethical actions integrated into the analytical process rather than impartial reporting selections.

Data security encompasses not only storage but also the long-term stewardship of analytical resources. Access to transcripts, memoranda, coding frameworks, and conceptual diagrams was limited only to the doctorate researcher and the supervisory team. All materials shall be preserved for the duration mandated by institutional policy prior to secure deletion, in accordance with University governance standards. These layered methods ensured that confidentiality and data protection were maintained as essential elements of analytic decision-making, hence enhancing trustworthiness and ethical integrity throughout the investigation.

Mitigating Potential Harm and Emotional Distress

Considering the emotional significance of addressing physical and mental health, trauma, moral distress, and organizational pressures during and following the COVID-19 pandemic, anticipatory ethical planning was essential to the design and execution of this study (Dickson-Swift et al., 2008). Despite all participants being deemed fit for work throughout data collection, it was acknowledged that reminiscing on earlier events can elicit emotional pain or anguish, even among individuals presently doing effectively in their professional responsibilities.

During the consent process, participants were apprised that recounting their pandemic experiences could elicit emotional reactions and were assured that participation was voluntary and participant-directed. Interviews and focus groups were held in discreet, tranquil environments that ensured anonymity and emotional security, enabling participants to express themselves freely without interruption or judgement. Data collection sessions were intentionally timed to last between 45 minutes and one hour, aiming to balance thorough research with consideration for participant wellbeing. This duration allowed for significant contemplation while reducing weariness and emotional strain, especially considering the cumulative stresses reported by numerous nurses during and after the pandemic.

In accordance with the British Psychological Society ethical framework (BPS, 2021), participants were consistently informed that they might suspend the interview, refuse to respond to questions, or withdraw from participation at any time. No participants choose to withdraw because of distress. Several participants characterised the interview experience as affirming or introspective, viewing it as a unique opportunity to express experiences that had previously gone unarticulated. This corresponds

with Charmaz's (2014, p. 30) assertion that qualitative interviews might facilitate participants in "revisiting, re-evaluating, and reinterpreting" experiences within a supportive research context.

Before data collection, I conducted a comprehensive risk–benefit analysis that identified potential emotional triggers such as sorrow, exhaustion, moral anguish, and unresolved professional experiences. A procedural plan was established to ethically assist participants in the event of distress. This encompassed meticulous observation of verbal and non-verbal signals, assessing participant comfort, interrupting interviews as necessary, and reminding participants of accessible support resources.

When interviews elicited emotional reactions, participants were tactfully informed, after the interview's end, of the accessibility of Occupational Health and staff wellbeing resources inside the Trust, should they want support. This signposting was provided as general information rather than as assessment or guidance and was aligned with company wellbeing policies. It was clearly stated that, during the research, I was functioning exclusively as a doctorate researcher and not as an Occupational Health practitioner, and that no clinical assessment or follow-up was included in the study.

My professional experience as a practitioner-researcher enhanced my sensitivity to emotional cues and ethical interviewing practices; yet I constantly upheld clear role boundaries to prevent the blurring of research and clinical obligations. Consequently, ethical responses were confined to acknowledging distress, honouring participant autonomy, and ensuring awareness of suitable support options, in accordance with qualitative research ethics rather than therapeutic intervention.
Addressing potential distress regarded not as a separate procedural activity but as a constant ethical obligation inherent in the study interaction. This methodology corresponds with Guillemin and Gillam's (2004) assertion that ethical research practices influenced by situational judgement and the "micro-decisions" made in real-time. These procedures prioritised participant wellbeing while maintaining the integrity, independence, and analytical focus of the research.

Constructivist qualitative research recognises that emotionally charged enquiries impact not only participants but also researchers. Researchers encounter emotional labour, ethical obligations, and cumulative cognitive strain while dealing with narratives of distress, moral dilemmas, and organizational stress (Rager, 2005; Dickson-Swift et al., 2008). This study necessitated a constant focus on nurses' comments regarding their experiences during and after the COVID-19 pandemic, which demanded deliberate consideration of my own wellbeing to uphold ethical sensitivity and analytical clarity.

To facilitate this, reflexive protections were built every step of the study process. Interviews were arranged with adequate intervals to reduce emotional strain and provide time for contemplation between sessions. Consistent supervisory talks provide organised opportunity for emotional

processing, methodological scrutiny, and analytical foundation. In conjunction with this, I kept a reflexive research notebook documenting emotional reactions, developing assumptions, and instances of confusion. These reflections were regarded as integral to the analytical process, enhancing transparency and reflexive accountability instead than being perceived as challenges to rigour. These practices align with Wray et al. (2007), who contend that acknowledging the researcher's emotional responses enhances qualitative research by rendering interpretive processes explicit and subject to examination. By prioritising researcher wellbeing as a methodological consideration, I was more effectively able to maintain attentiveness, ethical integrity, and analytical responsiveness during data collection and analysis.

Insider Status and Ethical Boundaries

Although positionality issues are discussed elsewhere in this chapter, upholding clear ethical limits was also crucial for protecting researcher wellbeing. As a practitioner-researcher inside the same NHS agency, I remained cognisant of the emotional and ethical challenges inherent in dual professional identities. To mitigate role strain and prevent perceived coercion, I refrained from recruiting participants with whom I had direct managerial or supervisory relationships, consistently emphasised the voluntary nature of participation, and clarified that the research was independent of organizational management or evaluation frameworks.

These limits facilitated the maintenance of relational integrity while alleviating the emotional strain linked to role uncertainty (Berger, 2015). By preserving clarity of function and purpose, I engaged empathetically with participants' narratives without assuming obligations outside the research context.

The integration of reflexive awareness, supervisory assistance, and explicit ethical boundaries safeguarded both my wellbeing and the integrity of the analytic process. This strategy corresponds with Charmaz's (2014, p. 167) focus on reflexivity as an ethical and methodological obligation in constructivist grounded theory.

Ethical Dissemination and Ownership of Data

The ethical obligation in this study encompassed not only data collection but also the depiction, dissemination, and stewardship of participants' narratives. Participants were notified during the consent process that anonymised segments from interviews and focus groups would be incorporated into this thesis, academic conference presentations, and peer-reviewed publications. Explicit consent for the utilisation of anonymised quotations for academic distribution was acquired and recorded in the consent forms (**Appendix**), with unequivocal guarantees that confidentiality and anonymity would be maintained throughout.

According to Charmaz's ethical representation guidelines (2014), participants' narratives were regarded as analytically relevant contributions rather than mere illustrative material. Excerpts were

chosen for their analytical importance and conceptual value and were meticulously contextualised to maintain meaning while reducing the risk of identification. Consideration was given to honouring participants' professional identities and emotional sensitivities, particularly when disclosing experiences pertaining to moral distress, organizational discord, and wellbeing.

Data ownership was thus perceived not as proprietary but as ethically managed. I maintained responsibility for analysis and interpretation, ensuring that participants' narratives were managed with transparency, respect, and accountability. Decisions about the use, interpretation, and dissemination of quotations were regarded as ethical actions integral to the analytical process rather than as impartial reporting decisions. This methodology embodies constructivist principles of relational ethics and interpretative accountability, guaranteeing methodological rigour while honouring participants' contributions.

3.9 Data Collection

Data gathering employed an emergent and iterative design, constantly influenced by insights gained from concurrent analysis. This methodology embodies Charmaz's (2014, p. 14) assertion that grounded theory evolves through constant interaction between data collection and analysis, rather than through strict compliance with a predetermined or linear research framework. This study's decisions about the timing, methodology, and collaborators for additional data collection were guided by constant analytical engagement, reflexive memo-writing, and constant comparison.

Data generation transpired in two interconnected phases. Phase 1 involved semi-structured extensive interviews aimed at examining nurses' own interpretations of their experiences during and during the COVID-19 pandemic. Phase 2 encompassed focus group talks aimed at investigating the collective negotiation of meanings, exploring both convergence and divergence in narratives, and validating and expanding emergent analytical ideas. This staged approach allowed initial interpretations to feed subsequent data gathering, aligning with the constructivist grounded theory premise that analysis directs further data generation (Charmaz, 2014; Bryant and Charmaz, 2019).

The utilisation of individual interviews and focus groups enhanced analytical depth by facilitating the emergence of diverse interpretations. Semi-structured interviews allowed participants to express personal and emotionally complex narratives in a confidential and contemplative environment. Conversely, focus groups allowed chances for collective thought, comparison, and engagement, elucidating how perceptions were validated, contested, or redefined through discourse with peers. Collectively, these approaches augmented conceptual depth and bolstered interpretive validity by contextualising individual narratives within a wider relational and organizational framework (Morgan, 1997; Birks and Mills, 2015).

In accordance with Constructivist Grounded Theory, data collection and analysis transpired simultaneously rather than as separate phases. Data were produced not to validate pre-existing hypotheses but to investigate participants' interpretations through iterative engagement, continual comparison, and reflexive memo-writing (Charmaz, 2014). As the study advanced, enquiries were honed, areas of analytical interest were explored more thoroughly, and subsequent data collecting got progressively conceptually targeted. Data gathering was thus perceived not as a straight procedural task but as an interpretive process that evolved along with analytic development.

The principal methodologies employed were semi-structured intense interviews and focus group discussions, chosen for their ability to extract detailed, contextually grounded narratives of experience. The procedures were enhanced via a pilot study that facilitated the improvement of the interview guide, clarity of question phrasing, and cultivation of interpretative sensitivity before formal data collecting commenced. During data generation, analytical judgements were informed by theoretical sensitivity, defined as the researcher's ability to identify meaningful patterns, correlations, and conceptual opportunities within the data (Glaser, 1978; Charmaz, 2014).

Data collecting persisted until theoretical sufficiency was attained. Following the participation of 17 individuals in interviews or focus groups, no further conceptual qualities were arising. Supplementary data enhanced and reinforced existing categories without modifying their fundamental attributes or interrelations. This judgement was guided by constant comparative analysis across interviews, care environments, professional positions, and career stages, aligning with constructivist interpretations of sufficiency as conceptual adequacy rather than numerical completeness (Charmaz, 2014, p. 200; Morse, 2015).

Rationale for Data Collection Methods

Constructivist Grounded Theory is especially appropriate for examining intricate, processual phenomena as it emphasises participants' viewpoints and the significance they assign to their lived experiences (Charmaz, 2014, p. 27; Mills et al., 2006). Consistent with this approach, intense semi-structured interviewing was chosen as the principal strategy for data gathering. Charmaz (2014) designates intense interviewing as fundamental to constructivist grounded theory, as it promotes depth, adaptability, and collaborative meaning-making within a concentrated yet open dialogue structure.

Semi-structured interviews enabled participants to steer the conversation while maintaining focus on essential aspects pertinent to the study issue. This structure facilitated the investigation of emotionally intricate experiences, permitted participants to contemplate events across time, and enabled the researcher to investigate emergent analytical insights through probing and clarification. From an interpretivist viewpoint, these interviews are perceived not as impartial data collection but as

relational interactions wherein meaning is actively generated through engagement (Denzin and Lincoln, 2013; Kvale and Brinkmann, 2015).

Focus group talks were included as a secondary phase of data collecting to expand and examine emerging interpretations. Focus groups were employed not to supplant individual interviews but to enhance them, enabling participants to collaboratively contemplate shared experiences and organizational circumstances. This strategy facilitated the observation of interactional dynamics, encompassing agreement, disagreement, and meaning negotiation, which are essential for comprehending the social context of professional experiences (Morgan, 1997). In a constructivist grounded theory framework, focus groups served as an analytical environment where emerging concepts could be scrutinised, refined, and contested through group discourse (Birks and Mills, 2015). The successive use of intense interviews and focus groups exemplified the iterative reasoning of Constructivist Grounded Theory, in which preliminary analysis guides subsequent data collection (Bryant and Charmaz, 2019). Collectively, these approaches optimised conceptual profundity, facilitated reflexive engagement with other views, and corresponded with CGT's focus on emergence, co-construction, and analytical responsiveness.

Semi-Structured In-Depth Interviews

The initial phase of data collection was semi-structured, comprehensive interviews with nurses and nursing associates who satisfied the study's inclusion criteria. The interviews aimed to investigate participants' experiences of employment during and after the COVID-19 pandemic, focussing specifically on the interpretation and management of physical and mental wellbeing within organizational settings.

Consistent with Charmaz's (2014, p. 56) Constructivist Grounded Theory methodology, interviews were framed as guided yet open dialogues. This perspective acknowledges interviews as dynamic exchanges where meaning is collaboratively created through discourse, attentiveness, and interpretive involvement, rather than merely retrieved as objective facts. The semi-structured format enabled participants to direct the story while ensuring that essential areas pertinent to the study topic were systematically examined using an interview guide (**Appendices**). Each interview commenced with general, rapport-establishing enquiries, such as prompting participants to elucidate their roles and experiences during the pandemic. The initial questions were deliberately non-directive, aimed at fostering trust, acclimating participants to the conversational format of the interview, and ensuring emotional safety.

The interviews subsequently advanced to more targeted enquiries regarding wellbeing, organizational support, ethical and emotional issues, and adaptation over time. This process adhered to Charmaz's (2014) opening–intermediate–ending interview framework, facilitating incremental depth, narrative consistency, and reflective conclusion.

Probing enquiries, pauses, and subsequent prompts were employed to stimulate elaboration, elucidate meaning, and address emotional subtleties, in accordance with interpretive interviewing methodologies (Kvale and Brinkmann, 2015). This method facilitated participants in expressing both descriptive narratives and the significance they attributed to their experiences, while enabling the responsive exploration of new analytical insights.

Interviews were performed in person in confidential research rooms at the Trust's clinical research facility, as specified in the sanctioned study protocol. These settings were chosen to guarantee secrecy, reduce interruptions, and create a tranquil atmosphere suitable for discussing sensitive situations. Interviews were audio-recorded with participants' consent using a University-owned digital recorder, transcribed verbatim, and securely kept in compliance with sanctioned data management protocols from BCU**.**

During the consent procedure, individuals choose their own pseudonyms (**Appendices)** Participant identities assigned by the researcher (e.g., P01–P17) were used during transcribing and processing to ensure anonymity and analytical traceability. Interviews generally spanned 45 to 60 minutes, providing adequate detail while being mindful of workload demands and emotional preparedness.

After each interview, I documented reflexive and analytical notes that encapsulated first interpretations, emotional reactions, contextual observations, and nascent conceptual ideas (Birks and Mills, 2015). These memos constituted a crucial element of the iterative analytical process, enhancing theoretical sensitivity and transparency by elucidating the evolution of views over time.

Reflexive memo (April 2024):

"*While a participant articulated feelings of inadequacy during pivotal moments, I recognised my own emotional reaction as a practitioner-researcher."*

I observed this behaviour to analyse how a shared professional context may influence interpretation and to promote reflexivity instead of presumption.

This reflective approach corresponds with Charmaz's (2014) assertion that grounded theorists must consider both participants' narratives and the way data is generated through interaction, positionality, and interpretation.

The interview guide was evaluated with a coworker who satisfied the inclusion criteria, after obtaining ethical permission (**Appendices).** The pilot facilitated the improvement of question phrasing, order, emotional cadence, and clarity, while augmenting my interpretative acuity during interviews on potentially unpleasant subjects. Preliminary analytical interaction with the pilot transcript facilitated modifications to the interview guide, guaranteeing greater congruence with participants' terminology and conceptualisations of experience.

This recurrent refining embodies the notion of constant comparison, in which insights from initial data inform the development of later data (Charmaz, 2014, p. 196). As the study advanced, the interview

questions were more targeted, directed by developing conceptual interests but remaining receptive to unforeseen interpretations. Interviews persisted until theoretical sufficiency was attained, characterised as the juncture at which further data ceased to provide novel conceptual features and instead served to enhance and reinforce existing analytical categories (Dey, 1999; Charmaz, 2014).

Focus Group Discussion

The second round of data collection comprised two focus group talks with participants who had not participated in the individual interviews. This design decision was made with deliberate analysis. In Constructivist Grounded Theory, incorporating new participants during later phases of data collection facilitates the exploration, critique, and expansion of emerging conceptual ideas from novel viewpoints, rather than merely reinforcing them through repetitive engagement with the same participants (Charmaz, 2014; Birks and Mills, 2015).

Consequently, focus groups were employed not to validate prior interpretations but to explore how nurses, who had not previously participated in the study, saw analogous organizational and professional situations. This facilitated consistent comparison among participant groups and enhanced analytical sensitivity beyond the initial interview sample (Charmaz, 2014).

One focus group included four participants, while the second consisted of two persons. Despite being smaller than originally expected, these group sizes enabled comprehensive discussions and fostered a confined, supportive atmosphere for examining emotionally and professionally delicate subjects. According to Krueger and Casey (2015), smaller focus groups are especially suitable for addressing unpleasant events or intricate organizational matters, as they foster psychological safety and provide an opportunity for reflection.

The focus group talks examined experiences related to employment during and after the COVID-19 pandemic, emphasising organizational practices, professional expectations, ethical dilemmas, and perceptions of support or fragmentation within teams. Open-ended prompts prompted participants to contemplate parallels and differences in experiences rather than to achieve consensus. Aligned with Constructivist Grounded Theory, the focus was on interpretive elaboration and communal sense-making instead of the validation of pre-existing categories (Charmaz, 2016). The focus group topic guide is in Appendices section**.**

Group interaction facilitated participants' responses to each other's narratives, eliciting instances of concurrence, divergence, and re-evaluation. The interactional dynamics were considered analytically significant, providing insight into how professional meanings were relationally and socially constructed within nursing contexts (Morgan, 2019). According to Tracy (2010), this resonance enables researchers to evaluate whether developing interpretations accurately represent participants' lived experiences without presuming a singular or immutable truth.

The two focus groups lasted around 45 to 60 minutes, were audio-recorded with consent, transcribed verbatim, and securely archived. As moderator, I employed a facilitative and egalitarian approach, maintaining cognisant of emotional tone, power dynamics, and equitable participation, while ensuring that all participants had the opportunity to contribute.

After each focus group, I composed analytical and reflexive memoranda that recorded interactional dynamics, areas of agreement and disagreement, emotional climate, and nascent conceptual enquiries. These documents facilitated a constant comparison between interview and focus group data, enhancing theoretical sensitivity and bolstering iterative analytical progress (Charmaz, 2014).
The utilisation of focus groups with novel participants served as a purposeful analytical expansion of the study, facilitating the exploration of emerging interpretations across a wider spectrum of nursing experiences while adhering to the interpretive and co-constructive tenets of Constructivist Grounded Theory.

Pilot Interview and Feasibility Considerations

A preliminary interview was performed at the commencement of data collection to assess the feasibility, ethical considerations, and practical implementation of the suggested interview methodology. This interview, initially designed as a pilot, was conducted with full ethical permission and complied with the procedural, ethical, and analytical standards established in the approved study protocol, consistent with all subsequent interviews.

In Constructivist Grounded Theory, data collection and analysis transpire simultaneously, and first interviews are not methodologically separate from subsequent ones if they satisfy inclusion requirements and enhance analytical category growth (Charmaz, 2014). As analysis began concurrently with data gathering, it became apparent that the data produced from this initial interview were conceptually substantial, theoretically pertinent, and aligned with the evolving analytical focus of the study. Consequently, there was no epistemological or methodological rationale for omitting the interview from the primary dataset.

Charmaz (2014, pp. 131–133) underscores that grounded theorists must stay receptive to employing all analytically significant data, especially when insights arise from initial interactions with participants' narratives. In this study, the preliminary interview fulfilled two purposes. It facilitated reflexive evaluation of the interview guide and the interactional method, while also significantly enhancing the ongoing analysis.

This early interview led several methodological improvements through reflexive involvement. The phrasing and order of initial questions were modified to enhance narrative flexibility, allowing participants to articulate their experiences in their own terms. The emotional intensity linked to reliving pandemic experiences highlighted the necessity for cautious pacing, explicit wellbeing

assessments, and ongoing consideration of relational ethics during data collection (Guillemin and Gillam, 2004; Ellis, 2007).

The interview affirmed the appropriateness of performing data collection in private study rooms within the clinical research facility, as specified in the protocol. These environments facilitated confidentiality, comfort, and emotional security. All enhancements identified during this initial interview were included into subsequent interviews and focus groups, so augmenting ethical preparation and theoretical awareness.

This initial interview serves as an integral component of Constructivist Grounded Theory, where preliminary data collection influences both methodological advancement and analytical understanding, rather than being treated as a separate pilot excluded from analysis. Maintaining the interview within the dataset supported methodological consistency and upheld the idea that grounded theory is developed by constant interaction among data, analysis, and reflexive decision-making (Charmaz, 2014).

Research Questions

This study is directed by five interconnected research questions that are rooted in nurses' lived experiences, facilitating the creation of a cohesive, explanatory narrative regarding the evolution of those experiences over time. Adhering to a Constructivist Grounded Theory framework, the questions are regarded not as propositions for validation, but as sensitising guides that influenced participant selection, the topics examined in interviews and focus groups, and the emphasis of analysis as categories emerged (Charmaz, 2014).

The questions guided sampling by focussing on the recruitment of nurses who had experience both during and after the COVID-19 pandemic, across various acute and community settings within the NHS Trust. This facilitated access to diverse roles, care contexts, and organizational experiences, hence enabling comparisons across various practices and support systems. As the study advanced, emerging patterns in participants' narratives informed categorisation, facilitating the inclusion of individuals who may enhance, expand, or contest evolving insights.

The questions contributed to data collecting through the formulation of the semi-structured interview and focus group the procedures. The prompts prompted nurses to discuss their everyday workplace experiences, their physical and mental wellbeing, their encounters with organizational support and leadership, and the methods they employed to maintain professional performance under extended stress. This open, dialogic methodology enabled participants to steer the discourse towards their most significant experiences, while emphasising processes, relationships, and temporal change rather than discrete events (Charmaz, 2014).

The research questions directed attention to patterns of action, interpretation, and outcome across many contexts and locations. The constant comparison among participants, settings, and temporal points facilitated the formation of categories that encapsulated common processes and distinctions across contexts.

The five research issues are delineated below as an interconnected framework rather than as discrete paths of investigation. They establish a coherent connection among sample decisions, data gathering, and the incremental advancement of the study's conceptual framework.

RQ1. In what manner do nurses articulate their experiences of employment during the COVID-19 pandemic inside an NHS Trust?

This inquiry established sampling among nurses with firsthand experience of pandemic work and directed initial interviews towards routine activities, interpersonal interactions, and organizational settings. It focused on how nurses articulated their duties, responsibilities, and professional identity under crisis situations.

RQ2. In what manner do nurses perceive the influence of these encounters on their physical and mental wellbeing during and after the pandemic?

This inquiry directed prompts towards physical and emotional sensations, encompassing tiredness, recuperation, and ethical tension. It focused on the notion that wellbeing is characterised as a sustained state across time, rather than a transient response to immediate occurrences.

RQ3. In what manner do nurses articulate the strategies they employed to maintain professional efficacy under extended organizational and clinical stressors?

This inquiry guided recruitment across several roles and environments where demands were perceived differently, emphasising the systematic methods by which nurses sustained, modified, or retracted their professional involvement under prolonged stress.

RQ4. In what ways do nurses perceive and interpret organizational support, leadership, and workplace transformation during and after the pandemic?

This inquiry influenced data gathering concerning leadership presence, communication, and policy modification, directing focus on the interpretation of organizational actions and omissions in personal, ethical, and relational contexts.

RQ5. In what ways do nurses' experiences and interpretations change across various clinical environments, jobs, and care contexts within the NHS Trust?

This inquiry maintained a comparative emphasis throughout the research, prompting consideration of disparities between acute and community environments, degrees of exposure, and types of organizational and peer support.

Collectively, these questions connect the participants in the study, the topics examined in discussion, and the way meaning was derived from the participants' narratives. They advocate for a progression from experience to pattern to integration, while prioritising nurses' perspectives and organizational circumstances within the evolving conceptual framework of the study.

Reflexivity was included into the data gathering process and regarded as essential to methodological rigour rather than as a distinct reflective activity. My role as a practitioner-researcher necessitated ongoing consideration of how professional identity, insider knowledge, and emotional proximity could influence both participants' disclosures and my interpretive interaction with the data (Berger, 2015).

In interviews and focus groups, reflexive awareness influenced the formulation of questions, the management of pauses, and the handling of emotionally intense times. After each data gathering session, I created comprehensive reflexive memos that included emotional reactions, underlying assumptions, analytical enquiries, and instances where my insider status might have affected interactions or interpretations. The memoranda were preserved as components of the study's analytical record and served as both an ethical and analytical resource, facilitating constant examination of the co-construction of meaning (Finlay, 2002).

In Constructivist Grounded Theory, reflexivity is regarded as fundamental to data generation rather than a challenge to validity. Charmaz (2014, p. 27) underscores that researchers must consider how they influence data through interaction, interpretation, and contextual knowledge. Upholding reflexive transparency throughout data collection enhanced theoretical sensitivity, fostered analytic openness, and guaranteed that emerging categories were rooted in participants' interpretations rather than professional biases.

Reflexive memoing established a transparent audit trail, demonstrating how emotional labour, ethical considerations, and positionality influenced analytical progression across interviews and focus groups. This reflective technique upheld both ethical integrity and conceptual profundity during the data collection phase.

3.10 Data Analysis

The data analysis was directed by the primary study question: ‘what are nurses' perceptions on their experiences during and after COVID-19, focussing specifically on physical and emotional wellbeing’. In accordance with Constructivist Grounded Theory, analysis commenced concurrently with data collection and evolved iteratively through ongoing transitions among data gathering, coding, memo writing, and conceptual refinement (Charmaz, 2014; Charmaz, 2016). I approached analysis not as a separate phase after data collection, but recursively, permitting initial interpretations to guide further enquiries, sampling choices, and analytical emphasis, while staying receptive to complexity, contradiction, and diverse interpretations.

My analytical methodology adhered to Charmaz's constructivist framework, emphasising initial coding, focussed coding, and theoretical integration, underpinned by frequent comparison, memo writing, and abductive reasoning (Charmaz, 2014; Charmaz, 2016; Glaser and Strauss, 1967; Thornberg, 2012). These analytical practices facilitated a transition from direct interaction with participants' language and meanings to increasingly abstract conceptual comprehension, while explicitly committing to anchoring interpretive assertions in the dataset and documenting the rationale behind analytical decisions.

All analyses were conducted manually, without employing computer-assisted qualitative data analysis software. Despite my initial intention to use NVivo, I consciously choose to persist with a manual methodology as the study advanced. This decision demonstrated my methodological commitment to maintain a close engagement with the details of participants' narratives and to uphold interpretive sensitivity throughout the coding and comparison process (Charmaz, 2014; Birks and Mills, 2015). Manual analysis entailed direct engagement with Word-based coding tables and structured documents, annotating transcripts, and creating ordered analytic tables to document codes, comparisons, and category development. This method enabled a clear audit trail demonstrating the generation, refinement, clustering, and conceptualisation of codes over time.

Throughout the dataset, I produced roughly 130 initial codes and about 60 focused codes (**Appendices**). Coding and note writing transpired concurrently with recruitment and data gathering to facilitate constant analytic decision-making (Charmaz, 2014; Morse, 2015). I consistently maintained acute awareness of how my role as a practitioner-researcher influenced my analytical sensitivity and interpretative judgement, meticulously recording assumptions, uncertainties, and analytical challenges to ensure methodological transparency (Finlay, 2002; Berger, 2015).

This study's analytical framework is based on the epistemological principles of Constructivist Grounded Theory, which posits that meaning is collaboratively created through the interaction between researcher and participant, situated within particular social, organizational, and historical contexts (Charmaz, 2014; Bryant and Charmaz, 2019). Knowledge is thus perceived not as an objective entity to be uncovered, but as an interpretive construct formed via analytical interaction with participants' narratives, the study situation, and reflective decision-making.

This attitude corresponds with the interpretivist paradigm foundational to the study, acknowledging that both participants and the researcher contribute pre-existing experiences, preconceptions, and professional stances to the analytical interaction (Finlay, 2002; Berger, 2015). Instead of striving to eradicate subjectivity, Constructivist Grounded Theory necessitates that the researcher recognises, examine, and record the processes through which interpretations are developed and modified throughout time (Charmaz, 2014). Analytic rigour is thus evidenced by transparency, reflexivity, and methodical interaction with facts, rather than assertions of impartiality.

My analytical job was not to derive pre-existing interpretations, but to critically interact with participants' narratives by enquiring about the events, the conditions surrounding them, and their consequences, while keeping cognisant of variance, contradiction, and context (Charmaz, 2014). The analysis entailed iterative movement among transcripts, codes, analytic tables, and memos, facilitating the refinement or abandonment of initial concepts as comparisons advanced.

All analytical tasks were performed manually with organised Word documents and analytical tables. This practical method facilitated extended engagement with the data and meticulous focus on language, tone, and contextual subtleties. Charmaz (2014, p. 114) underscores the significance of being sensitive to meanings, actions, and contextual language, whereas manual analytic engagement enhances this awareness by decelerating the analytical process and promoting prolonged interpretive contemplation.

Reflexive memo writing was integrated into this analytical framework and regarded as a fundamental analytical practice. Memos documented analytical enquiries, emergent trends, ambiguities, and contemplations regarding the influence of my practitioner-researcher stance on interpretation. This reflective documentation immediately enhanced theoretical sensitivity and analytic accountability (Glaser, 1978; Charmaz, 2014).

Initial Coding, Focused Coding and Constant Comparison

Initial coding represented the preliminary formal phase of analysis and was conducted simultaneously with data collection, consistent with the Constructivist Grounded Theory's focus on analytic immediacy and iterative involvement (Charmaz, 2014). The objective of this phase was to analytically examine participants' reports while keeping attuned to their language, meanings, and actions, without imposing an early structure.

Preliminary coding was performed systematically, examining each line of the interview and focus group transcripts. Each line or brief section of text was analysed to ascertain what participants were articulating, how experiences were contextualised, and what actions, processes, or significances were suggested. This micro-analytic methodology mitigated the risk of imposing preconceived notions and fostered receptivity to unforeseen emphases, omissions, and contradictions (Charmaz, 2014).

The codes at this stage were intentionally tentative and many. Where feasible, codes were developed to emphasise activity, movement, and process rather than static description. In vivo codes were employed when participants' own language effectively conveyed experiential significance. This method adheres to Charmaz’s (2014) recommendation that initial coding should prioritise participants’ language and maintain analytical flexibility.

All preliminary coding was performed manually. Transcripts were examined within organised Word documents, with sections emphasised and marked, and codes methodically recorded in analytical

tables. These tables facilitated the tracing of codes to their original data sources, hence enhancing transparency and analytical accountability.

Preliminary coding fulfilled multiple analytical purposes. Initially, it averted premature abstraction by grounding analysis in participants' narratives. Secondly, it fostered analytical curiosity by formulating questions instead of conclusions. Third, it facilitated the cultivation of theoretical sensitivity, defined as the ability to identify patterns, variations, and significance without imposing premature coherence (Glaser, 1978; Charmaz, 2014).

Approximately 130 preliminary codes were produced throughout the dataset. The first coding process involved ongoing memo writing that recorded analytical enquiries, preliminary insights, uncertainties, and musings on how my role as a practitioner-researcher could influence interpretation. These letters guaranteed that initial analytical concepts remained prominent, accessible, and subject to scrutiny.

Focused coding constituted the second phase of analysis, transitioning from analytic openness to synthesis and conceptual guidance. This phase necessitated analytical discernment to ascertain which preliminary codes were most significant, recurrent, and conceptually pertinent throughout the dataset (Charmaz, 2014).

Initial codes were methodically compared across interviews, focus groups, professional roles, care environments, and temporal periods. Codes that were less analytically fruitful were discarded, while those exhibiting explanatory promise were enhanced and prioritised. Manual coding was performed using structured analytic tables, involving iterative transitions between codes and original transcripts to maintain alignment with participants' meanings.

Constant comparison served as the primary analytical framework. Data were juxtaposed with data, codes with codes, and emergent clusters with novel content. This facilitated ongoing focus on similarities, differences, conditions, and variations, averting premature category closure and enhancing responsiveness to minority or conflicting narratives (Charmaz, 2014; Birks and Mills, 2015).

Concentrated coding was supplemented by rigorous memo writing that recorded the rationale for prioritising specific codes, the formation of groupings, and areas of conflict or ambiguity. These notes served as analytical connections between coding and conceptual advancement, offering a clear documentation of interpretive decision-making (Lempert, 2007).

Memo Writing, Abductive Reasoning, and Theoretical Sensitivity

The memo writing served as the primary analytical mechanism of this investigation. Memos were consistently composed from initial coding to focused coding and into subsequent analytic integration (Charmaz, 2014; Lempert, 2007). Initial memoranda documented preliminary observations and

enquiries, whilst subsequent memos examined the interconnections among codes, the factors influencing processes, and areas of analytical conflict.

Memo writing facilitated theoretical sensitivity, conceptualised as an analytical technique rather than an intrinsic quality (Glaser, 1978; Charmaz, 2014). It facilitated a pause for analytical contemplation, re-examinations of interpretations, and scrutiny of developing patterns.

Abductive reasoning was crucial when data failed to align with developing analytic clusters or when patterns necessitated further inquiry. Abduction entailed enquiring into which theoretical explanations may explain for observable patterns while remaining anchored in the evidence (Charmaz, 2016; Thornberg, 2012). These abductive notes recorded analytic uncertainty instead of assertions and were examined through additional comparisons rather than hypothesis testing.

Reflexivity was included into memo writing rather than addressed independently. Memos consistently recorded emotional impact, professional acquaintance, and insider presuppositions in conjunction with analytical findings, so enhancing accountability and interpretative precision (Finlay, 2002).

Rigour and Credibility

Rigour in Constructivist Grounded Theory is achieved by analytic transparency, coherence, reflexivity, and constant interaction with data, rather than through procedural standardisation (Charmaz, 2014). This study incorporated rigour throughout the analytical procedure.
Credibility was established by extensive interaction with the dataset, meticulous line-by-line coding, ongoing comparison, and a clear audit trail that included coded transcripts, analytical tables, memoranda, and diagrams. The supervisory discussion served as an analytical challenge rather than a means of validation, facilitating the refinement of conceptual limits (Birks and Mills, 2015).
The resonance was enhanced by the iterative interplay between interviews and focus groups, allowing for the exploration of analytical concepts within a collective professional framework rather than as static interpretations.

Originality arose from the formulation of conceptual explanations that transcended mere description to elucidate the mechanisms influencing nurses' feelings of physical and mental well-being within organizational settings.

Utility was integrated by focussing on organizational contexts, relational processes, and professional realities, ensuring that analytical findings were both grounded and provided interpretive insight. Collectively, rigour was attained by methodical analytical practice, reflexive transparency, and constant engagement with data, in alignment with the goals of Constructivist Grounded Theory.

To ensure the analytic process is transparent and auditable, I established a systematic audit trail that recorded the progression of data from raw transcripts to coding, comparison, memo composition, and integration. The audit trail comprised dated iterations of Word-based coding tables, constant

comparison matrices, analytical and reflexive memos, diagrammatic mappings, and documentation of supervisory analytical discussions. These tools facilitated the tracking and revisiting of analytic judgements, such as code refining, grouping, boundary setting, and conceptual linking, over time as new data emerged, in accordance with the iterative principles of Constructivist Grounded Theory (Charmaz, 2014).

Reliability

Guaranteeing the credibility of qualitative research necessitates deliberate focus on the production, substantiation, and transparency of knowledge claims to the reader. This Constructivist Grounded Theory study addressed trustworthiness through the criteria of credibility, dependability, confirmability, and transferability, as outlined by Lincoln and Guba (1985). These criteria were included into the research design, data creation, and analytical process to ensure methodological transparency and interpretive integrity, rather than being used as a post-analysis checklist.
The reliability of this study is based not on replication or standardisation, but on the transparency of documented analytical decisions and the degree to which interpretations can be linked to participants' narratives and the contexts in which they were generated (Charmaz, 2014).

Credibility

Credibility denotes the assurance in the reasonableness, profundity, and interpretive sufficiency of the results. This study established credibility through extensive involvement with the dataset, repeated data collection, and rigorous analytical comparison.
Data were produced in two phases: individual interviews and focus groups, which facilitated the exploration, elaboration, and interrogation of emergent interpretations across various interactional contexts. This sequencing facilitated constant engagement with participants' narratives and allowed for the development of analytical categories through continual comparison instead of dependence on isolated interactions (Charmaz, 2014).

Credibility was enhanced by ongoing comparisons among interviews and focus groups, as well as by constant memo writing that recorded analytical conclusions, uncertainties, and changes in interpretation. Instead, than pursuing validation in a positivist manner, credibility was enhanced through analytic resonance. Focus group reports frequently reflected, complicated, or nuanced trends recognised in prior interviews, reinforcing the credibility of developing categories.
Consistent supervisory discussion enhanced trustworthiness by offering organised chances to scrutinise analytic assertions, contest assumptions, and evaluate conceptual alignment (Birks and Mills, 2015). These discussions served as essential analytical evaluations rather than validation activities.

Dependability

Dependability pertains to the coherence and consistency of the research process throughout its duration. This study ensured reliability by maintaining a transparent audit trail that recorded the rationale behind analytic judgements and the evolution of categories.

The audit trail comprised coded transcripts from interviews and focus groups, several iterations of coding tables created in Word and Excel, dated analytical and reflexive memos, documentation of category refinement and integration, and diagrams used to examine linkages within categories. Every analytical modification, including the refinement of category borders, the consolidation of overlapping codes, or the reassessment of linkages, was documented and substantiated in memos or analytical tables. This documentation enables the reader to trace the analytical reasoning of the study and observe how interpretations evolved in response to the data rather than arising arbitrarily (Nowell et al., 2017). Dependability was thus evidenced by transparency and traceability throughout the analytical procedure.

Confirmability

Confirmability denotes the degree to which interpretations are based on participants' stories rather than predominantly influenced by researcher bias or assumptions. As a practitioner researcher inside the NHS, confirmability necessitated constant reflexive scrutiny.

Reflexive journaling was employed during data collection and analysis to record emotional responses, instances of resonance, interpretive tension, and assumptions necessitating scrutiny (Finlay, 2002). These entries were used as analytical resources, facilitating a rigorous differentiation between the participants' meanings and my professional experience.

Confirmability was further reinforced by explicitly connecting analytic claims to coded data, using verbatim extracts in subsequent analytic chapters, subjecting emergent interpretations to supervisory review, and evaluating alternative explanations throughout memo draughting and continual comparison. These tactics ensured that interpretations were grounded in the facts while recognising the researcher's interpretive role, in alignment with constructivist epistemological principles (Charmaz, 2014).

Transferability

Transferability denotes the degree to which findings can be relevant or informative outside the specific study environment. Although Constructivist Grounded Theory does not seek statistical generalisation, it facilitates analytic transferability by offering comprehensive contextual detail (Geertz, 1973).

This study offered contextual details regarding the organizational setting, participant roles and professional contexts, workload pressures, and care surroundings, as well as the socio-economic characteristics of the served population. By elucidating these traits, the study allows readers to

evaluate the applicability of the findings to other NHS organizations or healthcare environments encountering analogous structural and workforce conditions. Transferability is thus facilitated by analytical rigour and contextual precision rather than assertions of representativeness.

Credibility, dependability, confirmability, and transferability were collectively addressed through integrated methodological and analytical techniques. The reliability of this study is based on the clarity of the analytical process, the consistency of category formation, and the self-reflective responsibility of the researcher. These tactics bolster confidence in the study's interpretive assertions and establish a definitive foundation for assessing the quality and integrity of the research.

3.11 Chapter 3 Conclusion

This chapter delineates the methodological framework of the study, outlining the philosophical stance, research design, ethical considerations, and analytical methodologies employed in the inquiry. Using a constructivist interpretivist perspective, the chapter illustrates how Constructivist Grounded Theory offered a cohesive and adaptable methodological framework for examining nurses' experiences during and after the COVID-19 pandemic, focussing specifically on physical and mental well-being.

The chapter delineated the justification for employing Constructivist Grounded Theory, framing it as a methodology adept at encapsulating intricate processual experiences embedded within organizational and social contexts. By emphasising co-construction, reflexivity, and theoretical sensitivity, the technique corresponded with the study's objective to transcend mere descriptive explanations of well-being and to achieve an explanatory comprehension of the interplay between meanings, actions, and organizational conditions throughout time.
Meticulous consideration was afforded to the research context, recruitment methods, and sample strategy, illustrating the application of purposive and theoretically informed sampling to attain theoretical sufficiency instead of numerical representativeness. Ethical considerations were approached as relational and constant practices, encompassing permission, confidentiality, data protection, and the mitigation of emotional suffering for both participants and the researcher. These tactics were integrated throughout the investigation instead of being regarded solely as procedural mandates.

The chapter elucidated the analytic methodology, detailing the manual data analysis conducted through iterative cycles of initial coding, focused coding, constant comparison, memo draughting, and theoretical integration. These procedures were characterised as methodological practices rather than analytical outputs, preserving a clear difference between the conduct of analysis and its results. Reflexivity and trustworthiness were identified as essential elements of analytic rigour, substantiated by audit trail documentation, supervisory discussions, reflexive journaling, and clear documentation of analytic choices.

This chapter illustrates the coherence of philosophical assumptions, methodological selections, and analytical procedures. It lays the groundwork for the subsequent phase of the thesis by demonstrating how empirical data was methodically produced and examined in anticipation of conceptual advancement.

Chapter 4 extends this methodological foundation and delineates the analytic pathway comprehensively, demonstrating the development, refinement, and integration of initial codes into specialised categories by frequent comparison and memo-driven analysis. Chapter 4 aims to render the analytic process apparent and verifiable by illustrating the transition from raw data to conceptual framework in a clear and methodologically sound manner.

Chapter 4: Data Analysis

4.0 Introduction

This chapter delineates the analytical process undertaken in the data analysis of this Constructivist Grounded Theory study. I view analysis not as a linear series of technical tasks, but as an iterative, reflective, and comparative process through which meaning is progressively formed. In accordance with Charmaz's methodology, analysis commenced concurrently with data collection and progressed through iterative cycles of coding, comparison, memo composition, and analytical decision-making, with each phase informing and refining the subsequent one (Charmaz, 2014).

Adhering to a constructivist grounded theory approach, I regarded data not as a static collection of material to be analysed, but as interpretive narratives generated via interaction and contextualised within professional, organizational, and historical frameworks. The analysis was conducted as an active and interpretive practice, wherein I actively engaged with participants' language, actions, and embodied expressions, while maintaining reflexive awareness of how my practitioner-researcher position influenced analytic sensitivity and judgement (Charmaz, 2014).

The analytic work presented in this chapter lays the foundation for the theoretical integration that follows, where these categories are brought together to explain how endurance is shaped within organizational settings and extended toward wider questions of responsibility and governance. These stages were not regarded as distinct or linear phases to be finalised and abandoned. Rather, they operated as interconnected analytical processes that were explored, modified, and enhanced throughout time as patterns began to reemerge, transform, or disintegrate. Initial coding was intentionally flexible and tentative, facilitating the emergence of analytical enquiries without hasty abstraction. As the research advanced, concentrated coding facilitated a more profound engagement with the data, aiding in the identification of linkages, variations, and coherence among participants' narratives while staying anchored in their meanings. While this chapter traces the construction of categories through coding, comparison, and memo writing, the conceptual mechanisms and integrative structures that extend this analysis toward theory and governance-level interpretation are elaborated in Chapters 6 and 7.

Direct involvement in all eleven individual interviews and two focus groups was fundamental to this analytical methodology. Conducting analysis without qualitative data tools facilitated deep engagement with the data, enabling meticulous observation of emotional tone, pauses, hesitations, humour, and physical references that held analytical significance but could be diminished by more automated coding methods. This practical analytic engagement facilitated an awareness of how

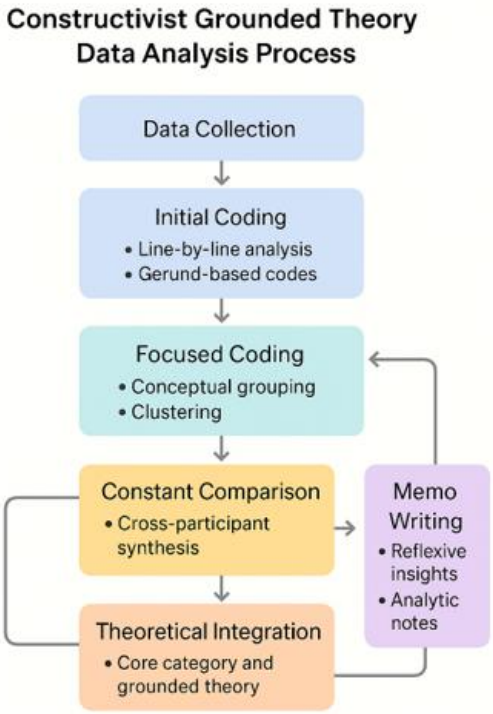
participants articulated their experiences and the methods they employed to regulate, contain, or navigate those experiences amidst the exigencies of daily nursing practice.

Constant comparison functioned as a fundamental methodological principle throughout the analytical process, rather than as a separate approach. Incidents were juxtaposed with incidents, codes with codes, and emergent analytical classifications across individuals, roles, care environments, and temporal contexts. This comparison study was employed to assess the stability of nascent analytical trajectories, to examine both differences and similarities, and to avert premature analytical conclusions. The memo writing process served as the primary analytical mechanism for documenting and addressing uncertainty, tension, and rising enquiries. Memos were used to scrutinise analytic conclusions in real-time, illuminating the evolution, alteration, or abandonment of interpretations throughout time, rather than merely serving as retroactive reflections (Charmaz, 2014).

Diagramming was employed strategically during moments of analytical complexity to facilitate visual comprehension and to investigate potential linkages among analytical components. These diagrams did not serve as representations of results or conclusive theory. They functioned as analytical instruments that facilitated movement, comparison, and decision-making at instances of heightened conceptual density or when several analytical options were available (Charmaz, 2016).

To enhance transparency and furnish the reader with a coherent framework. **Figure 4.1** below presents a visual representation of the analytical approach I employed in this investigation. This illustrates my iterative movement between data collection and analysis via initial coding, focused coding, frequent comparison, memo writing, and diagramming, along with Charmaz's constructivist methodology. (Charmaz, 2014; 2016).

Figure 4.1 Overview of Constructivist Grounded Theory Coding and Analytic Process (Charmaz, 2014;2016)



4.1 Initial Coding: Inputting the Data

My analytical approach to the dataset commenced with manual, line-by-line initial coding, following Charmaz's (2014) recommendations to maintain a tight engagement with participants' meanings prior to progressing towards abstraction or synthesis. I undertook this phase as a conscious effort of analytical immersion, aiming to decelerate the analytic process, avert hasty interpretations, and permit actions and processes to emerge through prolonged and meticulous interaction with the material. Initial coding commenced concurrently with data gathering and progressed iteratively as interviews and focus groups were finalised. Each transcript was meticulously examined line by line, occasionally sentence by sentence, with analytical focus on the actions, management, or containment exhibited by participants in their narratives, rather than their abstract feelings. This method embodies Charmaz's focus on employing initial coding to analytically dissect the data while staying rooted in the participants' language and experience nuances (Charmaz, 2014).

The manual analysis of interview and focus group transcripts was a conscious methodological decision at this phase. Manual engagement facilitated meticulous observation of affective tone, pauses, humour, hesitations, and embodied references, which frequently indicate regulation or coping efforts but may be diminished or disguised when analysis becomes excessively procedural. Due to the emotionally and physically intense character of participants' narratives, this degree of intimacy was

crucial for understanding how nurses articulated their self-sustenance amid challenging circumstances, frequently without directly identifying the tasks they performed.

In accordance with Charmaz's (2014) focus on action-oriented analysis, I categorised actions and processes instead than abstract psychological states. Analytic emphasis concentrated on participants' descriptions of regulating, containing, repressing, or overriding experiences to maintain their work performance. Examples encompassed restraint, perseverance, concealment, suppression, excessive functioning, and compartmentalisation. Participants seldom directly classified these activities; rather, they were integrated within narrative descriptions of customary practice and professional expectations. Utilising gerunds in coding illuminated the recurring patterns of regulatory work and emphasised the process over the outcome.

For instance, when a participant remarked:

"*I refrained from crying at that moment."* (P2, p.5)
This part was classified as suppressing tears, illustrating the deliberate effort of emotional restraint rather than the existence or lack of sorrow. In a similar vein, when another participant remarked:
"*I persevered despite experiencing dizziness*." (P8, p.14)

This was characterised as persevering despite tiredness, emphasising bodily override as a deliberate response rather than an immediate interpretation of fatigue or burnout. Now, the analytical emphasis was on the actions individuals undertook to maintain functionality, rather than elucidating the reasons behind those actions or their significance.

This action-oriented method yielded 31 unique initial codes, derived from all eleven interview participants and both focus groups. These codes encompassed emotional, physical, cognitive, temporal, and relational dimensions of regulation effort that were consistently seen across narratives. Initially, codes were regarded as analytical fragments rather than as markers of developing categories. Their objective was to facilitate data accessibility, maintain analytical versatility, and avert premature conclusions on explanatory interpretations.

Visualising Early Analytic Clustering

In addition to coding line-by-line, I commenced experimenting with visualising first analytic associations through physical sticky-note grouping. This technique transpired during and immediately following initial coding and served as a preliminary analytical tool rather than a formal analytical result. Initial individual codes were inscribed on sticky notes and spatially organised to examine the clustering, overlapping, or recurrence of acts across participants' narratives.

This visual method facilitated first comparative reasoning while intentionally postponing analytical interpretation. Instead of enquiring about the significance of the codes, I employed clustering to investigate the co-occurrence of acts, their dense representation throughout transcripts, and their

concurrent presence inside narratives related to labour during and after the epidemic. **Figure 4.2** below illustrates an instance of the preliminary grouping of in-vivo codes using sticky notes.

Figure 4.2: Early Clustering of Initial Codes Using Sticky Notes

The visual clustering depicted in **Figure 4.2** above facilitated the analysis of patterns of co-occurrence, density, and repetition among emotional and bodily behaviours without prematurely constraining their analytical significance. They endorsed reflective enquiries such as: Which kind of regulatory efforts seem most habitual? Which appear to escalate under certain conditions? At what point do emotional and physical behaviours converge?

At this point, clustering served as a conduit between the transparency of initial coding and the more discerning efforts necessitated in focused coding. The whole array of preliminary codes produced at this phase is displayed in **Table 4.1** below illustrates how action-oriented initial codes were immediately rooted in participants' language and disseminated across individual interviews and focus groups. These in-vivo extracts are provided to exemplify analytic grounding rather than to depict conclusions.

Table 4.1 Example Initial Codes Produced Using Line-by-Line Coding (n = 31)

Selective Code	Participants	Initial Code (In-Vivo)
Bottling Emotions	P02, P04, FG1	*"I held it in all shifts."*
Masking Distress	P06, P08	*"Had to put a brave face on."*
Pushing Down Anxiety	P07	*"Couldn't let myself think about it."*
Deferred Grief	P04	*"I just parked it until I got home."*
Surface Acting	FG2	*"Smiled for the patients, cried later."*
Emotional Numbness	P07	*"Felt nothing by the end."*

Suppressed Anger	P03	*"Couldn't say anything just swallowed it."*
Delayed Processing	P06	*"Only hit me a week later."*
Somatic Ignoring	P09	*"Even when dizzy, told myself to finish the round."*
Skipping Meals	P08	*"No time to eat patients came first."*
Missed Breaks	FG2	*"Breaks were a luxury."*
Working Through Pain	P05	*"Leg was killing me, but I couldn't stop."*
Post-COVID Breathlessness	P03	*"Still breathless but had to work."*
Fatigue Signals	P09	*"Just pushed past tiredness."*
Physical Collapse Post-Shift	P04	*"Collapsed on the sofa, uniform still on."*
Emotional Collapse Post-Shift	P02	*"Sobbed uncontrollably after shift."*
Self-Medicating	P07	*"Took painkillers just to keep going."*
Normalising Discomfort	FG1	*"We all just got on with it."*
Peer Endurance Pressure	P06	*"Didn't want to be the one to sit out."*
Professional Identity Pressure	P03	*"Felt I had to keep strong for others."*
Compartmentalising	P04	*"Put it in a box until later."*
Emotional Dissociation	P07	*"It was like I wasn't there."*
Hyper-Focus on Tasks	P06	*"Just kept doing the obs to distract myself."*
Delay in Help-Seeking	P05	*"Didn't tell anyone until it was bad."*
Suppression as Coping	FG2	*"It was the only way to survive the shift."*
Normalising Overwork	P03	*"Everyone was exhausted it was normal."*
Suppression Pride	P08	*"Felt proud I didn't cry at work."*
Self-Silencing	P05	*"Didn't want to make a fuss."*
Accumulation Effect	P04	*"It all came out later, like a dam bursting."*
Repeated Suppression Cycle	FG1	*"Day after day, same thing."*
Embodied Suppression	P09	*"Felt it in my chest, tightness."*

To further illustrate how initial codes were derived in vivo, **Figure 4.3** presents an annotated transcript excerpt demonstrating how segments of text were coded line by line during early analysis.

Figure 4.3. Annotated Transcript Excerpt Demonstrating Initial Coding (P1, p.7)

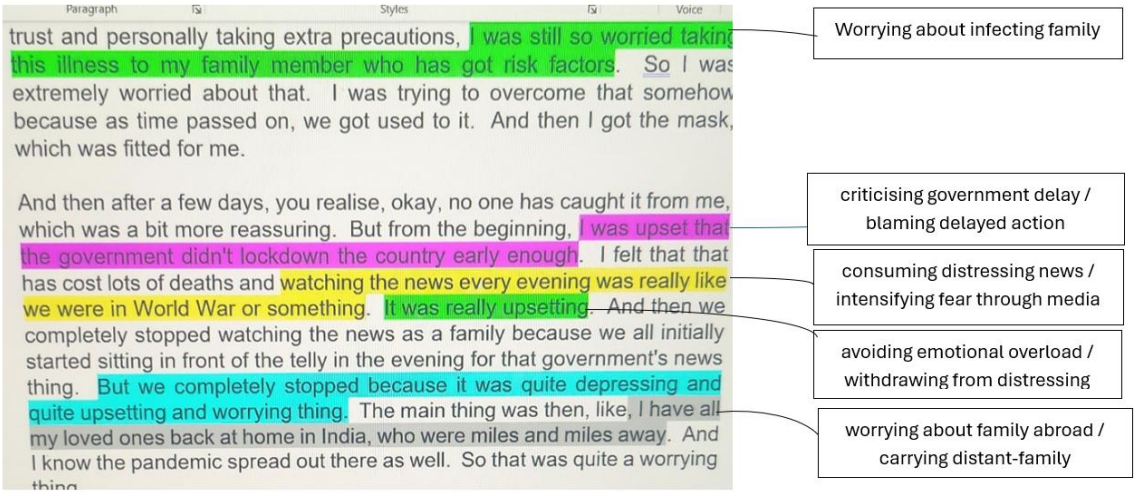


Figure 4.3 above shows highlighted segments from P1, p.7, illustrating how participants' language was fractured into action-oriented initial codes during line-by-line coding.

Analytic movement from Initial Coding

Initial coding did not function to explain or interpret participants' experiences. Instead, it enabled recognition of recurrent forms of regulatory action across the dataset. Through sustained comparison at this stage, I began to observe that many initial codes clustered around:

Repeated regulatory effort rather than isolated reactions

Professionalised responses embedded within expectations of competence and responsibility.

Bodily management occurring alongside emotional control.

Postponement of emotional engagement to maintain functionality

Consequently, I progressed to the subsequent phase of analysis: focused coding, wherein analytical emphasis transitioned from broad exploration to targeted synthesis.

4.2 Focused Coding: Developing Analytic Direction

Focused coding signified a point in the analysis where I transitioned from merely identifying discrete activities to analytically exploring the interrelations among those acts. According to Charmaz (2014), focused coding entails the selection and synthesis of the most relevant and analytically valuable starting codes for the analysis of bigger data segments. This phase necessitated a meticulous transition from analytical openness to analytical direction, while keeping anchored in participants' narratives and avoiding hasty abstraction.

Upon concluding the line-by-line first coding of all interviews and focus groups, I noted that specific actions manifested with remarkable consistency. Participants consistently articulated the suppression of emotional expression, the persistence in work despite physical discomfort, the postponement of emotional participation, and the preservation of professional composure notwithstanding ongoing organizational pressure. Focused coding allowed me to analyse these repeated acts comparatively, rather of perceiving them as discrete responses inside narratives.

I printed the complete set of initial codes and engaged with them physically, organising and reorganising the codes on my desk and whiteboard. This tactile method promoted constant engagement with the data and enabled comparisons among participants, care environments, and temporal instances. Codes were consistently categorised, divided, and reclassified as I analysed the clustering of various behaviours, identified necessary analytic distinctions, and determined which codes possessed the most significant explanatory power. The procedure was consistently supported by memo writing, which facilitated the documentation and re-evaluation of analytical enquiries, uncertainties, and tentative interpretations.

In accordance with Charmaz's (2014) recommendations, I consistently posed analytical enquiries centred on procedure and condition. The analysis encompassed the activities' effects on participants, the conditions under which they transpired, and the intersection of emotional, physical, and temporal

processes. A consistent set of analytical patterns emerged through constant comparison. These patterns pertain to the regulation of emotional expression, the suppression or management of physiological signals, the deferral of emotional involvement, the enactment of professional identity, and the collective normalisation of resilience within teams and organizational settings.

Concentrated coding facilitated more nuanced analytical differences among connected actions. For instance, the suppression of emotional expression was conceptually distinct from persisting in work despite physical illness yet both facilitated continued functionality. In a similar vein, postponing emotional engagement contrasted with the deliberate avoidance of contemplation, each possessing unique ramifications for the accumulation and reemergence of sadness over time. These distinctions arose inductively through constant comparison rather than using established conceptual frameworks.

To provide the transparency and auditability of this analytical transition, **Table 4.2** below illustrates the synthesis of repeated starting codes into concentrated analytical processes. At this stage, targeted codes were not seen as themes or outcomes. Instead, they served as temporary analytical frameworks that guided subsequent memo writing, ongoing comparisons, and examination of relationships between processes, consistent with the concepts of Constructivist Grounded Theory (Charmaz, 2014).

Table 4.2: Focused Codes Developed Through Comparative Analysis

No.	Focused Code	Clustered Initial Codes (from 31)	Participants Contributing	Analytic Interpretation
1	Professional Masking	*Masking distress; brave face; surface resilience*	P01, P06, P08, FG2	Emotional performance enacted to maintain a professional façade
2	Self-Silencing	*Swallowing frustration; not making a fuss; withholding*	P03, P05, P07	Protects team dynamics while intensifying internal emotional pressure
3	Humour as Defence	*Laughing instead of crying; joking*	FG1, P06	Group level strategy to diffuse tension and preserve morale
4	Temporal Deferral	*Delaying feelings; postponing emotional response*	P02, P04, FG1	Functional avoidance that creates an emotional backlog
5	Embodied Suppression	*Ignoring bodily warnings; pushing through exhaustion*	P09, P08, P05	Body overridden in favour of productivity and duty
6	Presenteeism	*Working while unwell; continuing despite symptoms*	P03, P08, FG2	Endurance framed as a moral expectation rather than a choice
7	Emotional Containment	*Holding back tears; suppressing panic*	P02, P07, P11	Tight emotional control to maintain operational stability
8	Moral Duty to Endure	*Just keeping going; guilt for resting*	P03, FG1, P06	Suppression justified through ethical narratives of care

9	Collective Normalisation	*We all just got on with it*	FG1, FG2	Cultural reinforcement that turns suppression into a shared norm
10	Desensitisation	*Emotional numbness; disconnection*	P07, P05	Functional detachment to survive repeated exposure to distress
11	Body Mind Separation	*Dissociation; acting on auto pilot*	P07, P09	Emotional disengagement paired with somatic shutdown
12	Emotional Leakage	*Crying privately; collapse after shift*	P02, P04	Suppressed emotions resurfacing in private spaces
13	Fear of Vulnerability	*Avoiding help seeking; fear of judgement*	P05, P10	Vulnerability framed as weakness reinforcing suppression
14	Role Preservation	*Protecting juniors; maintaining leadership façade*	P03, P01	Emotional masking to retain authority and support others
15	Adaptive Numbing	*Functioning through numbness*	P07	Temporary suspension of affect to maintain clinical focus
16	Institutional Reinforcement	*Praise for coping; organizational silence*	P06, FG2	Systems that reward suppression as professionalism
17	Cognitive Avoidance	*Avoiding reflection; mental distancing*	P06, P05	Conscious blocking of thought to prevent overwhelm
18	Internalised Endurance	*Pride in coping; shame for needing rest*	P08, P03	Endurance becomes internalised as a moral identity
19	Delayed Collapse	*Emotional flooding; somatic crash*	P02, P04, P11	The point at which suppression becomes unsustainable

Table 4.2 above illustrates how attentive coding diminished analytic fragmentation while maintaining a tight engagement with participants' narratives. This level facilitated progression from mere descriptive enumeration to analytical focus by amalgamating similar initial codes into concentrated procedures. Significantly, these concentrated codes remained tentative and subject to scrutiny.

To facilitate analytical reasoning during this phase, I employed diagramming in conjunction with memo writing. Diagramming enabled me to investigate linkages, intersections, and density among focused codes without prematurely establishing analytic significance. **Figure 4.4** below visually depicts the mapping of targeted codes to analyse developing clustering and related patterns.

Figure 4.4: Focused Coding Map Illustrating Analytic Clustering

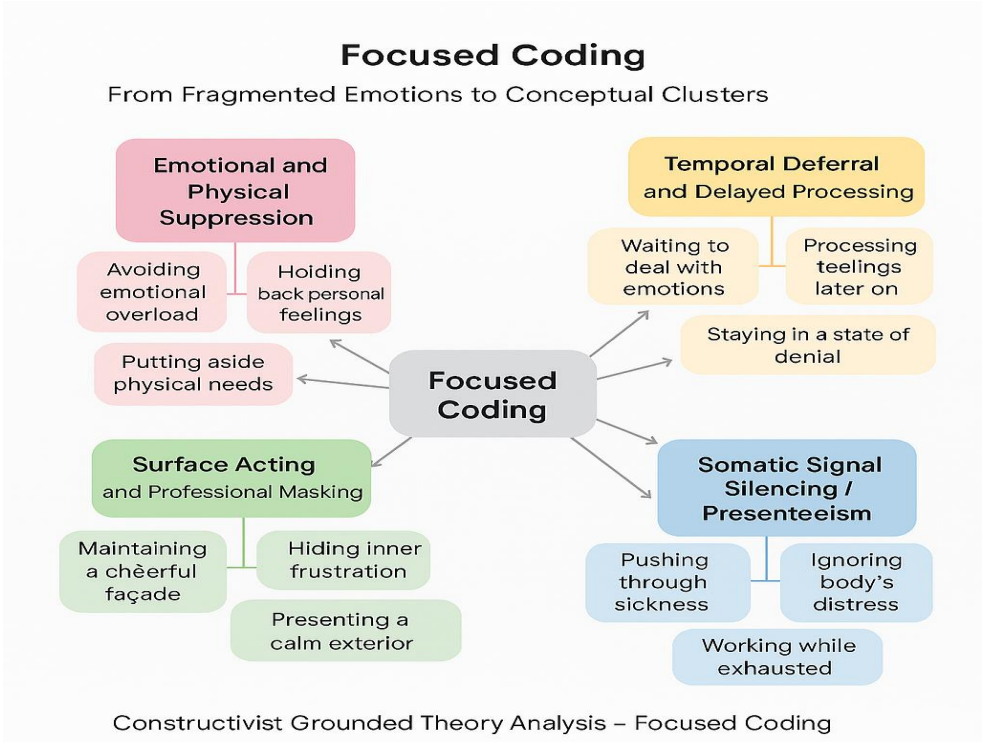
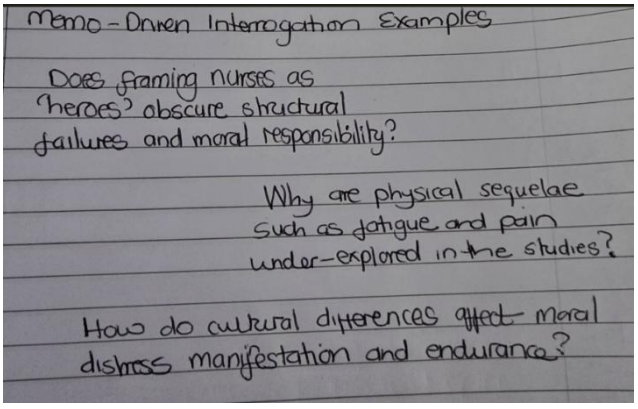


Figure 4.4 above serves as a functional analytical instrument rather than a depiction of results. It allowed me to evaluate coherence, tension, and proximity across concentrated processes while staying receptive to revisions as additional comparisons and memo draughting took place.

Memo-Driven Focused Code Interrogation

Memo writing remained crucial during focused coding. Memos were utilised to document analytical enquiries, instances of doubt, and developing lines of investigation, in addition to recording the processes of making, revising, or temporarily postponing analytical conclusions. These memos served as an analytical link between targeted coding and the ensuing construction of categories. **Figure 4.5** below demonstrates how memo-driven questioning facilitated the transition from concentrated codes to a more abstract analytical structure.

Figure 4.5. Memo-Driven Interrogation During Focused Coding



In accordance with Charmaz's (2014) recommendations, memo writing not only accompanied coding but also significantly influenced the analytical trajectory. Through recurrent engagement with codes, diagrams, and notes, focused coding established the analytical framework for the subsequent stage of analysis, when links among focused processes were scrutinised in greater detail through the construction of categories and subcategories.

4.3 Constant Comparison: Cultivating Analytical Precision

The constant comparison method served as the principal analytical tool for assessing variation, consistency, and distinction within the dataset. Initial and targeted coding facilitated the identification and consolidation of actions and processes; however, it was via ongoing comparison that analytic boundaries were evaluated, refined, and sharpened. Consistent with Charmaz's (2014, pp. 132–136) methodology, constant comparison was regarded not as a distinct phase but as an analytical mindset, entailing the ongoing disaggregation and reconfiguration of data to reveal patterns, tensions, and correlations that were not readily observable.

Comparison was initially conducted during individual interviews. Analysing participants' transitions between various periods within the same narrative facilitated a meticulous observation of fluctuations and tensions in emotional and physical regulation. This intra-interview comparison underscored that participants' experiences were dynamic, varying throughout a shift, day, or episode of care. One participant articulated an initial feeling of emotional disconnection, remarking, "*I felt nothing at first*," while subsequently depicting intense bodily worry as "*panic rising in my chest*" (P04, p.11). Analysing these episodes within a singular narrative illuminated the coexistence of emotional numbness and embodied suffering, demonstrating that regulatory processes are dynamic and situational rather than static.

This method of comparison highlighted the temporal aspect of regulatory action. Participants' narratives often exhibited cycles of increased control, brief liberation, and subsequent containment within short intervals. Addressing these shifts precluded the analytical consideration of behaviours such as repression, detachment, or endure as permanent characteristics. Rather, they were perceived as contingent reactions that heightened or diminished based on immediate requirements, physical capability, and contextual influences.

The comparison of interviews enhanced the analytical process by investigating the recurrence of comparable acts across various participants, positions, and contexts. Behaviours such as persisting despite physical symptoms, deferring emotional involvement, or emotionally detaching were prevalent throughout the dataset. Participants articulated experiences such as "*persevering despite dizziness*" (P09, p.14), "*deferring until later*" (P02, p.5), and "*emotionally disengaging" to maintain*

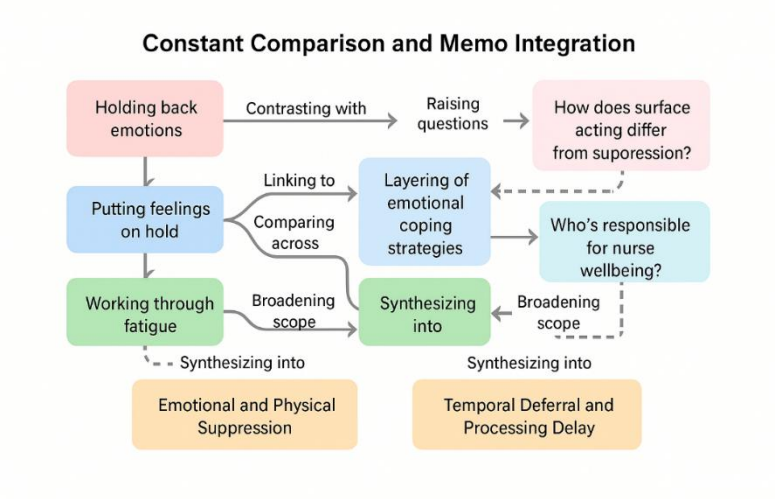
functionality (P07, p.9). The comparison of these narratives highlighted common regulatory practices while also emphasising contextual differences.

Variations in tempo were analytically discernible through this comparison analysis. Some participants reported swift cycles of containment and release during acute clinical tasks, but others detailed more gradual, cumulative processes that developed over weeks or months, especially in community and cross-site positions. The comparison among professional occupations further emphasised the discrepancies in the narration of regulatory actions. Junior nurses more commonly highlighted the hiding of anguish and the dread of seeming fragile, whereas senior nurses articulated ongoing efforts to maintain composure for others, frequently characterising suppression as a facet of leadership responsibility.

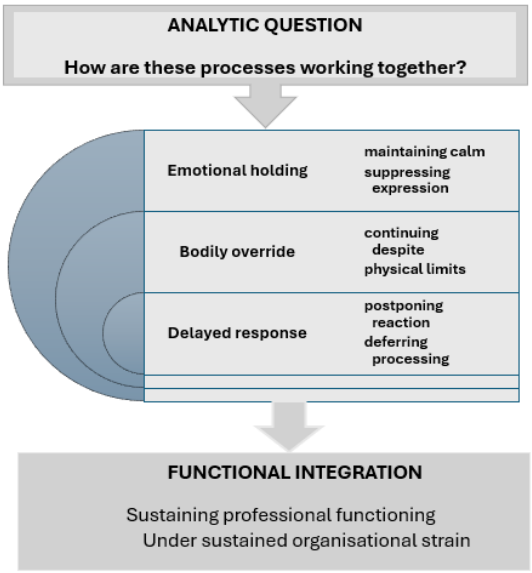
During this phase, memo writing was employed in conjunction with comparative analysis to record analytical enquiries, emerging differences, and areas of ambiguity. Memos documented instances of conceptual overlap in actions, ambiguous boundaries between processes, and the necessity for more comparison. Diagramming used as an analytical instrument to investigate the clustering, divergence, and interaction of actions during this comparison phase.

To ensure transparency in this analysis, **Figure 4.6** is provided below. The figure records the utilisation of constant comparison and memo writing as active analytical instruments during this phase of study.

Figure 4.6: Constant Comparison and Memo Integration



By contrasting acts, I was able to analyse similarities, variations, and tensions among stories, as well as to evaluate the consistency of developing analytical groups across diverse care settings and professional responsibilities. This visual configuration facilitated analytical enquiries into the locations of permeable boundaries, the need for refinement in distinctions, and the necessity for additional memo-driven investigation.



At this point in the analysis, my leading enquiries evolved. The analytical work no longer focused on the presence of certain processes in the data, as their recurrence was clearly established. The emphasis shifted to comprehending the interplay of various processes, the analytical cohesion among them, and whether separation or integration more accurately represented the occurrences across accounts.

Memo Excerpt: Analytical Integration

"*At this stage, I am no longer enquiring into the existence of these processes; they consistently manifest throughout the dataset. The analytical focus has transitioned to comprehending their interactions. Emotional suppression, physiological override, and deferred processing consistently manifest in conjunction rather than as independent phenomena. Analytical separation diminishes coherence instead of enhancing it. I must assess whether their function is more comprehensively understood through integration rather than additional subdivision*."

This memo delineates the point at which analytical efforts transitioned definitively from code enhancement to integration. Instead of viewing processes as isolated reactions, memo writing facilitated the exploration of their relational and functional interconnections throughout the dataset. Diagramming was employed as an auxiliary tool during the composition of memos to facilitate this analytical process. **Figure 4.7** below is a functional analytical artefact created at this level.

Figure 4.7: Analytic Integration During Memo Writing

Figure 4.7 above illustrates the memo-based analytic integration conducted during this analytical step. It was created as a functional instrument to illustrate the interplay and mutual reinforcement of emotional, physical, and temporal processes among individuals and environments. The memo writing was used in conjunction with this graphic to evaluate if the analytical separation of these processes

could be maintained by constant comparison. Repeated attempts to fragment these processes diminished analytic coherence, necessitating additional memo-based inquiry into integration and function.

Memo Excerpt: Testing Analytic Boundaries

"variations in tempo and expressiveness are apparent among participants and contexts; however, the fundamental regulating structure persists. analytical attempts to distinguish between emotional and physical processes become inadequate upon comparison. structuring the study by domain instead of function obfuscates the underlying dynamics. integration enhances analytical coherence at this point."

This memorandum demonstrates how memo writing facilitated boundary testing and prevented premature fragmentation of the analysis. Instead of imposing difference for analytical clarity, memo writing facilitated ongoing comparison and reflective decision-making based on the evidence.

From Memo Writing to Category Construction

Through recurrent memo draughting and frequent comparison, analytic integration achieved a stage where further examination of process linkages ceased to produce instability or contradiction. Conversely, integration consistently enhanced coherence throughout the dataset. The analytical focus transitioned from assessing the association of processes to contemplating their conceptual stabilisation. This transition signified the shift from memo-based integration to formal category formation. **Figure 4.8** below contextualises this analytical transition within the broader Constructivist Grounded Theory framework.

Figure 4.8: Iterative Analytic Movement in Constructivist Grounded Theory

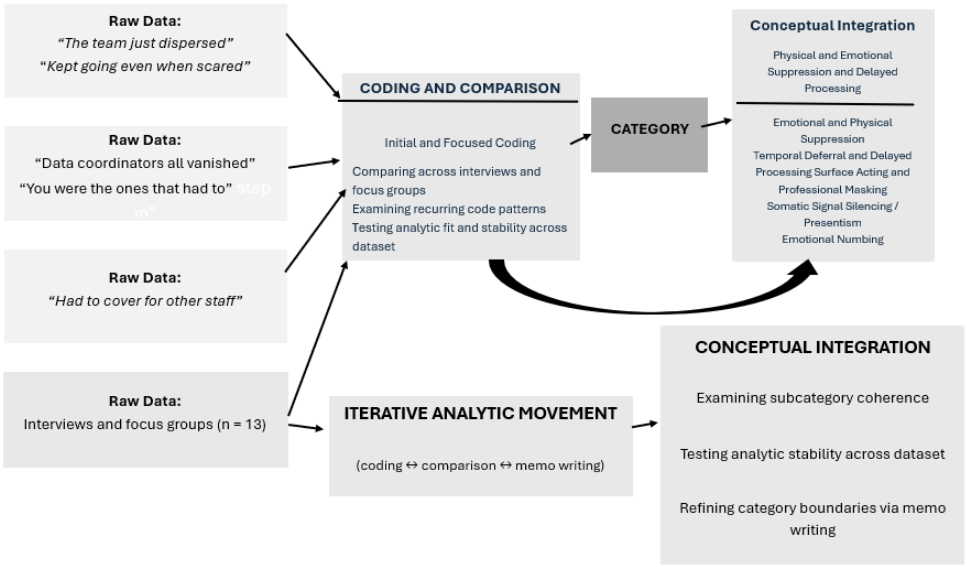


Figure 4.8 above presents a visual encapsulation of the iterative analytical process that supports this investigation. It places memo writing inside constant cycles of coding and frequent comparison, demonstrating how analytic integration facilitated the progression towards category formation. Significantly, the analytic progression was non-linear. Memo writing and comparative analysis consistently guided decisions about coherence, stability, and border integrity prior to the official establishment of categories. Upon finalising memo-based analytic integration, I subsequently transitioned to category construction.

4.4 Development of Categories

The four categories delineated in this chapter were developed through a collaborative analytical approach rather than through distinct category-specific methodologies. After concentrated coding and ongoing memo writing, my analytical objective at this step was to ascertain whether integrated clusters of processes exhibited adequate coherence, density, and stability to justify categorisation. Category development served as an interpretive and analytical decision-making phase based on constant comparison and memo analysis, rather than merely a descriptive sorting or theme organization task (Charmaz, 2014).

I constantly revisited focused codes within the dataset to see if processes operated in conjunction across interviews, focus groups, and contexts. These clusters were not initially regarded as temporary categories. I employed memo writing to evaluate if integration enhanced analytical clarity or if the perceived coherence was merely a result of data proximity rather than an intrinsic structured process. Now, memos focused on boundary testing, assessing whether integrated processes were conceptually separate from neighbouring clusters and whether variation indicated contextual expression or analytic instability.

In one memo, I observed that targeted codes pertaining to emotional restraint, physical endurance, and delayed response frequently co-occurred and seemed to operate as a regulatory pattern rather than as discrete or sequential reactions. I examined whether the distinction between emotional and physical components diminished analytic coherence by revisiting participants' narratives and analysing the descriptions of these processes across various roles, contexts, and instances of practice. Where integration enhanced explanatory capacity and maintained stability under constant comparison, category creation advanced. Where integration diminished coherence or disintegrated into adjacent process clusters, analytic boundaries were sharpened or creation was postponed.

Constant comparison remained crucial throughout this phase. I analysed clustering dynamics among individual and group stories, within acute and community contexts, and across temporal points in participants' narratives. This comparative analysis allowed me to differentiate between variations in expression and analytical inconsistency. This approach ensured that category construction was based

on consistent patterns throughout the collection rather being influenced by particularly striking, emotionally intense, or unusual narratives.

Subcategories were created during the process of category formation rather than being appended subsequently. The establishment of subcategories allowed me to delineate analytically significant distinctions within each category while maintaining coherence at the categorical level. Memo writing was employed to evaluate whether the suggested subcategories elucidated the internal organization or caused superfluous fragmentation. Where subcategories intersected, diminished integration, or replicated analytical efforts already conducted at the category level, they were refined, consolidated, or relocated until the internal structure of each category was analytically sound and sufficiently robust.

This analytical technique was uniformly used across all four categories. Categories were established solely after integrated process clusters exhibited analytical coherence, conceptual richness, and consistency through ongoing comparison. The formation of categories thus signifies extended analytical involvement rather than just aggregation or simplification of codes. Now, I intentionally refrained from developing a main category. I regarded each category as a temporary analytical unit, remaining receptive to subsequent integration instead of prematurely enforcing an explanatory hierarchy, in accordance with the ideas of Constructivist Grounded Theory (Charmaz, 2014).

Figure 4.9 below is designed to render the analytical processes supporting category development transparent and verifiable. The figure delineates the process by which targeted codes were examined, synthesised, and evaluated through memo writing and frequent comparison prior to their stabilisation as categories. The figure illustrates the recursive interplay among focused coding, memo-based boundary testing, and comparison analysis, revealing that determinations of fit, density, and stability were achieved by constant analytical effort rather than through forced frameworks. According to Charmaz, the figure positions category building inside a cyclical process of interpretation, comparison, and reflexive decision-making, rather than as a linear or procedural phase.

Figure 4.9 Analytic Pathway for Category Construction

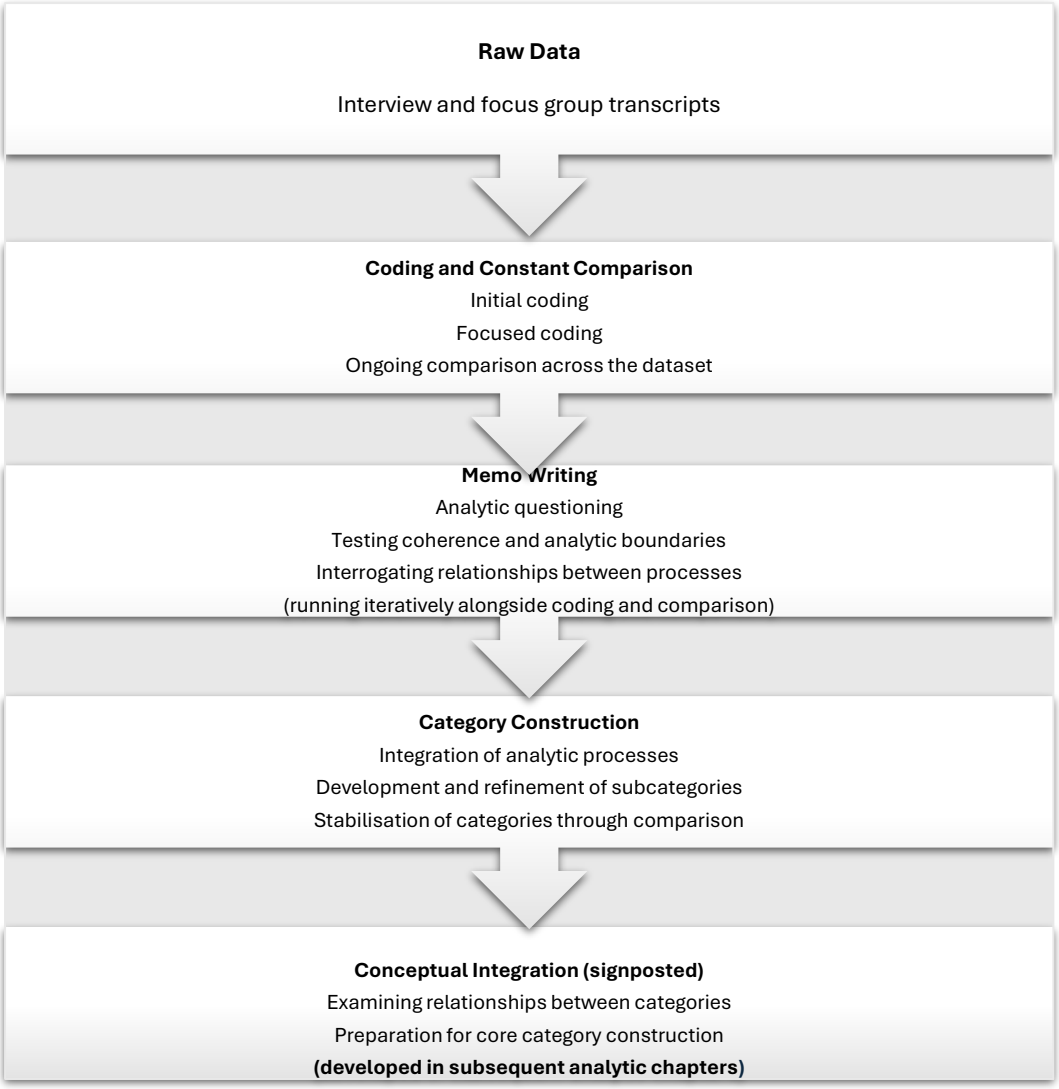


Table 4.3 below delineates the examination, integration, testing, and stabilisation of focussed codes through memo writing and continual comparison. This enhances methodological transparency and reliability by allowing the reader to follow the evolution of analytic claims, in accordance with Charmaz's focus on clarifying analytic reasoning.

Table 4.3 Analytic Pathway for Category Construction

Analytic stages	What I did at this stage	Analytic purpose
Focused codes	returned to focused codes generated through earlier stages of analysis and examined clusters of codes that appeared to operate together rather than independently.	To identify candidate process groupings suitable for higher level analytic integration.
Memo writing	wrote analytic memos to interrogate relationships between clustered processes, question analytic boundaries, and test whether integration strengthened or weakened coherence.	To move beyond code refinement and support analytic integration prior to category construction.

Constant comparison	compared emerging process groupings across interviews, focus groups, settings, and analytic groupings to assess consistency and variation.	To assess whether integration held under comparison and was not dependent on isolated accounts.
Analytic judgement fit	assessed whether proposed categories accounted for patterns across the dataset without forcing the data into predetermined frames.	To ensure analytic fit and avoid descriptive or thematic categorisation.
Analytic judgement density	examined whether categories were sufficiently developed through repeated comparison and memo writing to move beyond provisional groupings.	To confirm that categories were analytically robust rather than underdeveloped.
Analytic judgement stability	assessed whether category boundaries and internal structure remained stable under continued comparison and did not collapse into adjacent categories.	To ensure categories could be sustained analytically across contexts and accounts.
Subcategory development	refined subcategories to specify analytically meaningful distinctions while avoiding unnecessary fragmentation or overlap.	To articulate internal category structure while preserving conceptual coherence.
Category construction	stabilised categories once analytic integration strengthened coherence and remained consistent across the dataset.	To construct categories grounded in sustained analytic work rather than code accumulation.

I revisited concentrated codes produced in prior analytical stages and analysed clusters of codes that seemed to function together rather than autonomously. To discover candidate process groupings appropriate for advanced analytic integration.

At this stage of the investigation, the four categories and their corresponding subcategories had been methodically developed, evaluated, and solidified by constant memo writing and ongoing comparison. **Table 4.4** below provides an overview of the complete analytic architecture prior to the integration of key categories.

This arrangement prevents the gradual introduction of category structure in subsequent parts and allows the reader to maintain a comprehensive understanding of the conceptual framework.

Table 4.4 Summary of Established Categories and Subcategories

Category number	Category title	Subcategories
1	Physical and Emotional Suppression and Delayed Processing	Emotional suppression; Physical suppression; Delayed emotional processing; Professional masking and surface acting; Somatic signal silencing and presenteeism; Emotional numbing
2	Physical and Psychological Trauma and Aftershocks	Reliving events including flashbacks and nightmares; Triggers and reminders including alarms, PPE, media, and places; Panic and hyperarousal; Sleep disturbances and non-recovery; Physical sequelae and functional decline
3	Organizational Dissonance and Fragmentation	Directive Reality Mismatch; Communication Gaps and Policy Instability; Fragmented Teams and Structural Silos; Erosion of Trust and Loss of Predictability

4	Moral Suffering and Ethical Erosion	Ethical Breach Exposure; Internalised Moral Failure; Moral Coercion and Silencing; Betrayal of Professional Values

Progression from Category Construction to the Subsequent Analytic Phase

The establishment of the four categories represented a pivotal analytical phase in the research. By use of constant memo writing, ongoing comparison, and boundary testing, each category was established as an analytically coherent and adequately dense representation of structured processes throughout the dataset. The analytic focus transitioned from assessing the feasibility of constructing categories to exploring the interrelations of these categories within a comprehensive conceptual framework.

In accordance with Constructivist Grounded Theory, the formation of categories occurred prior to any efforts at theoretical integration. I consequently regarded the established categories as temporary analytical units instead of definitive results, and I refrained from assigning explanatory hierarchy now. This analytical restriction preserved openness to emerging connections and prevented premature theoretical closure (Charmaz, 2014).

After this transition, I transitioned into core category development. In Constructivist Grounded Theory, this phase entails discovering a core integrating category that explains systematic variation within the dataset, maintaining anchored in analytic comparison rather than being retrospectively imposed. I concentrated on whether a singular integrating technique might connect the four categories without diminishing their own analytical characteristics.

I undertook core category creation as an iterative and reflective analytical procedure. I revisited category memos and conducted targeted analytical enquiries, examining which conditions recurred across categories, the organizational and relational processes influencing the interconnections among categories, and whether any analytical process exhibited adequate integrative capacity. The enquiries were explored through constant note writing, which facilitated analytical detachment and enabled the testing of putative core categories instead of presuming them.

An essential analytical strategy at this stage entailed contrasting categories against one another instead of constantly revisiting specific instances. I studied sites of convergence and divergence among categories and assessed whether common organizational and relational circumstances facilitated their growth. This comparative study emphasised analytical relationships over descriptive similarities and entailed iterative movement between category definitions, memo reflections, and frequent comparisons among individuals and contexts to evaluate analytical coherence.

Memo writing encapsulated both analytical ambiguity and developing clarity. In multiple memos, I saw that organizational challenges manifested across all four categories but were not perceived by participants as discrete failures. Participants articulated feelings of exposure, lack of support, and the

burden of managing the repercussions of systemic actions in their professional capacities. These observations necessitated additional analytical testing to ascertain whether the integrating process transcended organizational irregularity to reveal a more profound relationship fracture between nurses and the institutions in which they were employed.

I subsequently evaluated prospective key categories using constant comparison. Each was evaluated for its ability to elucidate the regulatory mechanisms observed in Category 1, the persistent psychological and physical repercussions noted in Category 2, the systemic volatility apparent in Category 3, and the ethical dilemmas highlighted in Category 4. If a possible core category failed to explain variation among categories without merging their unique analytical characteristics, it was either refined or discarded. At this analytical level, the central category was necessitated to exhibit integrative capacity rather than mere recurrence (Charmaz, 2014).

To enhance analytical rigour, I proactively pursued narratives that confused or contested emerging interpretations. Cases that deviated from provisional integrative explanations were employed to refine analytical parameters and elucidate the scope of the main category. This enhanced analytical accuracy and mitigated the potential of rhetorical abstraction or overextension.

4.5 Development of Core Category by Integrative Coding and Memo-Based Comparison

After establishing and stabilising the four categories, I proceeded to develop the core category. In Constructivist Grounded Theory, this phase entails recognising a central integrating analytic concept that explains systematic variation throughout the dataset, while being anchored in ongoing continual comparison rather than being retrospectively imposed (Charmaz, 2014). The analytic focus transitioned from determining the internal consistency of categories to exploring their interrelations within a broader analytical framework.

I oversaw this phase by reverting to the four established categories as the principal analytical units, rather than persisting in the comparison of specific episodes or discrete codes. This transformation signified a significant analytical change. By means of persistent note writing and ongoing comparison, investigated whether a common organizational or relational process transcended several categories and whether this process might feasibly synthesise the analytical work without compromising the unique attributes of each category.

During this phase, prospective core categories were regarded as tentative analytical constructs rather than definitive conclusions. Each participant underwent analytical evaluation by memo-based enquiries and comparative analysis across participants, contexts, and analytical categories. This methodology preserved transparency and averted hasty theoretical finality, aligning with Charmaz's focus on integration as an emergent, reflexive process rather than a conclusive procedure.

In this endeavour, I synthesised initial codes, concentrated codes, and memo-based comparisons pertinent to organizational settings and institutional reactions across all four categories. This phase of integrative coding aimed not to produce new analytical content, but to illuminate how disparate, incident-driven processes coalesced into a structured organizational and relational dynamic that spanned individuals' experiences of physical and mental well-being.

To enhance analytic transparency and establish a definitive audit trail for this integrative activity, I have summarised chosen cases in see **Table 4.5** below. The table demonstrates that institutional processes were discerned by the convergence of coding, sustained comparison, and memo-based interrogation, rather than through thematic aggregation.

Table 4.5: Example Initial Codes, Focused Codes, Constant Comparison and Analytic Notes

Analytic strand	Illustrative initial codes across Categories 1–4	Focused code aligned with core category	Comparative insights across settings and analytic groupings	Brief analytic note
Exposure without adequate protection	*"Short of PPE again;" "sent in with no backup;" "rota left us dangerously short"*	Withheld protection and safety	Acute settings were characterised by sudden, repeated high-risk exposure. Community settings reflected prolonged under-resourcing and slow erosion of safety. Fractured Endurers most frequently linked these conditions to feeling "sacrificed" by the organization.	Institutional duty of care is experienced as breached when risk is normalised and protection is inconsistent. Endurance becomes equated with expendability rather than professional value.
Praise without material support	*"Emails saying thank you, but nothing changed;" "claps, then back to unsafe ratios"*	Symbolic recognition replacing practical support	Surface Endurers often framed this as well-intended but hollow. Fractured Endurers described it as dismissive or emotionally manipulative.	Organizational gratitude is interpreted as betrayal when it substitutes for structural change, such as staffing, recovery time, or psychological support.
Raising concerns without response	*"Kept flagging it, nothing happened;" "told to stop being negative;" "incident forms went nowhere"*	Silenced concerns and procedural deflection	Participants across bands described concerns being minimised or absorbed into bureaucratic processes. Senior nurses described reputational risk associated with being seen as "not coping."	Procedural deflection converts trust into suspicion and accelerates moral strain. The institution is experienced as protective of itself rather than responsive to staff.

Managing consequences alone	*"Nobody checked on us after that night;" "we just carried on like nothing happened"; "told to get OH to sign me off"*	Being left to carry the weight	Surface Endurers described persistence and functional continuation. Fractured Endurers linked these moments to later withdrawal, sickness absence, or exit.	Abandonment is felt most acutely following critical events. Responsibility for recovery is shifted onto the individual nurse rather than held institutionally.
Recalibrating future commitment	*"I started looking for jobs outside"; "I will never give them that much of myself again"*	Re-drawing professional and institutional commitment	Participants described both quiet disengagement and active exit strategies across roles and settings.	Institutional betrayal culminates in identity and career reconfiguration. Endurance becomes conditional rather than relational.

Through iterative testing, one integrating category shown superior analytic fit, density, and stability compared to alternative constructs. Rather, it served as an integrative analytical framework, with its efficacy rooted in its ability to connect the four established categories via a fundamental organizational and relational mechanism that influenced how participants perceived, interpreted, and coped with their working conditions.

Inadequate protection during exposure: "*Insufficient PPE again*"; "*deployed without support*"; "*schedule left us perilously understaffed*." *Lack of protection and safety*. Acute environments were marked by abrupt, recurrent high-risk exposure. Community environments exhibited sustained underfunding and a gradual decline in safety. Fractured Endurers predominantly associated these symptoms with a sense of being "*sacrificed*" by the organization. The institutional duty of care is deemed violated when danger is normalised and protection is irregular. Endurance is conflated with expendability instead of professional worth.

Commendation devoid of tangible assistance: "Emails expressing gratitude, yet no alterations occurred"; "applause, followed by a return to precarious ratios." Symbolic acknowledgement supplanting substantive support. Surface Endurers frequently characterised this as well-meaning but insipid. Fractured Endurers regarded it as contemptuous or emotionally manipulative. Organizational gratitude is perceived as betrayal when it replaces necessary structural changes, such as staffing adjustments, recovery periods, or psychological assistance.

Expressing issues without acknowledgement: "*Repeatedly raised the issue, yet no action was taken*"; "*instructed to cease negativity*"; "*incident reports yielded no results*." Suppressed concerns and procedural evasion: Participants across various levels said that their problems were trivialised or subsumed inside bureaucratic procedures. Experienced nurses articulated the reputational risk linked to perceptions of inadequacy. Procedural deflection transforms trust into scepticism and intensifies moral distress. The institution is perceived as self-protective rather than attentive to personnel needs.

Managing consequences independently: “*No one enquired about us following that night*”; “*we simply proceeded as if nothing occurred*”; “*instructed to have OH authorise my leave*.” Shouldering the burden alone. Surface Endurers characterised their experience as perseverance and ongoing functionality. Fractured Endurers associated these instances with subsequent disengagement, absenteeism due to illness, or departure. Abandonment is experienced most intensely after noteworthy events. The obligation for recuperation is transferred to the individual nurse instead of being maintained by the institution.

Reassessing future commitments: "*I began seeking employment elsewhere*"; "*I will not invest that much of myself again*." Redefining professional and institutional allegiance: Participants articulated both subtle disengagement and initiative-taking exit strategies across various professions and environments. Institutional betrayal results in the reconfiguration of identity and career. Endurance becomes contingent rather than relational.

Memo-Driven Evaluation of the Core Category

After integrative coding, I undertook focused memo writing to evaluate if the developing institutional process may serve as a core category instead of merely a contextual theme or descriptive term. These memos encapsulated analytical ambiguity and facilitated reflexive decision-making.
In multiple memos, I observed that participants were not delineating discrete organizational failures. They reported persistent exposure to risk, a lack of assistance after significant occurrences, and being held solely accountable for the repercussions of systemic actions. This necessitated additional analytical research to ascertain whether the integration process transcended organizational inconsistency, leading to a more profound relationship fracture between nurses and their respective institutions.

I subsequently employed sustained constant comparison to evaluate tentative core categories against the comprehensive analytic framework. Each was assessed for its ability to explain variation across all four categories while preserving its unique characteristics. When a candidate became excessively wide, descriptive, or unable to maintain analytical tension between categories, it was either refined or discarded. At this analytical level, the central category could exhibit integrative potential rather than mere recurrence (Charmaz, 2014).

To enhance analytical rigour, I deliberately pursued participant narratives that challenged or contradicted existing views. Cases that diverged from tentative integrative explanations were employed to refine analytical limits and elucidate the scope of the core category. This procedure mitigated the possibility of rhetorical abstraction and enhanced analytical precision.

Establishment of the Core Category

Through iterative testing, a singular integrating analytic construct exhibited superior analytic fit, conceptual density, and stability compared to alternative constructs. I consequently established the central category as *Institutional Betrayal and Organizational Abandonment*.

At this point, the core category served as an analytical anchor rather than a thematic summation. It was not regarded as possessing internal subdivisions. Instead, it functioned to structure the analytical framework by connecting the four established categories through a primary organizational and relational process that influenced how participants perceived, understood, and coped with their working situations across both physical and mental dimensions.

The core category did not supplant the four categories. Instead, it synthesised them by considering how systemic decisions, institutional reactions, and relational dynamics shaped individuals' experiences of oppression, trauma repercussions, organizational dissonance, and moral anguish within a unified analytical framework.

After establishing the core category, I conducted additional analytical comparisons to investigate the systematic variations in how participants coped with the institutional situations represented by Institutional Betrayal and Organizational Abandonment. This analytical action did not entail the creation of new categories or the expansion of theoretical elucidation. Rather, it concentrated on discerning variation within the fundamental category itself.

Through constant continual comparison and memo writing, I noted that whereas participants reported exposure to analogous organizational settings, their experiences of these conditions varied in both manner and duration. This analytical discovery necessitated a detailed investigation of endurance trajectories within the core category, establishing a foundation for the identification of analytical groupings discussed in the subsequent section.

Transition Toward Analytic Groupings Within the Core Category

After establishing the core category, I conducted additional analytical comparisons to investigate the systematic variations in how nurses coped with the institutional situations represented by *Institutional Betrayal and Organizational Abandonment*. This analytical manoeuvre failed to produce supplementary categories and did not enhance theoretical elucidation. The study concentrated on discerning variations in processes under same analytic contexts by comparing nurses' descriptions of maintaining professional functioning throughout time amidst comparable organizational pressures (Charmaz, 2014).

At this stage, I revisited my category memos and core category memos and reanalysed the dataset with a comparative inquiry. How did participants characterise sustained employment, ongoing involvement with the business, and the management of stress over time? I analysed narratives both

within and within contexts and roles, focussing on how participants described persevering, managing, retreating, disengaging, or arriving at a stage when further progress seemed unfeasible. This entailed ongoing comparative analysis among examples and persistent memo writing to ascertain whether emergent distinctions indicated analytical variance rather than superficial differences in job, context, or seniority.

Through this recurrent comparison, two analytically distinct endurance trajectories emerged. I created these as Surface Endurers and Fractured Endurers. These are not delineated as immutable participant categories, consistent identities, or definitive results. Rather, they serve as analytical frameworks that elucidate variations in endurance trajectories under identical organizational contexts. They assisted me in demonstrating how the identical institutional processes were assimilated, administered, and at times surpassed.

During memo writing, I saw that both analytical categories indicated exposure to analogous institutional conditions throughout the dataset, encompassing withheld protection, symbolic acknowledgement, minimisation of concerns, and inadequate follow-up following crucial occurrences. The analytical distinction was not based on the feeling of institutional betrayal and organizational abandonment. The focus was on the maintenance of endurance, the accumulation of strain, and the participants' descriptions of changes in functioning, organizational participation, and capacity over time. This observation necessitated meticulous boundary delineation. I examined if the differentiation persisted under comparison, if it elucidated variance without replicating the established categories, and if it remained consistent across role variations and caregiving situations.

To ensure transparency in this analytical process, **Table 4.6** below illustrates the comparison and memo-based procedures used to identify Surface Endurers and Fractured Endurers. The table delineates the analytical work supporting this classification, rather than offering interpretation or results.

Table 4.6 Analytical Development of Surface Endurers and Fractured Endurers

Analytic stage	What I examined	Analytic comparison undertaken	Analytic insight generated
Return to constructed categories and core category	revisited the four categories and the core category as stabilised analytic units	compared how participants described continuing to work and sustaining professional functioning across suppression, trauma aftershocks, organizational dissonance, and moral suffering	Endurance processes were present across all categories, but patterns of sustaining functioning varied across accounts
Cross category comparison	examined how participants responded to the same institutional	compared references to risk, organizational response, and support, and how these were linked to language of coping,	Differences were not about exposure to strain, but about how endurance was maintained and how

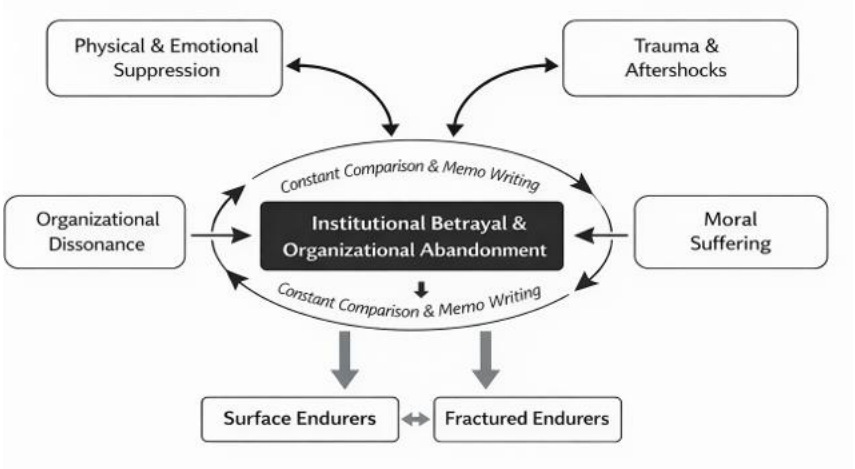
	conditions across categories	containment, stepping back, or withdrawal	capacity shifted over time
Case to case comparison	compared participants whose accounts emphasised continued outward functioning with those describing rupture or withdrawal	examined how participants narrated carrying on, reducing investment, reaching a limit, disengaging, or describing a change in self	Two endurance trajectories began to emerge as analytically distinct under constant comparison
Focused memo writing	wrote memos testing whether endurance variation reflected setting, band, or role	compared memos across acute and community settings and across levels of seniority, checking whether the distinction held under variation	The endurance distinction cut across setting and seniority and was better understood as process variation rather than participant type
Boundary testing	searched for accounts that complicated the emerging distinction	examined participants describing mixed patterns, ambivalence, or movement across time	Endurance was not fixed. Movement between patterns occurred with cumulative exposure and shifting supports
Analytic grouping	clustered comparative insights from memos and category comparisons	evaluated whether the grouping clarified variation without creating new categories or repeating existing category content	Surface Endurers and Fractured Endurers functioned as analytic groupings capturing variation within the same organizational conditions
Analytic decision	evaluated whether the grouping strengthened the analytic architecture	assessed whether the grouping illuminated patterned variation in endurance within the core category without becoming a claim of explanation	The groupings increased analytic clarity and prepared the ground for fuller illustration in the findings chapter

To elucidate the analytical transition from category construction to endurance groups, I created a visual map that illustrates the integration of the four generated categories through the core category, followed by an examination of patterned variation in endurance processes. This graphic is not meant to depict results or theoretical assertions. It records the analytical process wherein constant comparison and memo writing facilitated the transition from category-level integration to the recognition of analytical groups within identical institutional contexts.

Figure 4.10 below positions the core category, Institutional Betrayal and Organizational Abandonment, as the primary integrating construct connecting the four categories. This demonstrates that additional analytical comparisons within this integrative framework resulted in the categorisation of Surface Endurers and Fractured Endurers as process-oriented groups. The figure serves as a component of the audit trail, elucidating the process of analytic decision-making through iterative transitions between categories, memo-based inquiry, and cross-category comparison, in alignment

with the Constructivist Grounded Theory's focus on transparency and reflexive analytic progression (Charmaz, 2014).

Figure 4.10: Iterative Analytical Movement from Core Category to Endurance Groupings



According to Charmaz's (2014) Constructivist Grounded Theory, this figure positions memo writing as the analytical link between category formation and advanced analytical organization. This illustrates my transition from concentrated coding and category stabilisation to analysing patterned variation in processes, so preserving analytic openness while enhancing coherence and transparency in the construction of the study's analytic framework. In Chapter 5, I thoroughly examine the categories and analytic groupings, utilising participants' voices to illustrate how the analytic framework is rooted in the dataset. In Chapter 6, I formulate theoretical integration and elucidate the grounded theory generated from this analysis.

4.6 Conclusion to Chapter 4

This chapter has provided a clear and methodical audit trail of the analytical methodology employed in the data analysis utilising Constructivist Grounded Theory. I have illustrated the progression of analysis through initial coding, focused coding, memo writing, constant comparison, and analytic integration, resulting in the formation of four analytically stable and conceptually consistent categories. I have demonstrated that analytic conclusions were based on constant interaction with participants' narratives rather than influenced by preconceived frameworks or theme simplification, in accordance with Charmaz's (2014) constructivist methodology.

This chapter has recorded how integrative coding and memo-based interrogation facilitated the development of the core category, Institutional Betrayal and Organizational Abandonment. This core category was established as an integrative analytical construct that connected the four categories via a common organizational and relational process, while maintaining their unique analytical characteristics. The building was accomplished via cross-category comparison, constant analytical

inquiry, boundary testing, and reflexive judgement, rather than through the elevation of any singular category or prevailing narrative.

This chapter has demonstrated that subsequent analytic comparison after core category building facilitated the discovery of Surface Endurers and Fractured Endurers as analytic classifications. These classifications were established by constant comparative analysis and memo documentation, reflecting the predictable variations in how nurses experienced identical institutional settings over time. They are framed as analytical lenses instead of participant categories or outcomes, allowing for the examination of variations in endurance processes without restricting analytical flexibility or enforcing rigid categorisation.

This chapter has emphasised analytic openness at every point. Tables, diagrams, and memo extracts have been employed to elucidate the analytical processes, judgements, and judgements that influenced category formation, core category evolution, and analytical classification. Chapter 4 serves as an analytical framework, illustrating the development of the study's conceptual structure through methodical, reflexive, and data-driven analysis.

Consequently, Chapter 4 lays the analytical groundwork for the subsequent sections of the thesis. In Chapter 5, I go from the analytic procedure to the presenting of findings, emphasising participants' voices to elucidate each category and analytic grouping comprehensively. In Chapter 6, I establish theoretical integration and elucidate the grounded theory resulting from this research.

Chapter 5: FINDINGS

5.0 Introduction

This chapter presents the findings of my Constructivist Grounded Theory study, illustrating how the conceptual structure established through initial coding, focused coding, constant comparison, and memo writing is manifested in nurses' accounts regarding their experiences during and after to the COVID-19 pandemic, with a specific emphasis on physical and mental wellbeing. Consistent with Charmaz's framework, the findings emphasise actions, interactions, and consequences within organizational and professional settings, presenting findings as dynamic conceptual processes (Charmaz, 2014, pp. 126–128; 300–303).

The chapter emphasises the construction, negotiation, and preservation of meanings over time, rather than perceiving experience as a collection of static conditions. The framework is structured around four interconnected categories and a core category that links them, examining how systematic processes influence nurses' experiences in both acute and community environments across various timeframes.

Expanding upon the analytical framework introduced in Chapter 4, I explore the emergence of Physical and Emotional Suppression, Delayed Processing, Physical and Psychological Trauma and Aftershocks, Organizational Dissonance and Fragmentation, as well as Moral Suffering and Ethical Erosion in the daily professional experiences of nurses during and after the pandemic. This exploration examines the divergent categories of Surface Endurers and Fractured Endurers, which illustrate distinct methods of maintaining professional efficacy during extended organizational stress. Collectively, these elements guide the reader to the central themes of Institutional Betrayal and Organizational Abandonment, providing a cohesive narrative of how nurses withstand, manoeuvre through, and interpret the systemic factors that influence their physical and mental wellbeing.

5.1 Category 1: Physical and Emotional Suppression and Deferred Processing

"Repressing Mind and Body: The Burden of Suppression"

While analysing participants' reports, it became evident that not only the content described by nurses was significant, but also the way such experiences were articulated. Even while contemplating well after the severe moments of the pandemic, individuals communicated with a composed steadiness characterised by deliberate wording, measured tone, and calculated pauses. This constraint did not operate only as a narrative technique. It indicated a constant internal struggle to maintain composure when narrating experiences that had evaluated them both physically and mentally. Suppression, in this context, persisted during the act of narration, not solely during the experience itself.

In interviews and focus groups, common phrases like "*just getting on with it*" initially seemed to represent culturally ingrained professional terminology. Upon analysis through constant comparison among participants, contexts, and temporal markers, these sentences disclosed a systematic process of confinement rather than transient coping. Nurses were not only articulating emotional restraint. They were expressing a systematic approach to internal regulation that influenced their operations during shifts, encounters, and extended periods of uncertainty. Suppression developed as a persistent practice whereby emotions were constrained, postponed, or concealed to maintain professional stability in environments where emotional expression was deemed risky, impracticable, or inconsistent with clinical obligations.

Within this study, suppression mechanisms refer to the interconnected emotional, cognitive, behavioural, and embodied processes through which nurses contained distress to maintain professional functioning during prolonged uncertainty and pressure. These mechanisms included delaying emotional processing, concealing vulnerability through professional performance, overriding physical warning signs, and minimising personal needs to sustain care delivery and organizational stability. Rather than functioning as isolated coping responses, suppression mechanisms operated cumulatively and recursively, shaping how nurses managed, absorbed, and carried distress across clinical and relational environments over time.

In alignment with the principles of Constructivist Grounded Theory, suppression is framed as a form of labour rather than evasion (Charmaz, 2014, pp. 126–128). It was personified, ethically structured, and systematically arranged. Participants articulated a constriction both emotionally and physically to maintain functionality, managing suffering in manners that safeguarded patients, colleagues, and the broader professional setting. One nurse articulated this mental resolve succinctly: "*You simply persist*." Emotional expression is inappropriate in the workplace. "*You must maintain composure*" (P4, p.6). In this narrative, calmness is depicted not as a personal inclination, but as a professional need. Emotional expressiveness is deemed incompatible with clinical presence, whereas suppression is regarded as an ethical effort directed towards the needs of others.

Through constant comparison and memo writing, suppression was revealed as a process with an inherent structure rather than a singular act. It developed through four interconnected movements that functioned recursively instead of linearly. The decision to suppress was seldom presented as discretionary. It was presented as essential to maintain the role of a "good nurse" notwithstanding shortage, loss, and risk.

Secondly, suppression was sustained via professional reinforcement. Participants identified internal and external stimuli that reinforced suppression as a standard, including peer expectations, leadership reticence, and cultural narratives that associated endurance with ability. This reinforcement converted suppression from a situational reaction into a persistent mode of operation.
Third, suppression accrued by temporal postponement. Nurses articulated that instead of addressing their sorrow, they deferred it to a hypothetical future, anticipating a time or capacity to absorb their burdens. One participant remarked, "*I continually promised to address it later, yet that moment never arrived*" (P2, p.5). This postponement facilitated ongoing performance in the present while gradually accumulating unresolved mental and physical stress for the future.

Ultimately, suppression attained saturation. Participants identified instances where emotional and physiological systems could no longer maintain containment. At this stage, suppression ceased to operate as control and instead manifested as strain, establishing the analytical connection to the trauma aftershocks examined in Category 2.

This internal architecture depicts suppression not as a fixed characteristic or coping mechanism, but as a dynamic process influenced by professional norms, organizational settings, and the cumulative burden of unprocessed experiences.

Suppression did not occur in isolation, as analysed. It was generated and maintained by a series of recurring variables that influenced what nurses regarded as feasible or acceptable within their professional settings. A primary condition was exposure to prolonged clinical demand among uncertainty and danger. Nurses reported operating in settings characterised by high patient acuity, inadequate staffing, and swift policy changes, which afforded less opportunity for emotional respite.

In these situations, emotional restraint became essential for sustaining workflow and decision-making. A secondary criterion was the ethical framing of accountability. Participants consistently rationalised suppression by citing patient necessity, team cohesion, and professional identity. Emotional expression was regarded as a potential burden to others or a destabilising factor in care, but endurance was characterised as an ethical contribution.

A third requirement was the lack of organised places for processing. In the absence of formal debriefing, supervision, or constant visible leadership support, suppression occupied the relational void. Nurses transported items that were not communally possessed. These variables converged to establish suppression as a professional norm rather than a reaction to extraordinary situations. As time

progressed, this normalisation rendered suppression less apparent and more challenging to contest, despite the accumulation of its consequences.

The comparative research indicated that suppression functioned as active internal effort rather than as passive restriction. Nurses articulated the concealment of vulnerability via professional conduct, suppressing physical signals, and managing their emotional expression to provide stability in others. A participant articulated this external display succinctly: "*I smiled so they wouldn't see how scared I was"* (P10, p.14). In this context, emotional labour is distinctly relational. The nurse's internal condition is secondary to the emotional requirements of patients and colleagues. The expense of this stabilising function is absorbed internally, exacerbating emotional dissonance and fatigue.

Participants reported physical symptoms indicating the attainment of boundaries, although these signals were disregarded in the interest of professional obligation. A nurse remarked, "*My body was signalling me to cease, but one does not have the privilege to heed*" (P6, p.12). This account portrays the body as a voice that is deliberately muted. Presenteeism, in this context, refers not merely to being present at work while unwell. It represents a tangible manifestation of ethical obligation; wherein physical stamina serves as an indicator of professional value.

Conceptually, suppression was not perceived as uniformly intense. Participants articulated a chronological evolution in the manner it was experienced and maintained. In initial stages, suppression was frequently described as intentional and controlled. Nurses articulated the need to "*steel themselves*" for shifts, preparing emotionally and physically to address immediate demands.

During this phase, suppression was intricately linked to a perception of agency and professional ability. During the intermediate stages, suppression became routine. Emotional and physical overrides were characterised as habitual, no longer necessitating conscious deliberation. Participants described operating on "*auto pilot*," indicating that confinement had become ingrained in routine practice. This time progression underscores suppression as a dynamic process shaped by accumulating pressure rather than a static reaction to crises.

Distinct diversity was observed among the analytical categories of Surface Endurers and Fractured Endurers. Surface Endurers characterised suppression as a controlled internal holding pattern that enabled them to seem outwardly composed and proficient. This type of endurance was often described as standard, ingrained within professional standards that regarded serenity as a sign of competence and emotional breakdown as incongruous with clinical practice. For these participants, suppression served as a means of maintaining professional identity despite adversity.

Fractured Endurers, in contrast, characterised suppression as becoming challenging to maintain. Gradually, the accumulated strain of suppressing all emotions surpassed their emotional and physical limits. What originally served as control evolved into a sensation of pressure. Participants in this

group recounted instances where suppression ceased to provide protection and instead led to destabilisation, retreat, or breakdown.

This distinction did not indicate variations in individual resilience or dedication. It analytically demonstrated variations in saturation points within the identical containment system. Both factions participated in suppression. The duration for which that system could be maintained before its failure varied. The care setting influenced both the pace and manner of suppression. Nurses operating in acute settings reported swift, recurrent tension in reaction to high-intensity occurrences such as alarms, abrupt deterioration, and fatalities. Suppression functioned in brief, intense cycles that emphasised prompt action and emotional restraint. The work's tempo necessitated rapid emotional resolution to transition to the subsequent task or patient.

In contrast, community nurses have a more gradual and subdued perseverance. Suppression occurred due to prolonged solitary work, constant exposure without immediate peer support, and extended intervals of internal retention without opportunity for collaborative processing. Instead of intense, short-term containment, suppression in these contexts was characterised as a sustained, low-level pressure that built up over days and weeks.

These contrasts illustrate suppression as a culturally influenced process, emerging within varying temporal rhythms and relational frameworks rather than as a homogeneous or individualised reaction. Not all accounts conform precisely to a singular suppression trajectory. A limited number of participants recounted instances of partial release, including casual peer discussions or fleeting emotional expressions outside the therapeutic environment. Conceptually, these instances did not undermine the category. They delineated its borders. These releases were generally characterised as transient and inadequate to modify the overarching pattern of containment. Suppression recommenced upon the nurses' return to formal positions and organizational environments.

The border examples bolstered the analytical assertion that suppression was structurally reinforced rather than only a matter of individual choice. In instances where organizational or relational factors temporarily permitted expression, nurses were able to transcend limitations. In instances when those conditions persisted, suppression reemerged as the prevailing mode of operation.

Collectively, suppression manifested as the fundamental impetus of nurses’ endurance. Nurses engaged in this consistently across time, across many circumstances and relationships. It influenced their navigation of shifts, interactions with colleagues and patients, and emotional positioning within the organization. Significantly, it also influenced the subsequent manifestation of distress. What was restrained did not dissipate. It amassed.

Suppression was not uniform nor unchanging. The process developed as a complex and cumulative sequence characterised by emotional and physical constriction, delayed processing, professional facade, bodily tension, and ultimate desensitisation. One participant articulated this finality with

remarkable clarity: "*After a while, I just felt nothing*" (P1, p.7). Numbing is depicted not as alleviation, but because of extended internal exertion. Emotional systems become inactive when their capacity is surpassed.

To reinforce this conceptual synthesis, **Table 5**.1 below encapsulates the primary suppression mechanisms discovered within Category 1 and illustrates their influence on nurses' physical and mental wellbeing.

Table 5.1. Summary of Suppression Mechanisms in Category 1: Physical and Emotional Suppression and Delayed Processing

Suppression Mechanism	Core Analytic Meaning	Illustrative Participant Extract	How the Mechanism Operates	Physical and Mental Wellbeing Consequence
Emotional and Physical Suppression	Disciplined internal tightening to maintain professional presence and contain distress	*"You just keep going. You can't cry at work. You have to hold it together" (P4, p.6)*	Emotional and bodily responses are actively restrained to preserve composure	Short term stability with rising internal strain
Temporal Deferral and Delayed Processing	Emotions displaced into imagined future spaces for later engagement	*"I kept saying I'd deal with it later, but later never came" (P2, p.5)*	Distress is postponed rather than resolved	Accumulation of unprocessed emotion
Surface Acting and Professional Masking	Performance of calm to protect patients and colleagues	*"I smiled so they wouldn't see how scared I was" (P10, p.14)*	Emotional labour stabilises others while intensifying internal dissonance	Emotional exhaustion and identity strain
Somatic Signalling and Presenteeism	The body expresses what the mind suppresses, but signals are overridden	*"My body was telling me to stop, but you don't get to*	Physical symptoms are ignored to maintain performance	Fatigue and declining physical resilience

		listen" (P6, p.12)		
Emotional Numbing and Desensitisation	Affective shutdown when suppression capacity is exceeded	*"After a while, I just felt nothing" (P1, p.7)*	Emotional systems disengage to prevent collapse	Loss of emotional responsiveness

Table 5.1 above synthesises Category 1 by illustrating suppression as a cumulative and embodied system of internal effort rather than a unique coping mechanism. These processes collaborate to maintain short-term professional performance while gradually depleting emotional and physical resources.

As this capacity diminishes, suppression can no longer be maintained. What is deferred and restrained does not dissipate. It reverts. Category 2 thus presents the progression of this containment failure, mapping the resurgence of repressed emotional and corporeal elements as manifestations of physical and psychological trauma aftershocks. The elements that maintained the clinical atmosphere lead to a disintegration of experience for many nurses in its wake.

5.2 Category 2: Physical and Psychological Trauma and Aftereffects

"When All That I Suppressed Resurfaced".

Category 2 delineates the events that transpired after the containment measures outlined in Category 1 became untenable. This category examines the repercussions of the extended internal labour that allowed nurses to maintain professional functionality during and after COVID-19. What was postponed, suppressed, or numbed did not vanish. It has returned and this return was perceived not as a one moment of collapse, but as a regular sequence of aftershocks that traversed memory, body, sleep, and surroundings, frequently enduring long after the most severe phases of exposure had concluded.

During interviews and focus groups, these aftershocks were described less as psychological symptoms and more as experiences that manifested themselves. Nurses did not articulate a decision to reflect on past events. They recounted experiencing a sense of astonishment. The terminology of incursion, ambush, and loss of control was consistently present in the narratives. One participant remarked, "*I was merely driving when I abruptly found myself back in that bay*." "*I could hear the alarms once more*" (P3, p.9). In this narrative, memory is not a cognitive function. It pertains to spatial and sensory re-entry. The current instant disintegrates, and the clinical past is reconstructed by sound, movement, and physical reaction. This signifies a transition from emotional regulation to temporal breakdown.

What was suppressed in Category 1 resurfaces as lived experience rather than just recall. Participants often articulated these situations in the present tense, even when reflecting on them retrospectively. The conceptual importance resides not alone in what is recalled, but in how it is experienced again. According to Charmaz, this category delineates consequences by examining the outcomes when prior activities of containment and physiological control can no longer support physical and mental well-being (Charmaz, 2014, pp. 126–128). Participants consistently identified the body as the primary locus of return. Physiological activation frequently occurred prior to the subjective acknowledgement of its trigger. A nurse stated, "*My heart began racing inexplicably*" (P5, p.11). Meaning emerged subsequently, once a smell, sound, or location had been recognised as the stimulus. This sequencing holds conceptual synthesis significance. It subverts the conventional order of intellect over corporeality. The body predominates, while cognition strives to keep pace.

Physical prominence was characterised in several reports as unsettling and destabilising. Nurses reported experiencing tremors, nausea, dyspnoea, chest constriction, and abrupt episodes of panic that seemed to arise unexpectedly. One participant recounted an incident in a supermarket when "*my hands began to tremble, I struggled to breathe, and I was unaware of the cause until I recognised that the beeping resembled the monitors*" (P8, p.10). A commonplace sound transforms into a diagnostic indicator. The body reacts to a threat that is no longer physically there but continues to be neurologically and emotionally engaged.

Triggers associated trauma inside the quotidian environment. Common areas become imbued with clinical significance. One participant remarked, "*Certain odours transport me directly back*" (P7, p.8). Sensory stimuli circumvent introspective processing and stimulate embodied memory. Trauma is no longer exclusive to medical facilities or officially acknowledged instances of crisis. It infiltrates vehicles, thoroughfares, residences, and everyday interactions. The therapeutic atmosphere infiltrates the personal realm, dissolving any firm distinction between professional and personal life, so compromising psychological safety.

This signifies an expansion of the trauma field. What was once confined to the workplace is now disseminated throughout the nurse's broader lifeworld. The aftershocks are no longer contextual. They become pervasive. Participants reported surveying their surroundings for potential threats,

circumventing specific routes, sounds, or locations, and modifying daily routines to mitigate the risk of being "*triggered."* In this context, hypervigilance operated as a constant effort. It was not merely anxiousness. It involved incessant surveillance of the world for signals that could reawaken what had been subdued.

These repercussions extended beyond mere emotion or recollection. They restructured sleep, which numerous individuals identified as the moment when daytime containment faltered. Suppression could still be activated during awake hours. During the night, control disintegrated. A nurse recounted, "*I awoke struggling to breathe*." "*It seemed as though I had returned to that place once more*" (P2, p.6). Another elucidated, "*That is when everything is revealed*." "*During the day, I can maintain composure, but at night, I am unable to do so*" (P11, p.4). Sleep transformed into a mechanism of involuntary processing rather than recuperation. The place intended for restoration of capacity transformed into an arena where repressed experiences resurfaced with intensity.

Over time, persistent interruption converted weariness into a chronic ailment rather than a transient state. Participants characterised themselves as persistently operating without any restoration. A nurse remarked, "*I arrive at work fatigued, return home exhausted, and retire to bed weary*." "*It never truly resets*" (P9, p.13). This account characterises tiredness not because of an extended shift, but as a continual baseline. Recovery is no longer accessible. Operations persist, albeit in a diminished capacity.

In addition to intrusive recollections, hyperarousal, and sleep disturbances, individuals reported enduring physical consequences that they directly associated with their emotional burdens. Chronic weariness, recurring infections, gastrointestinal disturbances, headaches, palpitations, and chronic muscular tension were characterised as components of the aftermath rather than distinct health issues. One participant remarked, "I continually fell ill." "*My body could no longer endure*" (P6, p.12). Another articulated, "*It feels as though it has become entrenched within my body*." *My shoulders remain perpetually tense, as if I am still anticipating an impending event*" (P12, p.9). These accounts conceptualise the body as a repository of experience. What cannot be processed emotionally is manifested medically.

This underscores the analytical perspective that physical and mental wellbeing are interconnected rather than distinct entities. Distress was experienced as well. The body became the locus for the expression of unresolved emotional and moral tension, frequently long after the organizational circumstances that generated it had been redefined as "*over*."

Distinct patterned diversity was apparent among the conceptual categories. Surface Endurers are generally characterised by episodic aftershocks. Intrusions and physiological responses manifested, although participants frequently reported the ability to regain stability and maintain functionality. This steadiness, however, was not impartial. It necessitated constant self-regulation and initiative-taking

management. One participant stated, “*I can typically calm myself down*.” "*I reassure myself of my safety and persist*" (P14, p.6). In this context, recovery is not spontaneous. It is being worked on. Endurance persists, although at a price.

Fractured Endurers indicated a more persistent destabilisation. Aftershocks permeated work, home, sleep, and physical functions, influencing normal life instead than only disrupting it. A participant remarked, “*There is no longer an off switch*.” “*I remain anxious even in my own residence*” (P5, p.15). Another remarked, “*I ceased to perceive my house as a sanctuary*.” “*It trailed me incessantly*” (P1, p.10). The safety of these nurses was jeopardised. The boundary between clinical space and personal space disintegrated, resulting in an absence of an environment where the body could completely relax from alertness.

This variation does not indicate disparities in individual resilience or coping mechanisms. It conceptually indicated the saturation of the containment system categorised as Category 1 and the presence or lack of exterior holding structures. In instances when relational, organizational, or professional supports were partially preserved, episodic stability occasionally occurred. In areas where those supports had already deteriorated, aftershocks became ubiquitous.

The care setting further influenced the expression of aftershocks. Nurses in acute settings frequently reported intense, vivid sensory recollections associated with high-stakes occurrences, including alarms, rapid decline, and mortality. These accounts underscored urgency and intensity. Community nurses often articulated a subdued yet enduring apprehension that permeated normal care and domestic settings. Triggers manifested in commonplace streets, residences, and familiar interactions. A community nurse articulated, “*As I approach someone's front door, I experience a visceral apprehension, as if I am about to encounter yet another adverse circumstance”* (P10, p.18). The isolation of solitary work and restricted interaction with colleagues exacerbated this persistence, resulting in diminished opportunities for sharing, articulating, or processing experiences.

Aftershocks can be understood as an interconnected system of return, escalation, and saturation. Reliving transcends temporal limits and reconstructs the past within the present. Triggers tie distress to sensory and contextual specifics, disseminating trauma across daily existence. Hyperarousal designates the body as the principal locus of reactivation, necessitating perpetual attention. Sleep disruption impedes recovery and heightens susceptibility. Physical sequelae represent the enduring biological effects of prolonged mental and physiological stress. Collectively, these processes illustrate trauma not as a singular psychological occurrence, but as an embodied, temporal, and relational development influenced by prior experiences and the organizational and social contexts in which nurses persistently live and work.

Consequently, Category 2 signifies the resurgence of what was suppressed. It encapsulates the physical, sensory, psychological, and bodily reverberations of extended confinement. These aftershocks were not arbitrary occurrences. The repercussions were systematic outcomes of prolonged repression that exacerbated as the broader factors influencing nurses' working conditions went unresolved. **Table 5.2** below consolidates the identified core trauma aftershock mechanisms within this category and illustrates their impact on nurses' physical and mental wellbeing.

Table 5.2. Summary of Trauma Aftershock Mechanisms in Category 2: Physical and Psychological Trauma and Aftershocks

Trauma Aftershock Mechanism	Core Analytic Meaning	Illustrative Participant Extract	How the Mechanism Operates	Physical and Mental Wellbeing Consequence
Reliving events	Collapse of temporal boundaries where past clinical crises intrude into the present	*"I was just driving and suddenly I was back in that bay. I could hear the alarms again" (P3, p.9)*	Suppressed experience forces re-entry when conscious containment weakens	Intrusive memory, emotional flooding, loss of felt safety
Triggered reminders	Trauma encoded in sensory and environmental cues	*"Certain smells just take me straight back" (P7, p.8)*	Sensory cues bypass reflective processing and activate embodied memory	Heightened vigilance, avoidance, environmental distress
Panic and hyperarousal	Autonomic activation precedes conscious meaning making	*"My heart just started racing for no reason" (P5, p.11)*	Body reacts before cognition can contextualise threat	Physiological dysregulation, anxiety, exhaustion
Sleep disturbances and non-recovery	Sleep becomes the site where suppressed material resurfaces	*"I woke up gasping. It felt like I was back there again" (P2, p.6)*	Loss of daytime control enables involuntary processing	Chronic fatigue, emotional instability, impaired recovery

Physical sequelae and functional decline	Long-term bodily imprint of sustained emotional and physiological strain	*"I just kept getting ill. My body couldn't cope anymore" (P6, p.12)*	Prolonged hyperarousal and suppression accumulate somatically	Persistent illness, reduced functional capacity

Table 5.2 above illustrates that trauma aftershocks operated as a constant and embodied process rather than as a collection of distinct symptoms. The mechanisms combine and compound each other, exacerbating internal destabilisation and diminishing nurses' ability to recuperate. This synthesis substantiates the initial conceptual assertion of Category 2: that trauma manifested as a delayed result of extended repression, affecting the mind, body, and environment rather than occurring as a singular psychological response.

This category establishes the prerequisites for Category 3. Nurses, facing renewed trauma and physical aftershocks, sought comprehension, accommodation, or assistance from their Trust. Reports often indicated inconsistency, silence, or disagreement in the responses. Consequently, Category 2 concludes at the intersection of internal destabilisation and organizational process. The disparity between the recovery needs of nurses and the provisions made by organizations is fundamental to the conceptual synthesis emphasis of the subsequent category.

5.3 Category 3: Organizational Dissonance and Fragmentation

"Everything in My Surroundings Became Incomprehensible."

Category 3 conceptualises the organization as an active participant in nurses' experiences rather than merely a structural backdrop. The analytical focus here is not merely on the strain of organizational structures, but on the fact that nurses perceived their institution as internally inconsistent, relationally deficient, and ethically misaligned with the expectations imposed on them. Through constant comparison, organizational dissonance manifested as a systematic process that steadily undermined meaning, trust, and professional orientation.

Nurses reported operating in organizational situations that no longer provided interpretive stability. Leadership directives, guidance, and institutional communication did not offer a cohesive framework

for comprehending or legitimising practice. Nurses were compelled to interpret, reconcile, and internalise organizational inconsistencies. The internalization of organizational ambiguity signifies a crucial conceptual synthesis transition. Uncertainty transitioned from being regulated by the system to being internalized by the practitioner. According to Charmaz, the organization influences the conditions that shape actions and outcomes, rather than serving solely as the environment for experiences (Charmaz, 2014, pp. 126–128; pp. 132–136).

The dissonance was particularly detrimental because it did not manifest as a singular organizational failing. It arose from persistent discrepancies between verbal commitments and actual experiences, between assurances and feasibility, and between the responsibilities assigned to nurses and the support provided for their implementation. Nurses articulated the necessity of maintaining service operations while concurrently interpreting fluctuating organizational signals, resulting in an additional layer of effort alongside clinical responsibilities. They were engaged in activities beyond nursing. They were consistently converting organizational instability into practical application.

Directive Reality Incongruence as An Organizational Paradigm

Participants reported receiving instructions that were incongruent with the actual conditions of care, staffing, or workload. The dissonance was perceived not as an abstract irritation but as a daily clash between direction and actuality. A nurse articulated this through the cadence of perpetual alteration, "*Guidance varied daily*." One would enter with the belief that their actions were correct, only to be informed by the subsequent shift that they were erroneous" (P3, p.10). The conceptual relevance extends beyond mere perplexity. It constitutes the displacement of legitimacy. The organization fails to serve as a dependable professional reference, leaving nurses to determine what constitutes good practice without established guidelines.

Participants characterised unpreparedness not merely in technical terms, such as inadequate equipment, ambiguous infection prevention guidelines, or fluctuating protocols, but as a profound organizational and ethical disjunction. Nurses articulated their role as an intersection for addressing systemic deficiencies, illustrating how they "maintained cohesion" when institutional frameworks failed to offer protection, clarity, or ethical guidance. This trend was evident in narratives of exceeding physical boundaries, encompassing fear and anxiety to comfort patients and coworkers, and assuming accountability for decisions that ought to have been shared collectively. These experiences identify institutional failure not as an abstract organizational issue, but as a tangible reality experienced via the body and moral self, as nurses assumed the emotional and ethical burden of organizational deficiency. The findings indicated that preparation is a relational and ethical state, wherein the robustness or fragility of organizational support directly influenced nurses' perceptions of being safeguarded by the system or necessitated to function as its buffer.

This discrepancy was perceived as hazardous since it assigned accountability for outcomes to nurses while the organizational direction remained inconsistent. Nurses expressed a concern about potential retrospective judgement for judgements taken under uncertain instructions. The apprehensive anxiety of being held accountable was not separate from wellbeing. It exacerbated anxiety, heightened hypervigilance, and constrained the capacity for introspective practice. Organizational volatility compelled nurses to engage in continual justification efforts, necessitating the frequent defence and recalibration of their practices.

Communication was characterised as inconsistent, delayed, or fragmented between reports. Nurses expressed uncertainty on whose directives held authority and whether today's instructions would remain valid the following day. This compelled nurses to engage in a constant process of sensemaking, requiring them to assess both clinical necessity and organizational aim. Consequently, uncertainty evolved into a work condition rather than a transient interruption. Nurses were not merely functioning in upheaval. They were anticipated to normalise it.

This uncertainty work yielded discernible results. Participants reported increased cognitive load, exhaustion that extended beyond the physical realm, and a persistent sense of lagging behind organizational expectations. The corporate message was frequently perceived as an elusive aim. Nurses expressed a sense of perpetual inadequacy in performing the correct actions, as the meaning of "*right*" was fluid. This undermined confidence and created a widespread feeling of vulnerability, where correctness or incorrectness became a personal rather than an institutional risk.

The lack of leadership exacerbated this delegation of duty. Nurses did not merely observe that bosses were inaccessible. They viewed absence as a disengagement from the relationship. A participant remarked, “We never encountered our managers.” *It seemed as though we were abandoned to manage the situation independently”* (P7, p.9). The significance of this omission differed among the conceptual categories. Surface Endurers occasionally characterised leadership invisibility because of organizational overload and pressure. Fractured Endurers frequently perceived it as abandonment.

This distinction is significant as it illustrates how organizational behaviour was influenced by internal capacity. In contexts where nurses were already overwhelmed by the suppression and repercussions outlined in Categories 1 and 2, the absence of leadership was perceived as detrimental. It was established as evidence. The lack of visible leadership transformed the ethical framework of the workplace. In the absence of support, nurses forfeit not only practical guidance. They forfeit relational confinement. Participants expressed a sense of lacking upward accountability, absence of witnesses to the events, and no recognition of the gravity of their burdens. In these narratives, the silence of leadership became emotionally resonant. It exacerbated the divide between nurses and their institution, undermining confidence, especially as nurses endeavoured to recuperate while continuing to work.

Performative wellbeing further revealed this relationship divide. Nurses articulated an expanding disparity between organizational rhetoric and actual reality. A participant remarked, "*They consistently emailed regarding wellbeing, yet no one enquired about our actual condition*" (P10, p.14). This is not merely disappointment from a conceptual perspective. It indicates a transformation in the perception of care delivery within the organization. Wellbeing transformed into a symbol rather than a mutual exchange. Nurses were regarded as recipients of communication rather than collaborators in care.

This symbolic care was not perceived as harmless. In an environment where nurses were fatigued, physically drained, and psychologically unsettled, corporate communications regarding wellbeing could be perceived as insincere. It fostered the perception that wellbeing was being orchestrated as a narrative rather than executed as a responsibility. This intensified emotional fatigue as it necessitated that nurses maintain compassion and stability despite the perceived absence of institutional support. It indicated that the distress of nurses might be recognised verbally while going neglected in their circumstances.

Team fragmentation was the most immediate relational outcome of organizational dissonance. Teams operated not merely as functional entities but as venues for shared significance, informal support, and moral validation. Their disruption thus held conceptual importance beyond mere personnel or workflow considerations. A nurse stated, "*Our team was divided and dispersed*." "*You were uncertain about whom you could confide in any longer*" (P5, p.12). This story demonstrates how organizational restructuring disrupted relational continuity, eliminating the peer-based framework that had previously facilitated the negotiation of emotional pressure and ethical ambiguity.

Participants articulated how fragmentation altered the emotional quality of work. Acquainted colleagues were substituted by transient personnel, provisional redeployments, and fluctuating line management. The disruption of continuity impeded the sharing of experiences, fostered distrust in others' comprehension of events, and hindered the identification of informal avenues for reconciliation. Consequently, fragmentation converted communal resilience into personal hardship. Nurses assumed greater responsibilities precisely when internal resources were most exhausted.

Throughout these procedures, confidence was consistently portrayed as eroded rather than abruptly forfeited. Nurses did not explicitly identify a singular instance when trust was compromised. They characterised a progressive buildup of contradictions, omissions, and discrepancies that rendered corporate behaviour challenging to anticipate. Predictability is significant since it serves as a means of containment. When nurses are unable to predict the organization's actions, trust becomes contingent. Organizational dissonance can thus be understood as a misalignment in relational and moral dimensions through constant comparison. Nurses faced organizations that persisted in requiring professional dedication, adaptability, and resilience while retracting consistency, engagement, and

mutual care. This resulted in a structural asymmetry where obligation descended, while accountability and confinement did not ascend. The organization retained its ability to direct but diminished in its ability to retain authority.

This misalignment altered the way nurses positioned themselves in relation to their employment and the organization. Professional identity, once upheld by a collective corporate goal, now necessitates preservation in private or across disjointed peer networks. Organizational fragmentation did not merely exacerbate misery. It altered the ethical dynamics between nurses and the systems in which they operated. This reconfiguration is essential as it delineates the circumstances under which moral injury arises, not as an individual response, but as a resultant effect of prolonged organizational disengagement.

To reinforce this synthesis pattern, **Table 5.3** encapsulates the fundamental organizational processes recognised within this category and their conceptual implications for nurses' physical and mental wellbeing. Comprehensive code sets pertinent to this category are included in **Appendices**.

Table 5.3. Summary of Organizational Dissonance and Fragmentation Mechanisms in Category 3

Organizational process	Core analytic function	Illustrative participant extract	Conceptual consequence for physical and mental wellbeing
Policy instability	Displaces interpretive and ethical responsibility onto nurses	*"Guidance changed every day"* (P3, p.10)	Organizational authority experienced as incoherent, increasing anxiety, cognitive load, and moral exposure
Leadership invisibility	Converts managerial absence into relational withdrawal	*"We never saw our managers"* (P7, p.9)	Trust erosion and reduced psychological safety, with absence experienced as abandonment especially under saturated endurance
Performative wellbeing	Replaces reciprocal care with symbolic recognition	*"They kept emailing about wellbeing, but no one ever asked how we actually were"* (P10, p.14)	Emotional exhaustion and disillusionment as institutional care is experienced as rhetoric rather than responsibility

Team fragmentation	Removes collective meaning making and peer containment	*"Our team was split and scattered"* (P5, p.12)	Isolation and increased vulnerability, with endurance becoming individualised and harder to sustain
Loss of predictability	Normalises instability as a condition of work	*"You'd go in thinking you were doing the right thing and then be told it was wrong"* (P3, p.10)	Hypervigilance, reduced confidence, and ongoing exposure where nurses feel personally at risk for system instability

Table 5.3 above illustrates that organizational dissonance functioned as a relational process rather than a series of operational failures. These systems collaborated to transfer the responsibility of coherence, care, and ethical justification from the institution to individual nurses. Interpreted through Charmaz's focus on conditions and consequences, Category 3 illustrates how structural instability was internalised as emotional, cognitive, and ethical labour, influencing nurses' physical and mental well-being while transforming their relationship with their organization (Charmaz, 2014, pp. 126–128; pp. 132–136).

This conceptual shift is critical for the progression of the grounded theory developed in chapter 6. As organizational dissonance accumulated, nurses were increasingly required to reconcile professional values of care, safety, and responsibility with institutional practices experienced as misaligned or withdrawn. This tension establishes the moral terrain on which Category 4 is built. Moral suffering and ethical erosion do not arise solely from exposure to crisis. They arise through sustained participation in systems where nurses are required to hold what the organization does not.

5.4 Category 4: Moral Suffering and Ethical Erosion

"It Shattered Something Within Me."

Category 4 illustrates the stage at which the processes outlined in Categories 1 to 3 moves into a more profound type of injury, which participants consistently articulated in ethical rather than solely emotional terms. Nurses did not define themselves merely as upset, overburdened, or fatigued. They expressed feelings of moral compromise, ethical limitation, and a transformation in their self-perception as nurses. Moral suffering in this category is defined as a cumulative process arising from constant ethical constraints, repeated compromises, and a persistent lack of organizational recognition or remediation. In these circumstances, ethical discomfort remains unresolved. It consolidates and amasses, gradually undermining moral agency and professional identity.

In Category 1, suppression operated as regulated internal labour, while trauma aftershocks in Category 2 represented the physical manifestation of what had been endured. In Category 3, organizational dissonance undermined meaning, and trust. Category 4 illustrates the consequences of these pressures converging at the level of values. Nurses articulated a point where the primary inquiry shifted from their capacity to persevere to the compatibility of their assigned tasks with their fundamental beliefs about the essence of nursing. According to Charmaz, this category emphasises the influence of conditions on actions and outcomes across time, as well as the construction of meaning in the gap between nurses' commitments and the systemic obstacles they faced (Charmaz, 2014, pp. 126–128; pp. 132–136).

Participants recounted their experiences using the words of guilt, humiliation, compromise, and failure. These were not articulated as private sentiments apart from context. They constituted ethical evaluations regarding the individual and the system. One participant articulated the persistent burden of making care decisions in scarcity, remarking, "*Choosing who to see first still haunts me*" (P04, p.5). This haunting is not merely a recollection. It signifies an ongoing ethical obligation that remains unaddressed in the absence of organizational observation, recognition, or reparation. The determination lies with the nurse, even when the circumstances that led to it were systemic.

Moral Anguish as Impeded Ethical Action

Participants consistently articulated an understanding of the requirements for safe, compassionate, and ethically sound treatment, yet were obstructed from implementing it. This was not conveyed as situational irritation. It was perceived as a breach of professional ethics. A nurse stated, "*We lacked time for fundamental tasks, merely completing checklists*" (P06, p.7). This account indicates a transition from relational caring to procedural survival when moral activity is diminished to mere completion and compliance. The ethical transgression extends beyond the mere decline of standards. Nurses are perceived as the visual representatives of inadequate care, tasked with providing a diluted form of nursing while still bearing the obligation for the care patients ought to have received.

Significantly, obstructed ethical behaviour did not remain intermittent. Initial narratives frequently depicted isolated instances of ethical dilemma. Subsequent narratives depicted a widespread perception that compromise had transitioned from being an anomaly to a norm. Under constant pressure, the remarkable transformed into the mundane. Nurses articulated the experience of adapting to practices they did not initially perceive as exemplary care yet felt compelled to persist in these methods. This is the stage at which moral distress intensifies into moral residue, where unresolved ethical unease collects instead of dissipating (Jameton, 1984; Jameton, 1993; Epstein and Hamric, 2009).

A second repeating pattern involved the outcomes when nurses endeavoured to express ethical concerns. Participants in various contexts reported addressing concerns regarding safety, staffing, or

care quality, only to encounter deflection, minimisation, or social consequence. A participant in the focus group remarked, "*Questioning anything made you a troublemaker*" (FG1). This signifies the conversion of moral expression into organizational danger. The conveyed message was not merely that the worries were bothersome. Their upbringing jeopardised belonging, reputation, and relational security.

Silencing originally served as a form of protection. Nurses reported remaining silent to prevent conflict, maintain team cohesion, or ensure job security in challenging environments. Nevertheless, this protecting quiet incurred a price over time. When nurses consistently suppress moral concerns, they do not cease to care about ethical principles. They commence to bear interior afflictions. The internalization of silence redirected responsibility inward. Organizational failure was increasingly perceived as personal shortcoming, intensifying feelings of guilt and humiliation rather than fostering group accountability.

As compromise and suppression grew normalised, numerous participants articulated an increasing conflict between their self-perception as nurses and the nature of their profession. A nurse remarked, "*I felt like a robot, not a nurse*" (P05, p.6). This signifies a transition from moral distress to identity fragmentation. Ethical conflict now pertains to interconnected acts. It commences the redefinition of professional identity.

This identity disturbance manifested in the way nurses articulated their self-concept of care through ongoing comparison. Certain accounts exhibited language indicative of emotional detachment and constriction, when nurses articulated that diminishing their emotional investment was the sole means to maintain functionality. Others articulated a more significant fracture, wherein persisting under the same situations became incongruent with their moral self-conception. Surface Endurers often articulated a type of identity pressure that they navigated through distancing, comedy, or emotional detachment. Fractured Endurers frequently indicated a point at which moral coherence could solely be restored through retreat, redeployment, or exit. This was not presented as a lifestyle option. It was conveyed as a moral imperative.

Moral anguish in this category was not limited to ethical contemplation. It was consistently characterised as being physically transported. Participants associated insomnia, gastrointestinal disturbances, palpitations, chronic weariness, and physical tension with unresolved moral conflict. A nurse stated, "*My body never recuperated; even now, I am unable to sleep*" (P08, p.13). The body serves as the site of ethical conflict when organizational structures lack means for moral rectification. This perspective indicates that moral conflict is both contemplated and physiologically experienced, underscoring the relationship between physical and mental well-being in the way nurses sustain injury over time (Papathanassoglou et al., 2012; Rushton, 2018).

Table 5.4 below illustrates the systematic conceptual progression from initial moral anguish to profound ethical decay across the dataset. Comprehensive coding sets are included in Appendices.

Table 5.4. Example Analytic Trajectory in Category 4: From Moral Distress to Ethical Erosion

Analytic process	Illustrative extract	Memo based analytic insight	Patterned variation across groups and settings	Emergent conceptual meaning
Moral distress	*"Choosing who to see first still haunts me"* (P04, p.5)	Ethical pain is anchored in blocked action, not emotional overwhelm	Acute nurses described in the moment conflict, community nurses described delayed reflection	Value based distress rooted in constrained moral agency
Normalised compromise	*"We had no time for basics, just ticking boxes"* (P06, p.7)	Procedural survival replaces relational care	Faster in acute settings, slower and cumulative in community contexts	Ethical erosion through routinisation of unsafe practice
Silenced moral voice	*"You were a troublemaker if you questioned anything"* (FG1)	Silence becomes survival that undermines agency	Intensified where leadership was absent	Institutional shaping of moral muteness
Identity fracture	*"I felt like a robot, not a nurse"* (P05, p.6)	Self-concept is destabilised under sustained ethical conflict	Surface Endurers described strain, Fractured Endurers described rupture	Disruption of professional identity
Embodied moral harm	*"My body never recovered, even now I can't sleep"* (P08, p.13)	Moral conflict is carried somatically	Chronic in Fractured Endurers, episodic in Surface Endurers	Ethical strain becomes physiological burden

Desire for moral repair	*"We needed someone to say sorry, it never came"* (FG2)	Absence of acknowledgement deepens harm	Surface Endurers hoped for repair, Fractured Endurers interpreted abandonment	Blocked restitution and moral abandonment
Withdrawal and exit	*"I don't see a future here anymore"* (P11, p.10)	Exit becomes moral resolution, not a career move	Emerges earlier in Fractured Endurers	Moral disengagement from institution

Table 5.4 above indicates that moral distress was not static. Nurses frequently commenced with a distinct moral compass and articulated the anguish of recognising patients' needs while being obstructed from fulfilling them. Over time, their vocabulary transitioned from articulating moral conflict to delineating moral injury. The transition intensified as corporate constraints consistently obstructed ethical actions, normalised harmful practices, and provided minimal recognition or remediation. Thus, what commenced as moral discomfort evolved into moral residue that compounded and increased, especially when nurses were burdened with ethical repercussions without organizational acknowledgement (Jameton, 1984; Jameton, 1993; Epstein and Hamric, 2009; Hamric and Epstein, 2017).

Table 5.5 below consolidates the fundamental mechanisms within this category, summarising the essential processes via which moral anguish accumulated and ethical disintegration ensued.

Table 5.5. Summary of moral suffering mechanisms in Category 4

Mechanism	**Core analytic meaning**	**Illustrative extract**	**How the mechanism operates**	**Physical and mental wellbeing consequence**
Blocked ethical action	Knowing what care requires while being prevented from delivering it	*"We had no time for basics, just ticking*	Values are repeatedly constrained, care	Guilt, frustration, moral residue

		boxes" (P06, p.7)	becomes compliance	
Silencing and sanction	Speaking up is reframed as being difficult, negative, or disloyal	*"You were a troublemaker if you questioned anything"* (FG1)	Moral voice is suppressed to preserve safety and belonging	Reduced moral agency, shame, isolation
Internalisation of failure	System failure is absorbed as personal inadequacy	*"Choosing who to see first still haunts me"* (P04, p.5)	Responsibility remains with the nurse when the organization does not acknowledge harm	Persistent guilt, rumination, self-blame
Identity fracture	Professional selfhood destabilised through repeated compromise	*"I felt like a robot, not a nurse"* (P05, p.6)	Nurse identity becomes misaligned with lived practice	Emotional exhaustion, loss of professional confidence
Embodied moral harm	Ethical strain carried physiologically over time	*"My body never recovered, even now I can't sleep"* (P08, p.13)	Moral conflict becomes stored and expressed in the body	Insomnia, fatigue, somatic tension, reduced recovery
Blocked repair	Need for acknowledgement and apology remains unmet	*"We needed someone to say sorry, it never came"* (FG2)	Lack of restitution deepens harm and finalises rupture	Disillusionment, withdrawal, reduced belonging
Moral withdrawal	Stepping back, disengaging, or exiting becomes morally coherent	*"I don't see a future here anymore"* (P11, p.10)	Withdrawal protects moral self when repair is absent	Emotional detachment, career change, exit

Integrating these mechanisms, Category 4 signifies the point at which endurance becomes ethically untenable. Emotional repression diminished opportunity for immediate moral evaluation. Aftershocks of trauma diminished healing capacity. Organizational dissonance eradicated stability, coherence, and

relational containment. Collectively, these circumstances created a moral environment in which nurses were consistently compelled to contravene their professional principles without recognition, rectification, or substantial organizational response. Moral suffering arises not as an individual psychological response but as a relational and institutional phenomenon influenced by the interplay of ethical commitment and organizational disengagement (Fourie, 2015; Dean et al., 2019; Williamson et al., 2020; Greenberg et al., 2020; Billings et al., 2021).

When participants articulated their experience of shouldering guilt, compromise, and ethical duty in isolation, they ceased to recount organizational challenges. They were recounting the ethical disintegration in the nurse-institution relationship. The organization was no longer perceived as a high-pressure system. It was perceived as an entity that had neglected its mutual duty to safeguard, recognise, and nurture those who upheld it. This interpretive shift gives rise to the central category, Institutional Betrayal and Organizational Abandonment, which serves as the unifying conceptual synthesis framework that connects suppression, trauma aftershocks, organizational fragmentation, and moral erosion into a singular, coherent explanation (Smith and Freyd, 2013; Charmaz, 2014, pp. 126–128; pp. 132–136).

5.4.1 Synthesis of Cross-Category Subcategories and Conceptual Enhancement

This section conceptualizes the subcategories of the four categories as dynamic mechanisms rather than fixed components. In alignment with Charmaz's focus on conditions, actions, and consequences, I regard subcategories as processes that traverse categories, accumulate over time, and transform nurses' experiences of their work, their bodies, and their ethical relationship with their organizations (Charmaz, 2014, pp. 225–244). This synthesis serves as the conceptual link between category-level discoveries and the development of the core category.

The subcategories function as an interrelated regulatory system rather than as parallel threads, encompassing return, misalignment, and moral consequence. Regulatory processes in Category 1 dictate the magnitude and frequency of aftershocks in Category 2. Organizational processes in Category 3 determine whether these aftershocks are mitigated or exacerbated. Moral processes in Category 4 delineate the interpretation of this accumulation concerning values, identity, and institutional relationships. What emerges is not a linear trajectory but a recursive pattern wherein organizational conditions cyclically infiltrate nurses' internal realms and are perpetuated through physical, relational, and ethical endeavours.

Within the dataset, the subcategories of Category 1 served as regulating mechanisms that stabilised professional performance by redistributing pressure onto the nurse. Emotional and physical suppression, temporal deferral, professional masking, somatic signalling, and emotional numbing functioned as an integrated system of internal labour that enabled clinical work to continue despite ongoing demand and uncertainty. Within this study, somatic signalling refers to the ways physical

symptoms such as exhaustion, pain, headaches, sleep disturbance, bodily tension, and functional depletion functioned as embodied indicators of accumulated psychological, emotional, and organizational strain. Similarly, professional masking reflected participants' descriptions of continuing to appear composed, capable, and emotionally controlled in clinical environments despite experiencing significant internal distress. The internalisation of these pressures is evident in participants' descriptions of physical override and deferred processing, shown by statements such as, "*My body was telling me to stop, but you don't get to listen*" (P6, p.12) and "*I kept saying I'd deal with it later*, *but later never came*" (P2, p.5). These accounts analytically position the nurse as the site where organizational instability became absorbed, carried, and expressed through the body over time.

The subcategories of Category 2 delineate the return channels of this internalised strain. The reliving of events, triggered recollections, terror and hyperarousal, sleep disturbances, and physical repercussions did not manifest as independent phenomena. They manifested as deferred repercussions of prior regulatory efforts. What was suppressed re-emerged through the body and senses, hindering rehabilitation. Participants often reported physiological activation prior to interpretation, exemplified by statements such as "*My heart just started racing for no reason*" (P5, p.11), subsequently followed by the identification of a sensory or environmental stimulus. This arrangement is analytically important. It establishes the body as the principal locus of reactivation, with meaning emerging after arousal rather than guiding it.

In Category 3, subcategories including conflicting policy signals, leadership invisibility, performative wellbeing, and team fragmentation functioned as contextual amplifiers. They determined whether internal destabilization was mitigated by organizational containment or exacerbated by organizational disengagement. Policy instability, for instance, transferred interpretative and ethical responsibilities downward, necessitating that nurses internalise organizational ambiguity. This is documented in the account: "*Guidance changed daily… you would enter believing you were acting correctly, only to be informed by the subsequent shift that it was incorrect*" (P3, p.10). Organizational incoherence was analytically converted into individual moral danger.

The Category 4 subcategories delineated the interpretative and ethical ramifications of this accumulation. Guilt, diminished standards, erosion of professional identity, suppressed moral voice, and prolonged moral coping illustrated how persistent ethical constraints were increasingly perceived as self-harm rather than situational challenges. The assertion "*I felt like a robot, not a nurse*" (P5, p.6) signifies a transition from a conflict regarding one's actions to a disruption in the comprehension of one's identity.

Collectively, these moves demonstrate that subcategories do not remain restricted within categories. They traverse analytical dimensions, connecting internal regulation to embodied outcomes, organizational context, and ethical stance. This mobility enables them to serve as the connecting tissue

of the conceptual framework rather than as mere descriptive subdivisions. Mapping these mechanisms across the two categories enhances their conceptual validity by demonstrating how identical processes function under varying settings of organizational and relational constraints.

For Surface Endurers, the mechanisms often operated as regulated systems. Temporal deferral remained tentative rather than disintegrating. Sensory and relational stimuli were frequently episodic rather than ubiquitous. Silencing functioned as a deliberate strategy rather than a forced circumstance. Identity strain was described as exhaustion, detachment, or less emotional engagement rather than a rupture. Embodiment was characterised by episodic symptoms and partial healing instead of constant deterioration. This pattern indicates the ongoing existence of external scaffolding, such as leadership visibility, team continuity, or informal relationship support, which enabled internal regulatory systems to function, albeit at a cost.

For Fractured Endurers, the identical processes were saturated. Postponement deteriorated into continual interference. Triggers become pervasive in both professional and personal settings. Silencing transitioned from a strategy to a limitation. Identity strain evolved into identity fracture. Embodiment transitioned from indicating thresholds to documenting prolonged physiological deterioration. This variation does not indicate differences in individual endurance or coping ability. It illustrates disparities in the accessibility and resilience of organizational and relational confinement.

In the absence or withdrawal of leadership presence, team cohesion, and institutional recognition, internal regulatory mechanisms and sense-making were compelled to assume a burden beyond their capacity. This comparison substantiates a fundamental synthesis assertion of the study: these processes are not confined only to people. They are allocated among organizational, relational, and ethical frameworks. When those systems deteriorate or recede, the responsibility for sustaining coherence, safety, and ethical direction shifts to individual nurses, heightening the probability of saturation and fragmentation.

Table 5.6. Cross-Category Subcategory Integration Map

Subcategory mechanism	Analytic function	Appears in Category	Surface Endurers	Fractured Endurers	Cross-category analytic contribution
Temporal deferral and delayed processing	Postpones emotional and ethical engagement to maintain	1, 2, 3, 4	Managed postponement that supports continued functioning	Collapse of deferral into persistent intrusion and moral residue	Shows how unresolved strain accumulates in the absence of

	professional functioning				organizational acknowledgment
Sensory and relational triggering	Reactivates past harm through environmental and institutional cues	2, 3, 4	Episodic reactivation linked to specific cues	Ubiquitous reactivation across spaces and organizational encounters	Demonstrates how systems and environments become saturated with reminders of harm
Silencing and containment of voice	Regulates emotional and ethical expression	1, 3, 4	Strategic self-silencing to remain operational	Enforced muteness and loss of moral agency	Reveals institutional shaping of silence as a relational and ethical condition
Identity strain and self-disruption	Alters professional self-concept under sustained conflict	1, 2, 3, 4	Distancing and fatigue without full rupture	Identity fracture and disengagement	Shows how organizational misalignment reshapes professional belonging
Embodiment and somatic inscription	Translates organizational and moral strain into physical experience	1, 2, 3, 4	Episodic symptoms with partial recovery	Chronic decline and non-recovery	Makes visible how harm is carried physically when relational containment fails

Table 5.6 above illustrates that subcategories operate as an interconnected conceptual system rather than as separate components. Their agreement across categories indicates a systematic progression from internal control to embodied destabilisation, then to organizational contradiction, and ultimately to moral rupture.

Establishing a relationship between these mechanisms enhances the conceptual framework beyond just descriptive connection. A discernible patterned organizational and relational condition emerges, wherein nurses consistently characterise themselves as enduring the repercussions of instability, inconsistency, and ethical tension, lacking reciprocal recognition or remediation.

Emotional suppression, physiological regulation, ethical compromise, and relational silence are interdependent phenomena. They create an interdependent structure that influences nurses' professional efficacy while managing evolving directives, disjointed teams, and limited ethical agency. These processes function at various analytical levels. What starts as internal regulation transforms into embodied destabilisation. What seems to be an organizational contradiction manifests as a moral conflict. What is originally governed by remoteness and postponement becomes increasingly challenging to control.

This synthesis corresponds with Charmaz's focus on creating an explanatory framework that connects conditions, actions, and outcomes, rather than compiling a thematic inventory (Charmaz, 2014, pp. 303–306). This study identifies organizational inconsistency, leadership absence, and fragmented relational structures as the prevailing conditions. The actions consist of nurses' emotional regulation, bodily override, suppression of ethical concerns, and redefinition of professional identity. The repercussions manifest as persistent patterns of trauma aftershocks, physical deterioration, disillusionment, and ethical anguish across the dataset.

An essential conceptual discovery at this stage is the temporal directional shift of these systems. Processes that initially serve to maintain professional efficacy gradually become detrimental. Emotional suppression transitions to desensitisation. Triggers extend beyond stimuli to permeate daily surroundings. Silence transitions from a strategic option to an ethical obligation. Identity strain escalates into identity disruption. Embodiment transitions from indicating constraints to acknowledging prolonged physiological strain. This directionality illustrates not only the occurrences but also the alterations in processes under extended organizational and relational conditions.

At this stage of synthesis alignment, a common pattern emerges across emotional, physical, organizational, and ethical domains. Participants consistently characterised themselves as bearing the repercussions of organizational inconsistency without adequate mechanisms for acknowledgement, remediation, or containment. The conceptual significant aspect here is not merely a singular organizational failure, but rather a relational condition wherein the responsibility for managing harm, uncertainty, and ethical tension is consistently shifted onto individual nurses.

This pattern emerged solely when subcategories were analysed in relation to one another rather than as components confined to their respective categories. Temporal deferral, sensory and relational triggering, suppression of moral voice, identity disruption, and embodied strain emerged throughout the dataset as interconnected processes rather than discrete outcomes. Together, they unveiled a persistent organizational and relational dynamic wherein nurses perceived themselves as shouldering issues unaddressed by the institution.

This convergence signified a transition in the conceptual endeavour from delineating patterned variation within categories to formulating a cohesive analytical framework that could elucidate the

organization of these processes throughout the dataset. The central conceptual inquiry shifted from identifying the most prominent mechanisms to examining the institutional and relational conditions that could feasibly connect their co-occurrence and persistence.

At this point, the core category was developed. Instead of originating from a singular category, it emerged from the systematic alignment of subcategory mechanisms across emotional, physical, organizational, and moral domains. The core category serves as an integrative conceptual framework that organizes the four categories through a central relational process based on constant comparison, memo-based inquiry, and reflexive conceptual judgement (Charmaz, 2014). This section lays the conceptual synthesis groundwork for the formal presentation and theoretical advancement of the core category, transitioning from analytical construction to theoretical integration and conceptual contribution.

5.5 Core Category: Institutional Betrayal and Organizational Abandonment

"We Were Left to Carry Everything Alone."

The core category, Institutional Betrayal and Organizational Abandonment, encapsulates the fundamental conceptual process that synthesises and elucidates nurses' experiences across the four categories. This section elucidates how nurses interpreted the internal labour of physical and emotional suppression, the delayed trauma manifested as aftershocks, the organizational contradictions influencing daily work, and the resultant cumulative moral suffering, all through a

shared institutional and relational framework. It became conceptually evident that the challenges of employment and harsh conditions were compounded by organizations increasingly perceived as neglecting their reciprocal obligations of protection, ethical stewardship, and care for individuals providing therapeutic services.

Participants across the dataset articulated a noticeable interpretative shift in their comprehension of their relationship with their NHS organization. The organization was no longer regarded as merely overstretched or unable to meet unprecedented demand. It was reinterpreted as absent, disinterested, or complicit in the harm inflicted by nurses. This transition is apparent in statements such as "*They abandoned us to manage on our own*" (P03, p.8), "*We were sacrificed to sustain the system*" (P10, p.9), and "*There was no one safeguarding us, either physically or emotionally*" (FG2). These assertions serve as relational evaluations rather than operational grievances. They express a perceived violation of the ethical and institutional link between nurses and their organization.

This signifies the moment when organizational tension is redefined as institutional violation. Nurses articulated a reversal of the caring contract they perceived as vital to their professional existence. They expected their organization to offer not only information and procedural guidance but also a visible presence, ethical leadership, and recognition of harm. Instead, they faced fragmentation, quiet, and symbolic gestures perceived as disconnected from actual experience. This category serves as a fundamental explanatory framework for understanding the factors that compromised nurses' physical and mental wellbeing in the context of Constructivist Grounded Theory. The harm was not exclusively linked to the pandemic context, but also to the organizational withdrawal that accompanied it and to the interpretations nurses formed seeing that separation as betrayal and abandonment (Charmaz, 2014, pp. 225–244; pp. 303–306).

Figure 5.1 Integrated Core Category Model: Mapping Pathways to Institutional Betrayal and Organizational Abandonment

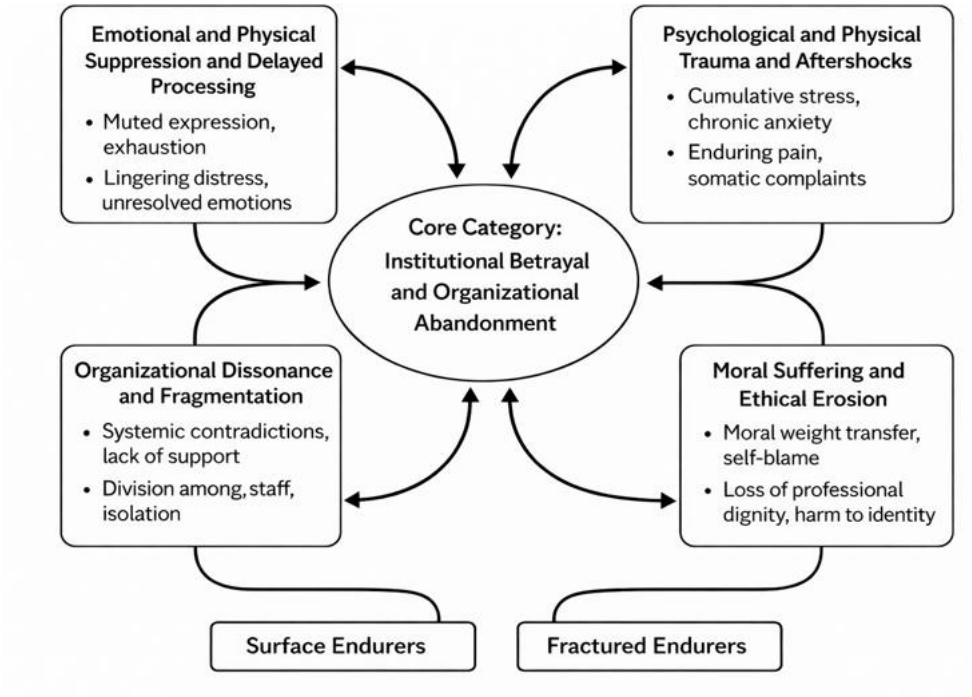


Figure 5.1 illustrates the interconnections among the four categories, culminating in the central category of Institutional Betrayal and Organizational Abandonment. The figure demonstrates that the process accumulates over time through recurrent encounters across various health care settings and stages of the pandemic, rather than attributing it to a singular organizational shortcoming.

The visual commences with Physical and Emotional Suppression and Delayed Processing when nurses articulate the necessity of restraining physical manifestations and emotions to maintain their professional duties. Subsequently, it addresses Physical and Psychological Trauma and Aftershocks, illustrating how repressed experiences frequently resurface later as intrusive recollections, sleep disturbances, and physical distress.

Organizational dissonance and fragmentation underscore shifting policies, ambiguous leadership, and disjointed teams that exacerbate uncertainty and diminish trust, whilst moral suffering and ethical erosion encapsulate the ethical burden of assuming responsibility without sufficient support.

Surface Endurers and Fractured Endurers, were influenced by organizational protection levels and cumulative exposure, and demonstrating varying methods by which nurses either persevered or disengaged from their professional roles under constant stress.

5.5.1 Properties and Dimensions of Institutional Betrayal

As I progressed methodically through transcripts, focus group discussions, and analytical notes, it became evident that institutional betrayal was not represented in the data as a singular organizational failure, occurrence, or policy decision. Rather, it was established as a relational fracture between nurses and the institutions upon which they relied for safety, legitimacy, and ethical foundation. Through constant comparison, what previously seemed like separate traits were honed into four interconnected aspects of organizational abandonment. These dimensions did not function independently. They converged, intermingled, and strengthened one another, transforming nurses' perceptions of their work, their physicality, and their professional identities throughout time.

Nurses did not characterise unsafe staffing, inconsistent infection control, or inadequate resources as just technical or logistical issues. They characterised these instances as relational breaches. The conceptual transition transpired when organizational guarantees of safety were perceived as performative rather than protective. What was retracted was not merely material protection, but also institutional credibility.

A participant articulated this breach concisely: "*They claimed PPE was adequate, yet they were not the ones exposed*" (P06, p.9).

The injury is both interpretative and physical in this account. The assertion characterises the organizational voice and frontline realities as ethically discordant. Nurses must advocate for their own safety rather than relying on the institution to provide it. This dimension was linked to a redefinition of value throughout the dataset. When protection was regarded as lacking or diminished, participants expressed a sense that their risk, and consequently their life, were subject to negotiation inside organizational decision-making. This signifies a transition from organizational oversight to individual vulnerability.

Emotional abandonment manifested not as an isolated incident of neglect, but as a gradual accumulation of absence. In my memo synthesis, I identified a consistent pattern characterised by restricted emotional expression, a physically and symbolically detached leadership, and wellbeing programs perceived as rhetorical rather than relational. Participants characterised an environment where discomfort might be recognized theoretically but not effectively managed in practice.

Nurses consistently articulated a division between being regarded as operationally indispensable and being emotionally overlooked. The absence exacerbated the suppression mechanisms observed in Category 1, as emotional demands were addressed privately instead than relationally. Over time, this absence facilitated the intensification of aftershocks in Category 2, due to the scarcity of institutional venues for processing, legitimising, or collectively addressing experiences. Emotionally, abandonment serves as a circumstance that transforms individual coping mechanisms into a persistent internal burden.

A notable and profoundly significant aspect, especially apparent among Fractured Endurers, was moral abandonment. Nurses reported being compelled to provide substandard care while organizational stakeholders either normalised, rationalised, or remained silent regarding the ethical implications of such concessions. This was perceived not as a series of moral dilemmas, but as ethical seclusion.

One participant articulated this as a diminishment of self rather than a failure of circumstance: "*You lose yourself to maintain the system*" (P07, p.6).

The emphasis on findings transitions from the behaviours imposed on nurses to the implications of those activities on their permitted identities. Moral abandonment was defined as the lack of institutional recognition that ethical harm had transpired. Nurses reported bearing moral residue in isolation, devoid of acknowledgement, remorse, or restitution. Over time, this led to identity fragmentation, as professional principles were perceived as incongruent with organizational practices.

Collectively, nurses' physical well-being, emotional states, ethical assessments, and professional identities lacked mutual institutional safeguarding. Betrayal was thus not perceived as a mere act of neglect, but as a constant relational state engendered by organizational silences, absences, and changes in duty. These factors transformed not only nurses' perceptions of their institutions but also their self-perception within those institutions.

By including conceptual and analytic memoranda with cross-category comparisons, institutional betrayal emerged not merely as an experience, but as a process manifested through persistent organizational mechanisms. These systems functioned quietly and subtly. They employed repetition, subtlety, and normalisation to gradually shape nurses' emotional, ethical, and practical realities. Identifying these strategies enhances the conceptual narrative by elucidating the production of betrayal, rather than only conveying its emotional experience.

Conflicting policies, fluctuating instructions, and uneven communication were previously described as reasons of uncertainty. Through constant comparison, they assumed an alternative synthesis significance. Instability served as a mechanism of organizational detachment. Nurses reported being in a perpetual state of recalibration when direction shifted abruptly or was inconsistent.

This continual modification constrained the opportunity for challenge or collaborative understanding. Efforts were focused on maintaining operations rather than evaluating the strategic direction. Thus, contradiction functioned as a mechanism that perpetuated dispersed organizational power and disguised accountability. Abandonment was normalised not by overt departure, but by the lack of reliable reference points that could be held accountable.

5.5.2 Leadership Through Absence: Silence Perceived as Disposability

Leadership invisibility has become one of the most powerful forms of betrayal. Participants regarded leaders as inaccessible. They characterised the interpretation of absence as a relational assessment. The absence of visibility, auditory acknowledgement, or bodily presence was perceived as an indication that their distress did not merit institutional consideration.

This absence exacerbated identity fragmentation for Fractured Endurers specifically. In the absence of visible leadership to observe, recognise, or address moral complexity, nurses reported feeling diminished to mere functional units rather than esteemed professionals. Silence functioned not as neutrality, but as a kind of communication. It communicated a sense of disposability.

5.5.3 Symbolic Assistance: Care Delivered Without Actual Provision

Wellbeing efforts were often regarded as symbolic rather than substantive. Posters, emails, campaigns, and occasional check-ins communicated a semblance of concern without providing relational or structural support. Participants characterised this as organizational theatre, wherein acknowledgement was provided without safeguarding, and apprehension was articulated without substantive response.

This strategy exacerbated betrayal by invoking care while simultaneously withholding it. The disparity between organizational messaging and actual experience intensified rather than alleviated moral unease. One participant in a focus group remarked, "*They claimed to care, yet no tangible changes occurred*" (FG2). Symbolic support served to preserve institutional image while the frontline load remained unaltered.

Collectively, these methods establish institutional betrayal as a structural and social phenomenon, rather than a mere accident, oversight, or communication failure. They were entrenched in organizational frameworks that emphasised service continuity, superficial stability, and distributed responsibility rather than enduring presence, ethical accountability, and mutual caring.

This mechanistic account enhances the explanatory capacity of the core category by illustrating how nurses were not only subjected to challenging circumstances but were also consistently compelled to internalise, understand, and endure those conditions. Emotional suppression, physical hardship, ethical compromise, and relational quiet did not arise in isolation. Nurses were moulded and burdened by organizational procedures that caused them to internalise the repercussions of systemic strain.

5.5.4 Patterned Variation: Surface Endurers and Fractured Endurers

The core category did not present as a consistent experience throughout the sample. By consistently comparing interviews, focus group discussions, and analytical memoranda, I developed two conceptual categories, Surface Endurers and Fractured Endurers, to illustrate the systematic differences in how nurses managed institutional betrayal and organizational abandonment. These classifications do not represent personality types, coping mechanisms, or result categories. They

denote relational situations influenced by cumulative exposure, organizational context, accessible assistance, and the constraints of physical and ethical capabilities.

The distinguishing factor among these groupings is not the occurrence of betrayal, but rather the duration and nature of its absorption prior to the disruption of professional functioning, identity coherence, or physical and psychological stability.

Surface Endurers reported persisting in their work, frequently for prolonged durations, under conditions they acknowledged as contradictory, hazardous, or ethically incongruent. Their accounts reflected the normalisation of organizational disengagement as a standard practice, along with deliberate methods for emotional management, moral confinement, and external composure.

One participant characterised this subdued internalisation of stress as a professional obligation: "*You simply maintain composure and complete the shift*." "*That is your action*" (P02, p.6).

This indicates the continued application of the regulatory procedures specified in Categories 1 and 3. Suppression, deferral, and professional concealment continued to operate effectively. Policy conflicts were justified rather than challenged. The absence of leadership was perceived as pressure rather than neglect. The discourse surrounding wellbeing was regarded as shallow yet acceptable.

The breakdown was frequently characterised as episodic and secretive. Participants described instances of emotional inundation, fatigue, or retreat occurring outside the clinical environment, subsequently followed by a resumption of outward functioning. This pattern indicates that organizational and relational scaffolding, like peer support, team continuity, or informal validation, remained somewhat intact. These supports did not eliminate harm, but they postponed saturation.

For Surface Endurers, identity strain was predominantly described as distancing rather than rupture. Nurses articulated concepts such as "*stepping back*," "*diminished emotional investment,"* or "*maintaining professionalism*" instead of interrogating their role within the nursing profession. This positions Surface Enduring as a regulated tolerance to organizational conditions rather than merely an absence of damage.

Fractured Endurers indicated arriving at a point where internal and relationship confinement become untenable. Their narratives were characterised by ongoing aftershocks, enduring medical ailments, and heightened moral dilemmas that permeated both professional and personal environments.

One participant expressed this disintegration of coherence in relation to identity rather than exhaustion: "*I didn't recognise myself anymore*." "*I was not the nurse I believed myself to be*" (P09, p.11).

The conceptual synthesis emphasis transitions from the persistence of conditions to the interruption of self-perception. Suppression ceased to operate as regulation and instead became a means of emotional numbness. Triggers become ubiquitous rather than episodic. Silence transitioned from a strategic

option to an enforced limitation. Participants expressed a sense of entrapment between ethical obligations and organizational practices, with no feasible means to reconcile the two.

Withdrawal, prolonged illness leaves, redeployment, emotional detachment manifested not as career choices, but as responses for relational and moral survival. For these participants, continued presence in the same organizational setting was perceived as detrimental to physical and psychological wellbeing, and moral identity.

Both cohorts were subjected to analogous organizational settings, encompassing policy volatility, leadership obscurity, symbolic wellbeing, and disjointed teams. The conceptual contrast is not in commitment, resilience, or professional principles, but in the accessibility and longevity of external confinement.

In contexts where leadership presence, peer continuity, and institutional recognition were somewhat present, internal regulatory mechanisms remained operational for an extended period. In the absence or withdrawal of these circumstances, the responsibility of managing organizational strain was predominantly transferred to the individual nurse, heightening the risk of burnout and breakdown.

This systematic variation reinforces the fundamental category by demonstrating that institutional betrayal is not perceived as a singular threshold event. It is assimilated, mediated, and ultimately surpassed in manners that adhere to identifiable and systematic pathways influenced by organizational context rather than personal inclination.

5.5.5 Institutional Betrayal as the Central Organizing Process

Institutional Betrayal and Organizational Abandonment serve as the central organizing mechanisms linking emotional, physical, organizational, and moral consequences rather than allowing them to build independently.

Throughout the dataset, individuals uniformly articulated a transformation in their comprehension of the origin of their distress. What commenced as reactions to crisis situations was subsequently perceived as reactions to organizational disengagement. Harm was no longer confined to the pandemic context, but rather in the manner institutions addressed nurses' vulnerability, risk, and ethical strain.

This transition is reflected in the participants' interpretive expressions: "*We were serving the system, but the system was not serving us*" (FG2), and "*They abandoned us, then blamed us for the consequences*" (P04, p.7).

This signifies a change in the construction of meaning. Distress transforms into bewilderment. Fatigue leads to moral degradation. Suppression transforms into relational disintegration. The nurse-organization connection is characterised as asymmetrical, with commitment, flexibility, and

endurance directed downward, but protection, acknowledgement, and accountability do not reciprocate.

Betrayal did not manifest in the data as a singular policy decision, leadership failure, or crisis moment. It was developed as a cumulative process resulting from recurrent organizational silences, inconsistencies, and transfers in responsibilities. Every category provides an essential aspect to this process.

Physical and emotional suppression, along with delayed processing, illustrates how organizational strain is internally managed through bodily and emotional regulation, enabling services to persist while transferring the burden onto the nurse.

Physical and Psychological Trauma and Aftershocks illustrate how the costs of displacement manifest over time as intrusive memories, physiological dysregulation, sleep disturbances, and physical deterioration.

Organizational dissonance and fragmentation illustrate how instability, leadership invisibility, and symbolic care eliminate relational containment now when vulnerability is most pronounced.

Moral Suffering and Ethical Erosion illustrates how persistent ethical limitations and silence transform professional identity, moral agency, and sense of belonging.

These processes collectively demonstrate that organizational disengagement is experienced not simply emotionally or cognitively, but also physically, morally understood, and relationally lived.

What is evident in the data is the way institutional betrayal redefined nurses' perceptions of their value and obligations. Participants articulated their role as crucial to system operation, while concurrently found themselves responsible for managing risk, harm, and ethical implications independently.

This resulted in a persistent inversion. Organizational failure was internalised as personal deficiency. Structural strain manifested as self-blame. The ethical compromise transformed into an individual encumbrance instead of a shared or institutional issue. This synthesis demonstrates that betrayal functions not merely through a lack of support, but also through the transfer of physical, moral, and emotional labour from the organization to the individual.

The differentiation between Surface Endurers and Fractured Endurers elucidates the progression of this process throughout time. For certain individuals, organizational and relational scaffolding postponed saturation, enabling professional performance to be sustained through distancing, rationalisation, and intermittent recovery. For some, the removal of such structures hastened disintegration, resulting in enduring repercussions, identity fragmentation, and disengagement from practice.

This predictable diversity illustrates that betrayal is not a homogeneous experience, but a systematic process with identifiable trajectories influenced by exposure, context, and confinement rather than by individual character or coping ability further illustrated in **Figure 5.2** below.

Figure 5.2 Conceptual Structure of Institutional Betrayal and Organizational Abandonment

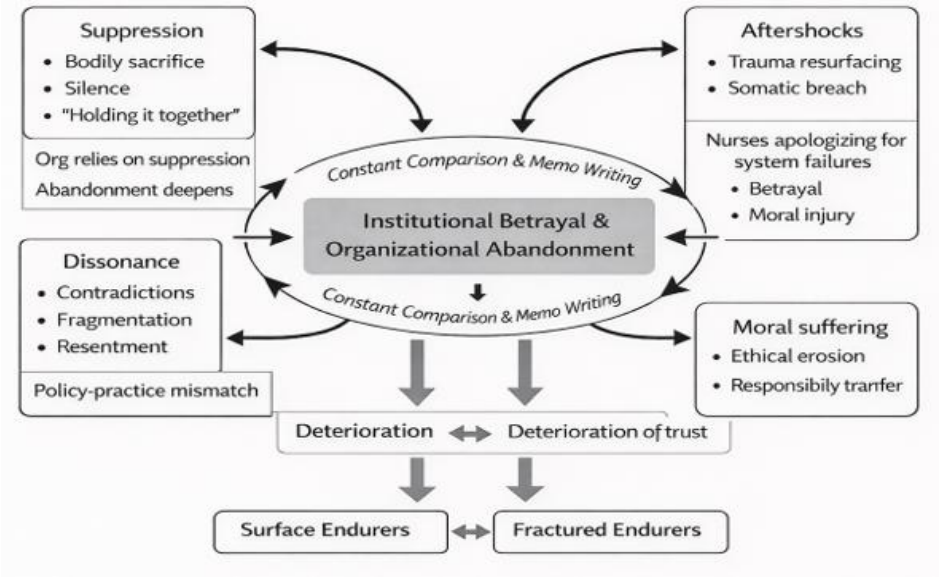


Figure 5.2 depicts the ultimate conceptual synthesis of the findings and demonstrates the way the four principal categories function as converging paths leading to the core category, Institutional Betrayal and Organizational Abandonment. In accordance with Constructivist Grounded Theory, the model illustrates an interactive system of processes rather than a linear sequence, developed through constant comparison across interviews, focus groups, contexts, and temporal points (Charmaz, 2014).

The concept illustrates how organizational pressure is frequently internalised, as nurses cope with stress via suppression and deferred processing. This tension re-emerges over time as trauma aftershocks, experienced physically, emotionally, and through memory and sensation. Organizational dissonance and fragmentation weaken transparency, trust, and relational support, heightening vulnerability, while moral pain signifies the ethical burden of being continually compelled to act contrary to professional values.

Surface Endurers sustain external functionality via self-regulation and minimal peer support, while Fractured Endurers ultimately find such practices ineffective, resulting in withdrawal, instability, or strain on their professional identity. The structure integrates emotional, physical, organizational, and moral processes into a cohesive conceptual structure that illustrates the convergence and divergence of nurses' experiences during and after COVID-19.

5.5.6 Connecting the Core Category to Theoretical Integration

The core category brings the four categories together as a shared account of how nurses' experiences unfold over time. Through this lens, Institutional Betrayal and Organizational Abandonment helps explain why these patterns continue and deepen, and why they are felt not only as pressures of the moment but as challenges to nurses' sense of professional identity and personal integrity.

The distinction between Surface Endurers and Fractured Endurers further clarifies this account. These trajectories do not point to differences in individual character, but to differences in how organizational and relational support shape the pace and direction of strain across settings and over time. Chapter 6 carries this account forward by bringing these relationships into a formal theoretical model, where the categories, groupings, and core process are drawn together within an explicit conceptual structure.

5.7 Implications of Findings

Implications for Understanding Physical Wellbeing

The finding indicate that physical wellbeing cannot be defined solely by the presence or absence of disease. It should be recognised as the physical embodiment of emotional, organizational, and ethical stress. Nurses reported symptoms including muscular tension, fatigue, migraines, gastrointestinal disturbances, sleep disruptions, tachycardia, and chronic fatigue across various categories. These symptoms were not arbitrary. Their characteristics were patterned, cumulative, and intricately linked to suppression, trauma aftershocks, organizational instability, and moral conflict.

In Category 1, suppression resulted in physical contraction. Nurses articulated the experience of suppressing emotions and disregarding physiological cues to maintain functionality. In Category 2, trauma manifested physiologically, with the body responding prior to the mind's ability to interpret the reactivated experience. These physiological responses provide empirical evidence for the neurophysiological connection among threat, emotional stress, and autonomic activation (Porges, 2011). It is suggested that the physical wellbeing of nurses declined as their regulatory systems were consistently compelled to function beyond safe thresholds.

This indicates that organizational conditions directly impacted physical wellbeing. Inadequate staffing, lack of protection, extended shifts, and constant exposure to hazards resulted in chronic physiological stress. This supports Maslach's (2016) assertion that occupational burnout can result in quantifiable biological and physiological repercussions. Participants reported immune disruption, recurrent infections, and a persistent sense of bodily inadequacy, exemplified by statements like "*My body never recovered"* (P08, p.5), suggesting that physical wellbeing was undermined not only by the virus but also by prolonged organizational neglect and unresolved physiological activation.

Physical wellbeing, consequently, embodies the interplay of personal control, environmental volatility, and institutional disengagement. It is not merely an individual health outcome. It serves as a systemic indicator of the physiological consequences of organizational failure.

Implications for Understanding Mental Wellbeing

Findings indicate that nurses' mental wellbeing cannot be comprehended as a singular aspect of distress or resilience. Rather, it manifested as a dynamic, cumulative, and relational process influenced by internal control and external constraints. The initial emotional constriction outlined in Category 1, the effort to uphold a professional demeanour, illustrates that mental wellbeing was limited by workplace standards necessitating serenity under anxiety, grief, and persistent uncertainty. This corroborates prior literature that recognises emotional labour as a frequently concealed requirement in nursing (Mann and Cowburn, 2005).

The findings enhance this concept by demonstrating that emotional labour served not just as a means of self-protection but also as a compensatory mechanism that maintained services when organizational containment was inadequate. Mental wellbeing did not decline solely during the acute crises. Conversely, it diminished in the extended aftermath, when previously suppressed issues reemerged as traumatic aftershocks. Participants rated these instances as invasive and destabilising, suggesting that mental wellbeing was influenced less by the intensity of concurrent occurrences and more by the provision of safe spaces, relational support, and organizational acknowledgement to process their experiences. This corresponds with van der Kolk’s (2014) assertion that repressed emotional and traumatic content may resurface later in disruptive physical manifestations.

Mental wellbeing was also influenced by relational absence. Invisibility of leadership, erratic communication, and disjointed teams exacerbated isolation and heightened emotional burden. Instead of offering containment, organizational structures often exacerbated destabilisation, illustrating that mental wellbeing is inextricably linked to the corporate context. Maben and Bridges (2020) contend that emotional support in healthcare is essential rather than discretionary. Findings demonstrate that emotional wellbeing is contingent upon relational anchoring, communicative consistency, and organizational presence, all of which were consistently undermined throughout and after COVID-19. This study indicates that mental wellbeing is not an individual characteristic. It is a relational, embodied, and structurally conditioned process influenced by the responsibilities assigned to nurses and the deficiencies of organizations in supporting them.

Implications for Understanding Trauma and Embodiment

This study indicates that the trauma experienced by nurses was substantially embodied. It manifested not just in memory and emotion but also in bodily expression. Aftershocks of trauma, flashbacks, sensory stimuli, fear, and physiological dysregulation signify that unprocessed experiences become ingrained and resurface spontaneously when internal resources are exhausted. This corresponds with

van der Kolk's (2014) conceptualisation of trauma as embodied. The data demonstrate that embodiment was not merely an aspect of trauma, but also a result of organizational conditions that provided insufficient opportunities for emotional expression, relational processing, or significant restoration.

This indicates that embodiment served as a conduit through which institutional betrayal was tangibly experienced. Entities exhibited conflicting policies, a lack of leadership, and ethical dilemmas. Nurses did not merely convey tension. They articulated the embodiment of organizational failure. Embodiment thus reveals the tangible consequences of organizational dysfunction, with the body serving as the locus where structural damage was endured in the absence of external containment.

Trauma was influenced by tempo and circumstance. Acute nurses frequently reported abrupt, high-intensity reactivations associated with alarms, patient deterioration, and mortality. Community nurses frequently articulated a gradual, pervasive anxiety that infiltrated daily environments and normal interactions. This suggests that embodiment is influenced by context, closeness, and relational exposure, aligning with trauma theory that highlights the contextual heterogeneity in the experience and reactivation of damage (Herman, 2015).

In this study, trauma is not regarded as a discrete psychological occurrence. It is a tangible remnant of repressed emotion, unresolved ethical dilemmas, and unmitigated organizational damage.

Implications for Understanding Moral and Ethical Wellbeing

The category of Moral Suffering and Ethical Erosion offers significant insights on the moral, ethical, emotional, and physical wellbeing of nurses. The findings indicate that moral wellbeing is not a mere abstract ethical notion. It is a psychological, emotional, and physiological phenomenon. Nurses who were compelled to compromise standards, restrict care, or suppress their moral convictions encountered ethical disorientation aligned with moral harm theories (Litz et al., 2009; Rushton, 2018).

Participants' narratives of shame, guilt, identity disturbance, and moral isolation suggest that moral injury was manifested physically. A nurse articulated, "*My body never recovered from the guilt*" (P08, p.5). This corroborates evidence indicating that moral harm may be linked to physiological arousal, hypervigilance, exhaustion, and enduring stress responses (Dean et al., 2019). In this investigation, moral injury did not remain purely cognitive. It became entrenched in the body where ethical restoration was unattainable.

This indicates that moral wellbeing is contingent upon structural alignment. When organizational values conflicted with professional ethics, the likelihood of moral damage escalated. This corroborates Smith and Freyd's (2013) assertion that institutional betrayal transpires when trusted systems breach moral expectations. The moral wellbeing of nurses declined not due to ethical failures on their part, but because organizations neglected to maintain reciprocal moral commitments. Moral flourishing is

thus inextricably linked to organizational fairness, ethical consistency, and relational integrity. The erosion serves as a crucial sign of institutional damage.

Implications for Understanding Organizational Culture

The findings indicate that organizational culture was not a peripheral factor but a primary determinant of nurses' wellbeing. Inconsistent directives, lack of visible leadership, superficial wellbeing initiatives, and disjointed teams fostered a culture of instability, distrust, and emotional isolation. This corresponds with Weick's (1993) examination of sensemaking collapse, wherein organizational incoherence erodes shared meaning and induces psychological distress.

Wellbeing was compromised by symbolic rather than substantive assistance. Nurses articulated wellbeing activities that predominantly relied on language, exacerbating distress by indicating care while lacking practical and relational support. This corresponds with Maben and Bridges (2020), who emphasise that symbolic practices might intensify suffering by revealing organizational inconsistencies.

This suggests that corporate culture functions as a dynamic force that influences wellbeing. Culture can enhance or alleviate emotional distress, affect the course of trauma, and determine moral reactions. Disparate cultures undermined relationship buffering, although existing pockets of coherence provided transient stabilisation. Organizational culture is a structural factor of psychological and physical well-being, rather than a neutral backdrop.

Implications for Leadership and Psychological Safety

The presence or lack of leadership has proven to be a significant factor influencing wellbeing. Participants consistently characterised leadership invisibility during pivotal occasions, resulting in a void that exacerbated uncertainty, isolation, and emotional burden. Psychological safety deteriorated when voicing concerns was met with punishment, neglect, or recharacterization as negativity, consistent with Edmondson's (2018) assertion that psychological safety is essential for workforce stability and learning.

This indicates that psychological safety is shaped not only by policy, but by everyday presence, consistency, and relational closeness. Nurses described feeling abandoned when leaders were physically absent and when silence was experienced as disengagement and disposability. This challenges accounts that locate psychological safety primarily in individual courage and instead frames it as an organizational responsibility shaped by leadership behaviour and organizational response. Leadership plays a vital role in nurses' wellbeing. When leadership is visible, transparent, and proactive, it can ease uncertainty and emotional burden. When it is absent, it can intensify trauma, weaken moral confidence, and strain professional relationships (Edmondson, 2018; West et al., 2020; Shanafelt et al., 2020; Maben and Bridges, 2020; Greenberg et al., 2020; Morley et al., 2021).

Implications for Understanding Variation Across Surface and Fractured Endurers

The conceptual differentiation between Surface Endurers and Fractured Endurers significantly influences the comprehension of variations in wellbeing. This differentiation is not predicated on personality. It illustrates the interplay among accumulating burden, organizational conditions, repression, aftershocks, and moral struggle. Charmaz (2014, pp. 239–247) asserts that constructivist grounded theory acquires conceptual strength by elucidating systematic variations in processes. The results indicate that the variation among participants was systematic rather than arbitrary.

Surface Endurers seemed externally stable yet reported significant interior stress. They discussed perseverance and maintaining cohesion, using emotional regulation and professional identity as stabilising resources. This reflects Hochschild's (2012) research on emotional labour, wherein external composure is preserved despite inward sacrifice. Surface Endurers maintained functionality through containment, compartmentalisation, and relationship upkeep; yet their narratives reveal a slow buildup of strain that frequently went unnoticed by others and was challenging to articulate within the organization.

Fractured Endurers, in contrast, delineated instances where internal capacity was surpassed. Their experiences correspond with McEwen's (1998) notion of allostatic overload; wherein cumulative stress exceeds physiological and emotional limits. They characterised more enduring trauma aftershocks, profound moral disintegration, and increased bodily deterioration. This suggests that a breakdown should not be viewed as ineffective coping, but rather as a foreseeable consequence of constant exposure without substantial respite, a phenomenon previously observed in research about UK healthcare personnel during COVID-19 (Greenberg et al., 2020).

Variation was influenced by organizational conditions. Surface Endurers frequently reported instances of peer support, shared humour, or moments of team cohesion that mitigated discomfort, aligning with Edmondson's (2018) focus on relational psychological safety. Fractured Endurers frequently articulated alienation, a lack of leadership, and moral dilemmas devoid of relationship support, circumstances that hastened deterioration. This supports Weick's (1993) assertion that sensemaking disintegrates as organizational coherence declines, resulting in individuals lacking interpretive frameworks or relational grounding.

The findings suggest that nurses in both groups were not experiencing separate realities but rather progressing along a continuum of cumulative strain. The distinction lay in the speed of pressure convergence and the accessibility of organizational and relational containment. Surface Endurers persisted in operation despite sustaining internal damage. Fractured Endurers encountered situations when containment failed, necessitating withdrawal, prolonged sick leave, emotional estrangement, or departure for survival.

This concept elucidates that disparities in wellbeing outcomes are structurally conditioned and relationally mediated rather than individually determined. Fracturing did not signify personal inadequacy. It indicated the threshold at which cumulative load surpassed the capacity that could be sustained without reciprocal protection, recognition, and restoration.

5.8 Conclusion of Chapter 5

This chapter has delineated the findings of my constructivist grounded theory study, providing an interpretive synthesis of nurses' experiences during and after the COVID-19 pandemic, with a specific focus on physical and mental well-being. Following Charmaz's guidance, the findings are presented as interrelated conceptual categories that illustrate processes over time, demonstrating how action, meaning, and consequence accumulate within nurses' daily professional lives rather than being confined to discrete events (Charmaz, 2014, pp. 239–249).

Across the four categories, a cohesive synthesis emerged in which nurses consistently internalised strain to maintain professional efficacy. Category 1 demonstrated how physical and emotional repression, along with delayed processing, functioned as regulated labour that allowed nurses to maintain functionality under uncertainty, danger, and loss. Category 2 illustrated that the confined issues did not dissipate but reemerged later due to trauma aftershocks, which impacted memory, sleep, physiological regulation, and recuperation. Category 3 demonstrated that organizational dissonance and fragmentation exacerbated vulnerability by eroding stability, relationship containment, and trust due to contradicting policy signals, leadership invisibility, performative well-being, and team disruption. Category 4 encapsulated the moral and ethical ramifications of extended exposure to inadequate care and limited agency, wherein guilt, suppression, and identity disintegration coalesced into moral anguish and ethical degradation.

Collectively, these findings indicate that the decline in physical and mental well-being occurred through a cumulative, embodied, and relational process. Initial emotional regulation incurred a physical toll. Trauma was perceived as a physiological response rather as a retrospective memory. Organizational instability influenced not only workload but also significance, security, and a sense of belonging. Moral distress arose when nurses were consistently compelled to bear ethical burdens without sufficient organizational recognition, safeguarding, or remediation. Wellbeing thus emerged not as an individual characteristic, but as a condition generated within structural, relational, and ethical contexts.

The structured diversity identified through the conceptual classifications of Surface Endurers and Fractured Endurers further reinforces this explanatory theory. These categories did not signify variations in individual resilience or dedication. They elucidated how analogous organizational settings were experienced variably based on cumulative exposure, available relationship support, and the constraints of physical, psychological, and moral capabilities. Surface Endurers typically

prolonged external functioning, frequently at the expense of heightened containment and personal cost, whereas Fractured Endurers more frequently identified moments when suppression, recuperation, and moral coherence became unsustainable.

This chapter elucidates that nurses' perceptions of their work during and after the COVID-19 pandemic were influenced by interrelated processes of denial, trauma aftershocks, organizational instability, and moral decay, exacerbated by institutional disengagement. These findings provide the empirical grounding for the theoretical integration that follows, where endurance is developed as a conceptual explanation of how nurses' physical and mental wellbeing becomes shaped through organizational, ethical, and relational conditions over time.

Chapter 6: Theoretical Integration and Grounded Theory Development

6.0 Overview and Orientation

This chapter marks a conceptual shift from the presentation of findings in Chapter 5 to the work of theoretical integration. Its purpose is to demonstrate how the four categories developed in the analysis in chapter 4, do not operate as parallel or discrete accounts but instead function as an integrated explanatory framework that accounts for nurses' experiences of working during and after the COVID-19 pandemic.

In keeping with Charmaz's (2014; 2016) guidance, the task of this chapter is to raise the level of abstraction by explicating relationships between categories and articulating the processes they collectively represent. Theoretical integration requires showing how categories fit together, work together, and explain what is happening in the data (Charmaz, 2014). Accordingly, this chapter foregrounds conceptual linkage, conceptual coherence, and process explanation.

The four categories and the core category developed through constant comparison, and sustained memo writing each illuminate different dimensions of nurses' experiences. Individually, they capture physical, psychological, organizational, and moral conditions. Conceptually integrated, they reveal a shared process through which nurses sought to continue functioning within conditions of sustained pressure, constraint, and institutional instability. This chapter focuses on how these categories converge to offer an integrated explanation of this process.

Throughout this chapter, theoretical integration remains conceptually grounded in the category structure established in Chapters 4 and 5. In line with Constructivist Grounded Theory principles, external theories are not imported as explanatory frames but are only drawn upon where they illuminate and extend the conceptual explanation generated from the data (Charmaz, 2014).

The purpose of theoretical integration is to move from category level analysis to an interpretive explanation that identifies underlying processes, conditions, and mechanisms. It is not an additional stage of coding, but a phase of conceptual synthesis that draws together the analytic work undertaken throughout the study. In this chapter, I make explicit how that synthesis occurred.

Through sustained memo writing and iterative comparison across interviews and focus groups, I identified a patterned movement in how nurses described their efforts to endure, adapt, and continue functioning across physical, emotional, organizational, and moral domains. These conceptual comparisons illuminated endurance as a central process operating across categories. Importantly, endurance is theorised here not as an individual attribute or personal resilience, but as an adaptive process shaped by organizational conditions, structural constraint, and moral exposure.

This chapter also serves a transparency function. Consistent with Constructivist Grounded Theory principles, I make visible the conceptual practices that shaped theory development, including constant comparison, memo writing, theoretical sensitivity, and progressive focusing. By doing so, the chapter demonstrates how the grounded theory was constructed, not merely what it proposes. This positioning prepares the ground for the applied conceptual tools developed later in the chapter and for the wider theoretical and organizational discussion that follows in Chapter 7.

6.1 Positioning, Synthesis, and Conceptual Alignment

This section positions the conceptual work undertaken in Chapter 6 and clarifies the transition from the presentation of findings in Chapter 5 to the process of theoretical integration and the analytic groupings Surface Endurers and Fractured Endurers developed in chapter, which captured patterned trajectories within nurses' accounts. The conceptual task at this stage is to integrate them into a coherent explanatory account that specifies how the categories relate, interact, and collectively account for nurses' experiences. This shift reflects Charmaz's requirement that grounded theorists move beyond categorisation to explicate relationships between major analytic components (Charmaz, 2014; 2016).

A key conceptual movement underpinning this integration involved a shift away from resilience as an organising concept. While resilience appeared in participants' language and in early analytic consideration, it did not adequately account for the processes described in the data. Participants' accounts emphasised sustained functioning under constraint rather than recovery, growth, or adaptive capacity in conventional terms. Through constant comparison and memo development, endurance emerged as a more analytically coherent process. This redirection was data led rather than concept driven, aligning with Charmaz's caution against imposing pre-existing frameworks that do not arise from the analytic categories themselves. Within this framing, Surface Endurers and Fractured Endurers are positioned not as typologies or outcomes, but as theoretical positions that reflect variation in how nurses navigated prolonged organizational, emotional, physical, and moral pressures (Charmaz, 2014; Traynor, 2018; Berlant, 2011; Baraitser, 2017; Maben and Bridges, 2020).

Theoretical integration also required attending to the interdependence of physical, psychological, and moral processes across the four categories. Rather than treating physical and mental wellbeing as separate domains, theoretical integration demonstrates how bodily exhaustion, emotional strain, ethical exposure, and organizational conditions are mutually reinforcing. These interconnections shape how nurses describe their capacity to continue functioning over time. Consistent with Charmaz's emphasis on conceptualising process and consequence, the categories are understood here as dynamically related components of a broader analytic process rather than as discrete thematic areas.

Memo writing played a vital role in tracing connections between categories and in refining the integrative focus from descriptive accounts to explanatory relationships. As Charmaz argues, theoretical integration emerges through this iterative movement, which links categories and sharpens conceptual interpretation (Charmaz, 2014). The interpretive logic developed in the sections that follow reflects the cumulative theoretical integration that led to the identification of the core category Institutional Betrayal and Organizational Abandonment and to the articulation of the grounded theory *Enduring the System and Bearing the Weight*.

To support theoretical integration clarity, the chapter aligns the study's research questions with the categories, core category, and grounded theory. **Figure 6.1** below provides a visual representation of this conceptual alignment.

Figure 6.1. Conceptual linkage between research questions, categories, core category, and the emergent Grounded Theory

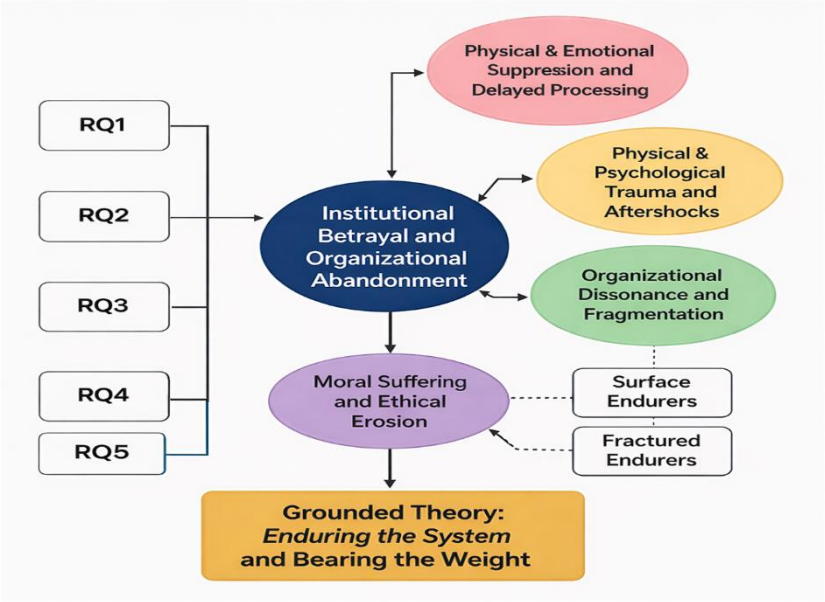


Figure 6.1 illustrates the theoretical integration of five research questions into the study's conceptual and theoretical framework: RQ1 examines how nurses articulate their experiences of working during and after the COVID-19 pandemic within an NHS Trust; RQ2 explores nurses' perceptions of the effects of these experiences on their physical and mental wellbeing during and post-pandemic; RQ3 investigates how nurses maintain professional functionality amid sustained organizational and clinical pressures; RQ4 assesses nurses' experiences and interpretations of organizational support, leadership, and workplace changes during and after the pandemic; and RQ5 synthesises the variability of nurses' experiences and interpretations across diverse clinical settings, roles, and care contexts.

The figure illustrates how these questions informed the development of the four categories by repeated coding and constant comparison, and how those categories condense in the core category of Institutional Betrayal and Organizational Abandonment. The patterned trajectories of Surface Endurers and Fractured Endurers are aligned with the categories to illustrate how nurses' experiences develop in context-dependent manners influenced by organizational, ethical, and embodied conditions. The grounded theory, '*Enduring the System and Bearing the Weight*,' is introduced as the cohesive theoretical contribution resulting from this alignment, providing a conceptual framework for the theoretical integration discussed in this chapter.

6.2 Revisiting the Research Aims, Objectives, and Questions

Charmaz (2014; 2016) emphasises that theoretical integration requires a return to analytic purpose, demonstrating how the categories constructed through grounded theory analysis respond directly to the study's aims and research questions. Revisiting these elements at this stage is not a procedural restatement, but an analytic act that establishes coherence between the empirical synthesis and the emerging theoretical explanation. This section therefore reconnects the theoretical integration undertaken in this chapter with the study's original analytic intent.

The study began with a single, open question that invited nurses to speak about their experiences of working during and after the pandemic in their own terms. As their accounts accumulated, certain concerns and connections surfaced repeatedly, drawing my attention to how organizational demands, physical and emotional strain, and questions of responsibility were woven together in everyday practice. Over time, these recurring lines of attention took shape as a small set of more focused questions, which helped me trace how different dimensions of experience contributed to the development of the four categories and their integration within the core category. These questions do not stand apart from the analysis but make visible the path through which the grounded theory took form. This analytic refinement did not introduce new aims or redirect the study's intent but rather provided a structured way of tracing how different dimensions of nurses' experiences contributed to the development of the four categories and their integration within the core category. The five research questions presented here **Table 6.1** below therefore function as analytically derived signposts that make visible the pathway through which the grounded theory was constructed.

The overarching aim of the study was to develop a grounded theory explaining how nurses navigated prolonged systemic demands and moral complexity, and with what consequences for their physical and mental wellbeing. This aim is reflected across the four categories and the core category, which together account for how nurses sought to continue functioning within conditions of sustained organizational pressure, ethical exposure, and institutional instability.

The first objective, to explore how the pandemic shaped personal and professional identities and wellbeing, is addressed through the categories Physical and Emotional Suppression and Delayed Processing and Physical and Psychological Trauma and Aftershocks. These categories capture how nurses described maintaining composure and professional functioning in the immediate context of crisis, while experiencing delayed physical and psychological consequences that unfolded over time.

The second objective, to examine organizational responses and their influence on perceptions of leadership, support, and institutional care, is addressed primarily through Organizational Dissonance and Fragmentation and Moral Suffering and Ethical Erosion. These categories illuminate how organizational actions, inactions, and inconsistencies shaped nurses' interpretations of institutional responsibility, ethical reciprocity, and the limits of organizational care.

The third objective, to identify strategies nurses used to sustain purpose, endurance, and integrity, cuts across all four categories and is conceptually expressed through the groupings Surface Endurers and Fractured Endurers. These conceptual groupings do not represent fixed identities or outcomes, but context dependent trajectories shaped by the interaction of organizational conditions, moral demands, and embodied strain.

The final objective, to generate a grounded theory that informs future models of workforce wellbeing and sustainability, is addressed through the integration of the categories into the core category Institutional Betrayal and Organizational Abandonment and the articulation of the grounded theory *Enduring the System and Bearing the Weight*. Together, these conceptual components move the study beyond descriptive explanation towards a conceptual account of how organizational systems shape nurses' capacity to continue functioning over time.

The research questions guided the analytic process through iterative cycles of coding, constant comparison, and memo writing across eleven interviews and two focus groups. Rather than being answered individually or sequentially, the questions functioned as sensitising prompts that shaped analytic attention as categories developed. **Table 6.1** below demonstrates how each research question contributed to the construction of the categories and how those categories converge within the core category to generate the grounded theory.

Table 6.1. Alignment Between Research Questions, Categories, Core Category, and Grounded Theory

Research Question	Related Categories	Core Category Link	Theoretical Integration into Enduring the System and Bearing the Weight

RQ1	Physical and Emotional Suppression and Delayed Processing; Physical and Psychological Trauma and Aftershocks	Institutional Betrayal and Organizational Abandonment	Reveals embodied and emotional holding as central to endurance processes
RQ2	Physical and Psychological Trauma and Aftershocks; Moral Suffering and Ethical Erosion	Institutional Betrayal and Organizational Abandonment	Demonstrates the entangled nature of physical and psychological consequences
RQ3	Organizational Dissonance and Fragmentation; Moral Suffering and Ethical Erosion	Institutional Betrayal and Organizational Abandonment	Shows how institutional responses shaped ethical disruption and moral strain
RQ4	Physical and Emotional Suppression and Delayed Processing; Moral Suffering and Ethical Erosion	Institutional Betrayal and Organizational Abandonment	Illustrates adaptive endurance through emotional regulation and ethical labour
RQ5	All categories	Core Category to Grounded Theory	Integrates conditions, processes, and consequences into the grounded theory

This alignment demonstrates that the grounded theory did not emerge from pre-existing conceptual assumptions, but from sustained engagement with the data through iterative analytic-synthesis practices. In line with Charmaz's criteria for grounded theory quality, the integration presented here reflects synthesis transparency, conceptual coherence, and methodological rigour. It shows how conditions, processes, and consequences identified in the data were synthesised into an explanatory theoretical account that remains grounded in participants' experiences while operating at a higher level of conceptual abstraction (Charmaz, 2014).

6.3 Theoretical Integration of Categories

In line with Charmaz (2014; 2016), theoretical integration requires specifying how major categories relate and demonstrating how they collectively account for the processes identified in the data. This section therefore moves from presenting categories to integrating them within a single explanatory system. Rather than treating the four major categories as parallel conceptual strands, I theorise how they interlock as mechanisms within a shared process. That process is conceptualised here as

endurance, understood as a threshold phenomenon shaped by institutional conditions, moral exposure, and embodied consequences (Tronto, 2013; Freyd, 2014; Berlant, 2011).

Endurance emerged from the analysis not as a synonym for resilience, but as a dynamic balancing process between functioning and fracture under sustained moral, physical, and emotional load. This conceptual move was grounded in constant comparison across interviews and focus groups. Early analytic memos noted that participants spoke less about recovery or growth and more about hanging on, running on empty, or holding everything in to get through shifts. These expressions pointed to an ongoing negotiation with limits rather than responses to discrete events. In Charmaz's terms, this reflects participants living within constraint, and the theoretical integration extends this by demonstrating how those constraints were repeatedly reshaped through organizational and moral conditions rather than individual capacity alone (Lipsky, 2010; Bolton, 2010; Maslach and Leiter, 2016).

Framing endurance as a threshold process foregrounds accumulation over time. The conditions shaping nurses' experiences did not resolve between pandemic phases. Instead, pressures layered, with limited opportunity for recovery or repair. Crucially, the threshold was not located solely within the individual nurse. It was co constructed through staffing levels, leadership behaviours, policy instability, and moral expectations that normalised sacrifice while constraining institutional responsibility. Endurance is therefore theorised as a system level process rather than an individual attribute (Weick, 1995; Greenberg et al., 2020; WHO, 2021).

The mechanisms articulated in this section do not represent newly generated analytic constructs. They are integrative refinements of properties and processes already developed within the four categories in Chapter 5. Through sustained memo writing and constant comparison, these category properties were repeatedly examined, collapsed, and refined to articulate how each contributed to the endurance threshold. Naming them as mechanisms at this stage serves an explicitly integrative purpose, making visible how previously developed analytic elements operate together within the overall process (Charmaz, 2014; Timmermans and Tavory, 2012).

Across the data analysis, four interlocking mechanisms were identified. First, affective, and somatic regulation captured how nurses managed emotion and bodily responses to preserve functioning. This mechanism derives from Physical and Emotional Suppression and Delayed Processing, where containment enabled continued work in the short term while seeding delayed physical and psychological consequences. Second, cycling threat exposure captured the reactivation of distress through repeated cues and unresolved trauma (Hochschild, 2012; van der Kolk, 2015). This mechanism integrates properties of Physical and Psychological Trauma and Aftershocks, demonstrating how threat was continually re animated through organizational and clinical environments (Litz et al., 2009; Williamson et al., 2021). Third, structurally constrained recovery

articulated how opportunities for rest and repair were nominally present but systematically limited. Grounded in Organizational Dissonance and Fragmentation, this mechanism clarifies how organizational architectures narrowed the space between strain and fracture (Buchan et al., 2019; Maben and Bridges, 2020). Fourth, moral erosion captured the gradual wearing a way of ethical coherence and professional identity under conditions of repeated compromise and institutional silence. This mechanism extends Moral Suffering and Ethical Erosion and shows how moral harm accelerated movement towards fracture (Dean et al., 2019; Freyd, 2014).

Taken together, these mechanisms form a processual storyline linking conditions, processes, and consequences. Organizational conditions such as understaffing, policy contradiction, and leadership absence activated mechanisms of suppression, re triggering, constrained recovery, and moral erosion. These mechanisms shaped trajectories of endurance, influencing whether nurses remained within Surface Endurance or moved into Fractured Endurance. In Charmaz's terms, this integration explains variation by linking conditions to consequences rather than presenting static categories or typologies (Charmaz, 2014; Lipsky, 2010; Weick, 1995).

This integrative framing prepares the ground for the Threshold Model of Endurance presented in the following section. The model (see **Figure 6.2** below) does not introduce new analytic elements, but synthesises relationships already established, rendering visible how endurance is produced, stretched, and fractured within institutional contexts (Tronto, 2013; WHO, 2021; ICN, 2021).

Figure 6.2. Threshold Model of Endurance: Synthesising conditions, processes, and consequences

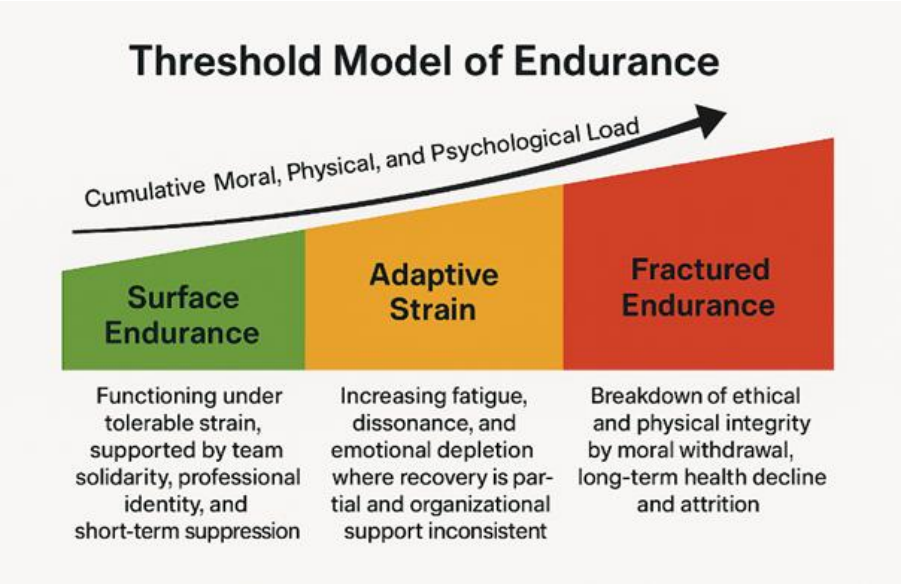


Figure 6.2 above represents endurance as a continuum regulated by cumulative moral, physical, and psychological load. Endurance is conceptualised not as a fixed capacity or stable trait, but as a dynamically maintained state that shifts in response to changing organizational conditions and access to recovery and repair.

The continuum is organised into three analytically distinct zones reflecting patterned states described in the data. Surface Endurance represents a state in which nurses maintain functioning under high but tolerable load, supported by professional identity, team solidarity, and short-term regulatory strategies such as emotional suppression. Although strain is present, care delivery remains ethically coherent and professionally meaningful.

Adaptive Strain represents a state in which cumulative load intensifies, and recovery becomes partial or inconsistent. Participants described early erosion in this zone, including emotional numbing, heightened vigilance, moral discomfort, and persistent fatigue. Functioning continues, but at increasing internal cost, and the space between strain and fracture narrows.

Fractured Endurance represents a state in which accumulated load exceeds what can be absorbed or repaired. Here, moral, and physical integrity deteriorate in ways that become visible through sickness absence, psychological injury, withdrawal, or decisions to leave roles or the profession. Fracture does not occur suddenly but emerges through prolonged exposure to conditions in which recovery and moral repair are repeatedly constrained.

The curved arrows between zones indicate that movement across the continuum is cyclical rather than linear. Nurses may oscillate between Surface Endurance and Adaptive Strain, or temporarily retreat from fracture, depending on shifts in staffing, leadership support, workload intensity, and access to meaningful recovery. These movements reinforce that progression towards fracture is neither inevitable nor irreversible, but structurally shaped.

The Threshold Model synthesises the mechanisms identified earlier into a single theoretical representation. It extends beyond classic burnout models by situating tipping points not only in workload and exhaustion, but in moral and relational domains. Endurance is conceptualised as a regulated state whose stability depends on the interaction between cumulative load and the availability of relief.

Load in the model is generated through sustained exposure to crisis conditions, repeated trauma, organizational dissonance, and institutional betrayal. Relief depends on whether recovery and moral repair are structurally enabled. Where protected time, ethical acknowledgement, leadership presence, and realistic staffing are provided, endurance can be recalibrated. Where relief remains symbolic or inaccessible, cumulative load intensifies and thresholds are more readily crossed.

A central theoretical integration contribution of the model is that it makes visible how endurance can be functional for institutions while harmful for individuals. Organizational performance may appear stable while nurses remain in Adaptive Strain, holding systems together through personal sacrifice. By the time fracture becomes visible through turnover, sickness, or safety events, the moral and bodily cost has already been incurred.

In Charmaz's (2014;2016) terms, **Figure 6.1** functions as a theoretical rendering that distils complex social processes into conceptual form. It synthesises relationships already established in the analysis and provides a bridge to the elaboration of the core category and conceptual groupings that follow.

6.4 Elaborating the Core Category: Institutional Betrayal and Organizational Abandonment

The core category Institutional Betrayal and Organizational Abandonment occupy a central analytic position within the Threshold Model of Endurance as the structural and moral condition that shapes how endurance is sustained or undermined over time. It encapsulates participants' accounts of a breakdown in reciprocal obligation between nurses and the organization they served, in which institutional dependence on professional sacrifice was not matched by protection, transparency, or sustained care. As a core category, it functions not as a descriptive summary of organizational failure, but as an explanatory construct that clarifies how organizational arrangements actively shaped nurses' capacity to continue functioning.

Conceptually, this category extends existing work on institutional betrayal by situating it within the prolonged and routine conditions of healthcare delivery during and after the COVID-19 pandemic (Smith and Freyd, 2014; Freyd, 2014; Monteith et al., 2020). Rather than centring on isolated events, betrayal was described as an accumulation of ordinary organizational practices, including persistent understaffing, redeployment without adequate preparation, leadership presence framed as symbolic rather than relational, and wellbeing initiatives that were perceived as disconnected from everyday working realities (Maben and Bridges, 2020; Billings et al., 2021; West et al., 2020; Greenberg et al., 2020). These conditions did not merely increase workload. They altered how nurses interpreted organizational intent, responsibility, and moral standing (Tronto, 2013; Tyler, 2011; Fassin, 2012).

The abandonment dimension captures a distinct experiential layer within this process. Participants described a felt withdrawal of institutional presence at moments of heightened risk and ethical exposure. Accounts of delayed protective equipment, inconsistent testing, shifting guidance, and the absence of structured follow up for physical and psychological harm were interpreted as signals that responsibility for unsafe systems had been displaced onto individual nurses (Greenberg et al., 2020; Billings et al., 2021; West et al., 2020; UK COVID-19 Inquiry, 2023). This produced a sense of being left to carry organizational risk without institutional backing (Lipsky, 2010; Freyd, 2014).

Within the theoretical model, institutional betrayal and organizational abandonment operate as conditions that recalibrate endurance trajectories rather than as outcomes in themselves. They intensify moral and emotional load by undermining narratives of mutual obligation and professional solidarity that had previously supported continued functioning. At the same time, they restrict access to moral repair by framing harm as an individual issue of coping rather than as a collective organizational responsibility. In this way, the category explains why endurance could be sustained

temporarily in some contexts but became increasingly fragile across prolonged exposure (Charmaz, 2014; Dean et al., 2019; Williamson et al., 2021).

In Charmaz's terms, a core category should account for most of the variation in the data and integrate the major analytic components of the study (Charmaz, 2014, pp. 262–267; Charmaz, 2016). Institutional Betrayal and Organizational Abandonment perform this integrative function by clarifying how similar pandemic conditions generated divergent endurance trajectories (Smith and Freyd, 2014; Fassin, 2012). The category explains why Surface Endurance could be maintained where organizational signals of recognition and support remained partially intact, and why endurance fractured where organizational arrangements consistently communicated withdrawal, inconsistency, or moral silence (Tronto, 2013; Maben and Bridges, 2020; Greenberg et al., 2020). In doing so, it anchors the grounded theory in a structural and ethical explanation rather than an individualised account of capacity or resilience (Lipsky, 2010; Tyler, 2011; Charmaz, 2014; Traynor, 2018).

6.5 Surface and Fractured Endurers: Patterned Trajectories and Theoretical Implications

The conceptual groupings Surface Endurers and Fractured Endurers render visible how nurses' trajectories unfolded within the endurance process. These groupings do not represent stable psychological profiles or individual coping styles. They are conceptually derived positions that reflect how participants' capacity to continue functioning shifted over time in response to organizational conditions, moral exposure, and access to recovery and repair.

Consistent with Charmaz's emphasis on process and variation, these positions are conceptualised as relational and context dependent rather than as fixed states (Charmaz, 2014, pp. 240–244; Charmaz, 2016, pp. 9–11). A nurse's movement between Surface and Fractured Endurance is shaped by changes in staffing stability, leadership engagement, workload intensity, and opportunities for ethical acknowledgement and physical recovery (Lipsky, 2010; Tronto, 2013; Maslach and Leiter, 2016; Maben and Bridges, 2020; Greenberg et al., 2020; Charmaz, 2014). Endurance is therefore theorised as a socially patterned response to structural and moral conditions rather than as an individual trait (Fassin, 2012; Traynor, 2018; Tyler, 2011).

Table 6.2 below presents a comparative patterning of Surface and Fractured Endurers across key conceptual dimensions. The table functions as an integrative device rather than a classificatory tool. Its purpose is to make visible how endurance trajectories diverged as cumulative load interacted with organizational and moral conditions.

Table 6.2. Surface and Fractured Endurers: Comparative Patterning

Dimension	Surface Endurers	Fractured Endurers	Theoretical Insight
Emotional stance	Regulated composure and private management of distress	Emotional depletion, numbing, withdrawal, irritability	Early regulation stabilises functioning but becomes fragile without organizational recognition
Physical presentation	Sustained functioning with persistent fatigue	Chronic exhaustion, long COVID symptoms, prolonged sickness absence	Bodily decline signals the crossing of endurance thresholds
Moral positioning	Continued commitment despite constraint	Moral disillusionment, guilt, cynicism, contemplation of exit	Moral erosion accelerates movement towards fracture
Relationship to organization	Ambivalent loyalty and sense of being needed	Interpretations of betrayal, abandonment, or disposability	Trust trajectories distinguish repairable strain from enduring rupture
Relational ecology	Reliance on peer solidarity and informal support	Social withdrawal and reluctance to speak	Relational disconnection compounds structural strain

This patterning demonstrates that Surface and Fractured Endurers are best understood as positions produced through the interaction of conditions and mechanisms rather than as attributes located within individuals. Participants described occupying Surface Endurance during periods supported by team cohesion and ethical purpose, and moving into Fractured Endurance following repeated organizational disruption, unresolved moral distress, and cumulative physical decline. This movement reflects Charmaz's insistence that grounded theory should explain change and variation over time rather than fix participants within static analytic categories (Charmaz, 2014, pp. 241–243).

Several theoretical implications follow from this synthesis. First, endurance emerges as socially patterned rather than idiosyncratic. The trajectories identified here align with wider evidence linking organizational justice, leadership practice, and moral climate to workforce wellbeing, suggesting that endurance positions are predictable responses to structural configurations rather than reflections of individual strength or weakness (Tyler, 2011; Maslach and Leiter, 2016; Traynor, 2018; Maben and Bridges, 2020). Second, endurance functions as an ambivalent organizational resource. Surface Endurance enables service continuity and patient care, but it can also delay institutional recognition of harm by absorbing strain within individual nurses (Lipsky, 2010; Bolton, 2010; Fassin, 2012). Third, Fractured Endurance operates as a precursor to workforce exit. Participants linked emotional depletion, physical deterioration, and moral disillusionment to decisions to reduce hours, change

roles, or leave nursing, situating endurance trajectories within broader debates about workforce sustainability and retention (Aiken et al., 2012; ICN, 2021; ONS, 2023; RCN, 2023).

By conceptualising Surface and Fractured Endurers as positions within a process rather than as static identities, this section remains aligned with Constructivist Grounded Theory principles. It foregrounds movement, relationality, and structural conditioning, and demonstrates how the analytic framework explains patterned variation in both experience and outcome (Charmaz, 2014; Timmermans and Tavory, 2012). This positioning provides a coherent bridge into the applied, policy, and governance focused discussion that follows in Chapter 7.

6.6 Integrated Synthesis of Conditions, Processes, and Consequences

This section consolidates the theoretical integration developed across Chapter 6 to clarify how the grounded theory functions as a middle range explanatory model. Rather than revisiting categories as separate accounts, the synthesis specifies how conditions, processes, and consequences are linked within a single analytic system that explains patterned variation in nurses' endurance trajectories during and after the COVID-19 pandemic.

Endurance unfolded within organizational contexts characterised by sustained staffing instability, constrained resources, and managerial expectations that positioned continuation as normal. During the pandemic, these conditions intensified through policy volatility, inconsistent leadership engagement, and staff support that was frequently articulated as wellbeing discourse without consistent material enactment in everyday practice. Together, these organizational features formed the context in which nurses' physical and mental wellbeing was shaped and in which endurance was repeatedly demanded.

Within this context, nurses enacted processes that enabled continued functioning, including regulation of emotion and bodily response, reliance on peer support, and a continued commitment to professional standards even as strain accumulated (Hochschild, 2012; Bolton, 2010; Kinman and Teoh, 2021). At the same time, organizational arrangements generated repeated exposure to threat, restricted access to recovery and repair, and intensified moral harm through the ongoing experience of institutional betrayal and organizational abandonment (Smith and Freyd, 2014; Greenberg et al., 2020; UK COVID-19 Inquiry, 2023). Endurance therefore emerged not as a stable capacity but as a threshold phenomenon, continually recalibrated through the interaction between cumulative strain and the availability of relief (Berlant, 2011; Charmaz, 2014; Tronto, 2013).

The consequences of this system were cumulative and multi-level. At an individual level, participants described persistent fatigue, trauma related distress, and moral injury (Greenberg et al., 2020; Williamson et al., 2021; Dean et al., 2019). Relationally, trust within teams and towards organizations deteriorated, contributing to fragmentation, withdrawal, and silence (Bolton, 2010; Tyler, 2011; Maben and Bridges, 2020). Organizationally, these dynamics were reflected in sickness absence,

workforce instability, and heightened risk to continuity of care (NHS England, 2022; Buchan et al., 2022). At a wider system level, the loss of experienced staff and the erosion of professional meaning raised questions of longer-term workforce sustainability. The analytic groupings Surface Endurers and Fractured Endurers capture variation within this system by showing how some nurses sustained functioning at increasing personal cost, while others crossed thresholds where recovery and return became increasingly difficult.

In Charmaz's terms, this synthesis returns theoretical abstraction to the empirical world by demonstrating how conceptual constructs illuminate patterned consequences in lived experience (Charmaz, 2014, pp. 239–247, 266). It also clarifies why approaches centred solely on individual resilience are insufficient. Where structural conditions remain unchanged, and where moral repair and recovery are not enabled, continued functioning becomes increasingly dependent on personal sacrifice, with predictable harm to nurses' physical and mental wellbeing.

This integrated model provides the conceptual platform for the next stage of the chapter. Section 6.7 formalizes the theoretical architecture and names the grounded theory, establishing a clear handover into Chapter 7 where the theory is placed in dialogue with wider literature, policy, and organizational accountability.

6.7 Constructivist Grounded Theory Development

The development of a grounded theory requires more than assembling theoretical categories. It requires demonstrating how integrative theoretical components cohere into a conceptual explanation that accounts for process and variation across contexts and participants. Charmaz emphasises that theoretical integration should produce an interpretive rendering that explains how the studied world works, how processes unfold, and why consequences occur as they do (Charmaz, 2014, pp. 262–268; Charmaz, 2016). In this section, I consolidate the theoretical architecture generated through the analytic process and formally name the grounded theory as *Enduring the System and Bearing the Weight*.

Across sustained memo writing and iterative comparison, the theoretical integration demonstrated that nurses' continued functioning was shaped by the interaction between organizational demand, moral exposure, and embodied consequence. Endurance emerged as the organizing process because it accounted for what participants repeatedly emphasised, namely continuation without restoration, functioning under constraint, and persistence in contexts where institutional support was unstable, symbolic, or absent. The explanatory strength of the theory lies in its capacity to link what nurses did to keep going with the organizational conditions that required this persistence and with the consequences that followed when recovery and moral repair were repeatedly constrained.

Charmaz argues that naming a grounded theory is an act of conceptual commitment, and that the name should capture both the analytic core and the generative processes of the theory (Charmaz, 2014, pp. 266–268). The title *Enduring the System and Bearing the Weight* capture two inseparable conceptual insights.

Enduring the system foregrounds the structural dimension of the theory. It reflects how participants described working within organizational instability, directive reality mismatch, and constrained support, where continuation was treated as expected and where institutional responsibility was frequently displaced. Endurance here is not conceptualised as a trait, but as a response to organizational conditions that demanded sustained functioning.

Bearing the weight foregrounds the embodied and moral dimension of the theory. It captures the physical and mental load absorbed by nurses through accumulated fatigue, trauma, and ethical compromise, particularly when organizational acknowledgement, protection, and restoration were limited. The weight is therefore not only emotional, but also bodily and moral, carried by individuals while systems remained operational.

Together, these phrases articulate the central theoretical contribution of the study. Endurance is shown to be simultaneously imposed and enacted, produced at the intersection of institutional demand and professional commitment. This framing distinguishes the grounded theory from individualised models of burnout, coping, or resilience by locating wellbeing within a structural and moral field rather than within personal psychology alone. Whereas resilience discourse often implies recovery or return, the theory developed here explains continuation in the absence of restoration, and the cumulative consequences of that continuation for nurses' physical and mental wellbeing.

Figure 6.3. Theoretical Model of Enduring the System and Bearing the Weight

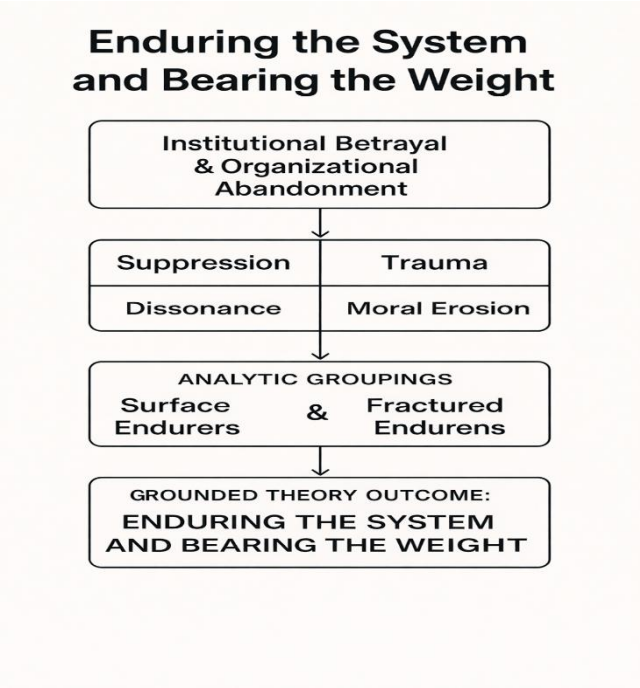


Figure 6.3 above presents the theoretical architecture of *Enduring the System and Bearing the Weight,* showing the theoretical movement from major categories to the core category and to the emergent theory. In line with Constructivist Grounded Theory, the figure demonstrates how theory was constructed through iterative comparison and memo development (Charmaz, 2014, pp. 239–242). Relevant conceptual terrains, including resilience and moral injury, operated as sensitising concepts that supported integrative questioning rather than functioning as deductive foundations (Charmaz, 2014, p. 30). The core category Institutional Betrayal and Organizational Abandonment occupy the integrative position within the model because it explains how organizational conditions shaped endurance demands while simultaneously constraining the organizational responses required to sustain endurance without harm.

Institutional Betrayal and Organizational Abandonment functions as the theoretical nucleus of the grounded theory. Its integrative strength lies in its ability to bind conditions, processes, and consequences into a single explanatory system. Participants consistently located distress not in isolated events but in repeated organizational patterns, including unmet obligations, opaque decision making, and the normalisation of sacrifice. In this study, institutional betrayal is theorised as cumulative and embedded in routine practice rather than episodic, operating as an organizing force that intensified strain and narrowed the space for recovery (Freyd, 2013; 2023).

Structurally, organizational abandonment was enacted through chronic understaffing, limited protected recovery time, inconsistent communication, and organizational narratives that emphasised individual coping within contexts where coping was systematically undermined. These arrangements increased endurance demands while removing the conditions required to sustain endurance without progressive harm.

Crucially, the core category explains patterned movement in endurance trajectories. The shift from Surface Endurance to Fractured Endurance corresponded not simply to accumulated workload but to the progressive erosion of trust and moral meaning associated with repeated experiences of betrayal and abandonment. In Charmaz's terms, this consolidation returns the theory to the empirical world by demonstrating how abstract concepts illuminate lived experience and patterned outcomes (Charmaz, 2014, p. 266). Institutional Betrayal and Organizational Abandonment reframe nurses' wellbeing away from individual failure and towards organizational responsibility. It explains how nurses endured, why endurance was repeatedly required, and why endurance could not be sustained indefinitely without structural change, establishing a clear conceptual handover into Chapter 7.

The conceptual groupings Surface Endurers and Fractured Endurers provide the final empirical anchoring of the grounded theory *Enduring the System and Bearing the Weight*. Rather than functioning as descriptive categories or psychological classifications, they operate as patterned positions within the endurance process, demonstrating how shared organizational and moral

conditions generated divergent trajectories over time. In Charmaz's terms, this positioning foregrounds variation within process rather than difference between people, showing how conditions shape movement, stability, and rupture (Charmaz, 2014, pp. 243–247; Charmaz, 2016, pp. 9–12).

Crucially, movement between these positions was contingent rather than inevitable. Participants described shifts in response to changes in leadership presence, staffing continuity, perceived fairness, and the degree to which harm was acknowledged or addressed. This fluidity reinforces the central theoretical claim that endurance is produced through organizational arrangements. Systems, rather than individuals, generated the conditions under which endurance could be sustained or fractured.

By returning to these patterned trajectories at the close of theoretical integration, theoretical integration and grounded theory development fulfils Charmaz's expectation that grounded theory should reconnect conceptual abstraction to lived experience (Charmaz, 2014, p. 268). Surface and Fractured Endurers show how the theory is enacted, evaluated, and ultimately bounded in practice, providing a secure transition to the conceptual extensions and governance focused discussion that follows.

While earlier sections demonstrated how endurance was generated through interacting conditions, processes, and consequences, the purpose here is to position the theory in relation to broader debates on moral economy, ethical sustainability, and institutional responsibility for workforce wellbeing. In line with Charmaz's guidance, this engagement illuminates the conceptual contribution of the emergent theory (Charmaz, 2014, pp. 281–283).

Endurance is theorised not only as a response to organizational strain, but as a structural and moral logic through which healthcare systems maintain functioning under sustained pressure while transferring risk, cost, and responsibility onto nurses. By engaging these conceptual domains, theoretical integration situates endurance at the intersection of organizational governance, moral obligation, and embodied professional labour (Lipsky, 2010; Bolton, 2010; Hutter and Power, 2005).

Participants' accounts indicate that during and after the COVID-19 pandemic, endurance functioned as a form of moral currency. Nurses absorbed organizational deficits through emotional labour, bodily sacrifice, and ethical self-regulation to keep services operational. Their willingness to continue functioning became both the mechanism through which systems endured and the moral justification for delayed or absent institutional response. This dynamic aligns with wider critiques of affective labour extraction in contexts where commitment and care are mobilised to stabilise structurally fragile systems (Hochschild, 2012; Berlant, 2011; Bolton, 2010).

This moral economy was asymmetrical. While endurance was publicly acknowledged through narratives of heroism and appreciation, it was rarely reciprocated through staffing stability, protected recovery time, or structured ethical support. Participants described a widening gap between organizational expressions of value and lived experiences of depletion, dissonance, and moral

compromise. It is within this gap that the core category Institutional Betrayal and Organizational Abandonment become conceptually core. Betrayal is theorised here not as a singular rupture, but as a patterned moral failure in which expectations of care and reciprocity repeatedly exceeded organizational provision (Smith and Freyd, 2014; Freyd, 2013; Maben and Bridges, 2020).

From a Constructivist Grounded Theory perspective, such contradictions are theoretically significant because they expose the collision between moral expectations and structural constraints, producing disillusionment and reinterpretation of professional identity (Charmaz, 2014, pp. 260–266). Positioning endurance within a moral economy reframes the grounded theory as a socio-moral account of how healthcare systems depend upon the ethical commitments of nurses while undermining the organizational conditions required to sustain those commitments over time (Fassin, 2012; Tronto, 2013).

Through this lens, endurance emerges as a relational achievement rather than an individual attribute. It demonstrates how nurses sustained systems that failed to sustain them, and how moral commitment itself became a governance resource within the healthcare organization (Lipsky, 2010; Tyler, 2011; Hutter and Power, 2005). This framing prepares the ground for the following section, which examines ethical sustainability and institutional responsibility.

Building on the moral economy framing, this section conceptualises ethical sustainability as the organizational condition required to interrupt harmful cycles of endurance. While sustainability is often associated with financial or environmental continuity, this study demonstrates the necessity of sustaining moral accountability, relational trust, and humane working conditions if endurance is to be maintained without progressive harm (Tronto, 2013; Fassin, 2012; Tyler, 2011).

Participants described organizational cultures marked by inconsistent leadership communication, limited acknowledgement of moral burden, and a reliance on wellbeing rhetoric in place of structural change. Such conditions are incompatible with ethical sustainability because they require staff to absorb ethical and emotional costs privately while institutions continue to operate without moral recalibration (Bolton, 2010; Maben and Bridges, 2020; Greenberg et al., 2020; West et al., 2020).

This conceptual move aligns with Charmaz's call for grounded theory to engage with broader moral and social worlds rather than remaining at the level of individual experience alone (Charmaz, 2014, pp. 281–284). Ethical sustainability is therefore positioned not as an aspirational value, but as a structural requirement for endurance without harm. Where ethical sustainability is absent, endurance becomes increasingly dependent on personal sacrifice, and fracture becomes a predictable organizational outcome rather than an exceptional event (Tronto, 2013; Fassin, 2012; Tyler, 2011; Bolton, 2010).

Viewing endurance through this lens strengthens the theoretical contribution of *Enduring the System and Bearing the Weight*. It clarifies that endurance collapses not simply because demands intensify,

but because reciprocal moral obligations are not institutionally sustained (Greenhalgh, 2020; Maben and Bridges, 2020; West et al., 2020). Ethical sustainability thus functions as both an interpretive concept within the theory and an evaluative principle through which organizational practices can be critically examined, providing a clear conceptual bridge to the applied, policy, and governance focused discussion in Chapter 7.

If ethical sustainability represents the organizational condition required to prevent harm, moral repair represents the process through which fractured relationships between staff and institutions can be addressed. Moral repair is theorised here as the work of rebuilding trust, accountability, and shared moral understanding following ethical injury (Walker, 2006; Fassin, 2012; Freyd, 2013). Within healthcare systems, this requires more than individual support or reflection. It demands institutional acknowledgement of harm, acceptance of responsibility, and demonstrable structural change.

The concept of institutional courage provides a counterpoint to the patterns captured in the core category Institutional Betrayal and Organizational Abandonment. Institutional courage refers to an organization's willingness to recognise wrongdoing, listen to those affected, and reform the conditions that enabled harm to occur. Positioned within the grounded theory, institutional courage represents the conceptual inverse of betrayal and abandonment, identifying a pathway through which endurance trajectories may be stabilised or redirected (Freyd, 2018; Smith and Freyd, 2014; Tronto, 2013).

Participants' accounts illustrated the consequences of absent moral repair. Unacknowledged ethical compromise, unresolved guilt, and perceived organizational silence persisted beyond the acute phases of the pandemic. These experiences were linked to emotional withdrawal, loss of professional meaning, and intentions to reduce roles or leave the profession. Such consequences underscore that harm does not dissipate through time or individual coping alone but accumulates where organizational response is limited or absent.

Situating moral repair and institutional courage within the grounded theory performs two analytic functions. First, it locates repair at the level of organizational systems rather than individual psychology. Second, it clarifies that restoring endurance is not achieved by promoting greater personal resilience, but by transforming the moral and structural conditions that generated harm. In this way, the theory maintains its central claim that endurance is relational and system shaped, contingent on how institutions respond to vulnerability, accountability, and care (Freyd, 2018; Tronto, 2013; Brown and Baker, 2012; Tyler, 2011).

This conceptual extension provides the foundation for the applied elements introduced later in the chapter. By establishing ethical sustainability and moral repair as organizational conditions, theoretical integration prepares for the articulation of the Endurance Framework and associated indicators, while preserving a clear boundary between theoretical integration in Chapter 6 and evaluative and policy engagement in Chapter 7.

6.7.1 Endurance as Ethical Architecture

This section consolidates the conceptual argument by positioning endurance not only as an experience lived by nurses, but as an ethical architecture embedded within healthcare systems. Ethical architecture refers here to the moral, organizational, and relational arrangements through which care is structured, sustained, and valued in practice. This framing relocates endurance from the domain of individual experience to the level of system design, shaping what forms of labour, sacrifice, and responsibility become normalised (Tronto, 2013; Brown and Baker, 2012; Bolton, 2010).

Within this architecture, suppression, trauma, organizational dissonance, and moral erosion operate as interdependent components that configure whether endurance functions as a stabilising condition, reflected in Surface Endurance, or becomes destructive, culminating in Fractured Endurance. These elements map the organizational environment through which endurance is produced, strained, and ultimately exceeded (Charmaz, 2014; Lipsky, 2010; Perrow, 1999).

Endurance becomes architectural when emotional labour substitutes for structural support, moral duty substitutes for institutional accountability, physical sacrifice substitutes for safe staffing, and personal coping substitutes for organizational repair. Under these conditions, endurance enables systems to continue functioning while concealing the absence of ethical sustainability. This architecture is therefore both enabling and constraining. It permits care delivery under extreme pressure yet embeds harm within routine organizational arrangements (Bolton, 2010; Tronto, 2013; Maslach and Leiter, 2016; Tyler, 2011).

Drawing on Mol's (2008) account of care as shaped by practice and arrangement rather than by intention alone, the grounded theory demonstrates that endurance is configured by institutional structures that define what is possible, permissible, and sustainable for nurses. Conceptualising endurance as ethical architecture shifts the theory decisively towards an account of organizational responsibility, clarifying how systems actively shape what levels of sacrifice become tolerated and expected. This framing reinforces theoretical integration and grounded theory development conclusion that responsibility for sustaining endurance without harm lies at organizational rather than individual level. It also prepares the conceptual ground for translating the theory into applied organizational frameworks in the following section.

6.7.2 Endurance as an Underdeveloped Construct in Healthcare Scholarship

Despite its empirical salience, endurance remains underdeveloped within nursing and wider healthcare scholarship (Maslach and Leiter, 2016; Traynor, 2018; West et al., 2020). Dominant constructs such as resilience, burnout, compassion fatigue, and occupational stress tend to frame wellbeing as an individual psychological outcome rather than as a structural, moral, and embodied process shaped by organizational conditions. As a result, the sustained capacity to continue

functioning under prolonged systemic strain is often assumed rather than theorised (Maslach and Leiter, 2016; Traynor, 2018; West et al., 2020).

Endurance appears only intermittently in adjacent literatures, including palliative care, sports science, and sociological analyses of constraint, but has not been developed as a healthcare workforce construct capable of explaining how organizations depend on continued human functioning under conditions of ethical ambiguity, material scarcity, and prolonged exposure to harm. There is no established conceptual model or organizational lens through which endurance is examined, despite its centrality to nurses' experiences during and after the COVID-19 pandemic (Berlant, 2011; Lipsky, 2010; Mol, 2008).

The grounded theory developed in this study makes an original contribution by theorising endurance as a system shaped, morally configured, and embodied process rather than as an individual capacity. It identifies how endurance thresholds are generated, links endurance to institutional betrayal and organizational abandonment, and positions endurance as an ethical indicator of organizational integrity. In doing so, it moves endurance from an implicit background condition to the organising process through which healthcare systems persist, stabilise, and fracture (Freyd, 2013; Tronto, 2013; Charmaz, 2014).

This conceptualisation establishes the theoretical foundation for the applied frameworks introduced in the following section. It frames endurance as a socio moral construct and an institutional responsibility, creating the conditions for translating theoretical insight into organizational reflection and governance without reducing conceptual complexity or moral significance.

6.8 Translating the Theoretical Model into Applied Frameworks

Charmaz emphasises that grounded theory earns its theoretical significance by demonstrating its usefulness through conceptual insight rather than through technical application or measurement (Charmaz, 2014, p. 341; Charmaz, 2016, pp. 35–36). In this study, usefulness is understood as the capacity of the grounded theory to illuminate organizational conditions, moral consequences, and pathways for institutional reflection and accountability (Tronto, 2013; Freyd, 2013; Monteith et al., 2020).

The grounded theory *Enduring the System and Bearing the Weight* provide a structural account of how moral, physical, psychological, and organizational processes converge to shape patterns of endurance among nurses working during and after the COVID-19 pandemic. Theoretical integrative work in this chapter demonstrates that endurance operates as a system level process governed by institutional arrangements rather than by individual disposition. This insight points to the need for a conceptual apparatus capable of rendering endurance visible and discussable at organizational level

without reducing its relational or moral complexity (Braithwaite et al., 2017; West et al., 2020; Traynor, 2018).

This section therefore introduces three interconnected applied frameworks: The Endurance Framework, The Endurance Gauge, and The Endurance Index, structured around a twelve-month organizational cycle. These frameworks do not function as instruments of measurement or evaluation. They operate as conceptual translations of the grounded theory, designed to support organizational sense making by mapping conditions, processes, and consequences within the endurance system (Weick, 1995; Torraco, 2016; Charmaz, 2014).

The Endurance Framework provides a conceptual map linking the core category, theoretical mechanisms, and threshold dynamics identified in the theory, enabling the organization to reflect on how endurance is produced, sustained, and destabilised within specific contexts. The Endurance Gauge offers a visual representation of organizational balance across moral, physical, psychological, and structural domains, highlighting where strain accumulates and where recovery or repair is enabled or constrained (Greenberg et al., 2020; Maben and Bridges, 2020). The Endurance Index extends this logic temporally, positioning endurance as an ethical indicator of organizational integrity over time rather than as an individual capacity to cope.

Together, the Endurance Frameworks fulfil Charmaz's expectation that grounded theory should offer abstract understanding that people can use to interpret and engage with the worlds they inhabit (Charmaz, 2014, p. 341). They preserve the conceptual integrity of the theory while creating structured space for ethical reflection, organizational accountability, and governance focused dialogue that extends beyond the immediate empirical setting of the study.

6.8.1 The Endurance Framework: Conceptual Model

The Endurance Framework represents the primary conceptual synthesis of this grounded theory. It translates the theoretical mechanisms, the threshold model of endurance, and the core category into a coherent system of relations. In keeping with Charmaz's guidance that theoretical integration should demonstrate how major categories are woven into a larger explanatory framework, the model captures endurance as it unfolded across the data as structurally conditioned, morally textured, physically embodied, and psychologically sustained (Charmaz, 2014, p. 247).

The Endurance Framework is organized around three interdependent domains, physical, psychological, and moral and ethical capacities, which theoretical integration demonstrated as inseparable in practice. Rather than treating domains as discrete or additive, the Endurance Framework conceptualises endurance as a relational state emerging from the interaction between bodily load, emotional regulation, and moral integrity. These domains align directly with the four mechanisms theorised earlier in this chapter. *Affective and somatic regulation* captures the containment of emotional and bodily distress to preserve functioning. *Cycling threat exposure* reflects

the persistence of aftershocks through repeated cues and unresolved trauma. *Structurally constrained recovery* represents how organizational dissonance limited rest, repair, and predictability. *Moral erosion* captures ethical strain, silencing, and loss of professional coherence. Their convergence produces Cumulative Endurance Load (CEL) and shapes movement between Surface Endurance, Adaptive Strain, and Fractured Endurance.

At the centre of The Endurance Framework sits the core category Institutional Betrayal and Organizational Abandonment. Its central placement reflects its conceptual role as the interpretive hinge connecting conditions, processes, and consequences across theoretical integration. Charmaz emphasises that a core category should account for most of the variation in the data and provide explanatory coherence across synthesis components (Charmaz, 2014, p. 140). In this Framework, institutional betrayal and organizational abandonment function as the organizing condition that shaped how nurses interpreted organizational intent, how their mental and physical resources were taxed, and how recovery and moral repair became possible or were blocked.

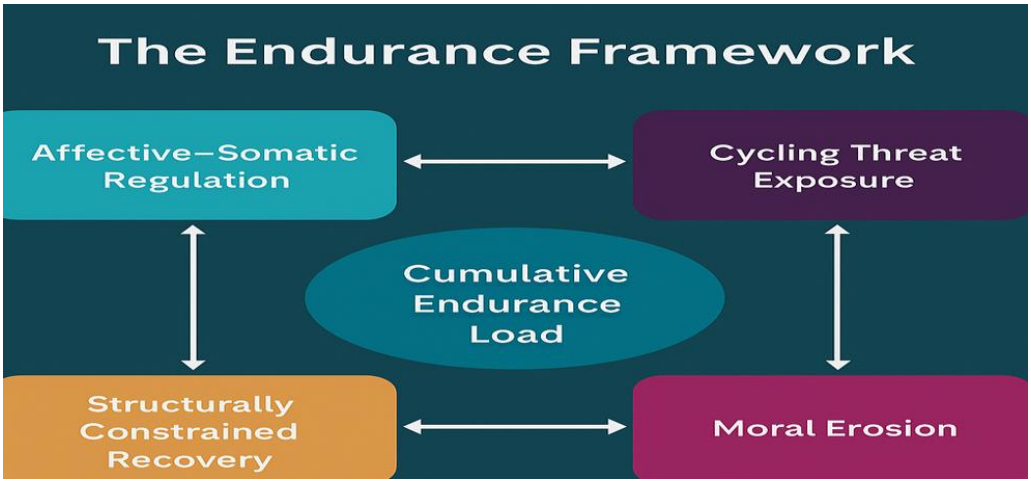
Surrounding the core category, The Endurance Framework incorporates The Threshold Model of Endurance. This element captures the shifting relational balance across the three domains, illustrating how nurses moved between surface endurance, adaptive strain, and fractured endurance in response to organizational conditions, moral climate, and embodied depletion. Movement is not linear and not reducible to individual capacity. It is structurally mediated, shaped by how systems organize demand, visibility, acknowledgement, and access to repair (Weick, 1995; Braithwaite et al., 2017; West et al., 2020).

The Endurance Framework also makes visible relational contingencies that moderated endurance trajectories, including team cohesion, leadership presence, access to repair spaces, opportunities for emotional processing, and the presence or absence of institutional courage. These contingencies influence whether cumulative strain stabilises through relief and repair or consolidates into fracture (Tronto, 2013; Greenberg et al., 2020; Smith and Freyd, 2014). By rendering these relationships explicit, the Framework demonstrates how endurance is governed through organizational arrangements rather than merely experienced as individual struggle (Traynor, 2018; Maben and Bridges, 2020).

Theoretical contribution of The Endurance Framework (see **Figure 6.4**) lies in its capacity to unify physical, psychological, and moral processes within a single relational system. Rather than separating distress as psychological, fatigue as physical, and betrayal as organizational, The Endurance Framework shows how these states are mutually constitutive. This responds to Charmaz's call to theorise processes that cut across spheres of experience rather than isolating them analytically (Charmaz, 2014, p. 260; Hochschild, 2012; Bolton, 2005). The Framework also shifts the theoretical integration focus away from resilience and towards structural and ethical endurance, foregrounding

organizational responsibility for the conditions that demanded endurance while obscuring its costs (Traynor, 2018; West et al., 2020; WHO, 2021).

Figure 6.4. The Endurance Framework



The placement of the Endurance Framework at this point in Chapter 6 reflects its role as the culmination of theoretical integration. Earlier sections established the mechanisms, the core category, and the threshold logic of endurance. The Framework consolidates these analytic components into a unified model that makes explicit the conceptual architecture of the grounded theory. In line with Charmaz's guidance that theoretical integration must demonstrate how conceptual parts cohere into a whole, the Framework functions as the bridge between theory development and applied translation (Charmaz, 2014, p. 247).

Having established the Endurance Framework as the conceptual architecture of this grounded theory, theoretical integration now turns to its applied elaboration. While the Framework clarifies how physical, psychological, and moral processes interrelate, the next section introduces two applied tools that render endurance movement legible at organizational level, the Endurance Gauge and the Endurance Index. Developed directly from the grounded theory, these tools extend the Framework by translating its relational logic into organizationally usable forms without reducing conceptual complexity. (Charmaz, 2014; Weick, 1995; Braithwaite et al., 2017).

6.8.2 Theoretical Integration Contribution of the Framework

The Endurance Framework advances the theoretical contribution of this study by providing a single conceptual structure through which nurses' physical and mental wellbeing can be understood as organizationally shaped rather than individually located (Traynor, 2018; Maben and Bridges, 2020; West et al., 2020). First, it integrates physical, psychological, and moral and ethical capacities within

one relational system, demonstrating how embodied strain, emotional regulation, and moral coherence interact to shape endurance trajectories. Second, it locates organizational responsibility at the centre of explanation by positioning Institutional Betrayal and Organizational Abandonment as the core condition shaping endurance demands and access to recovery and moral repair. (Smith and Freyd, 2014; Monteith et al., 2020; UK COVID-19 Inquiry, 2023). Third, it safeguards conceptual coherence for the applied models that follow by establishing a clear logic for how endurance can be rendered visible and discussable in organizational governance without collapsing the analysis into individualised coping or managerial metrics (ILO/WHO, 2021; WHO, 2021). The Endurance Framework therefore functions as a necessary conceptual bridge. It concludes theoretical integration by making the explanatory logic of the grounded theory explicit, and it provides the foundation for translation into The Endurance Gauge and The Endurance Index, which are introduced next.

6.8.3 The Endurance Gauge: Visualising Threshold Movement in Organizational Endurance

While The Endurance Framework establishes the conceptual architecture of endurance, it does not in itself render movement visible. The Endurance Gauge addresses this by visualising endurance as a threshold process. It depicts movement between Surface Endurance, Adaptive Strain, and Fractured Endurance as organizational conditions shift, and as recovery and moral repair are enabled or constrained. In line with Charmaz's emphasis on theorising process, The Endurance Gauge foregrounds transition rather than classification (Charmaz, 2014). It presents endurance as continually negotiated within organizations through the interaction of physical load, psychological regulation, moral and ethical strain, and the organizational conditions that shape access to relief.

Surface Endurance represents continued functioning under pressure. Demand is present, but buffering conditions remain partially intact, such as team cohesion, leadership presence, professional identity, and access to recovery windows. Adaptive Strain represents a narrowing margin in which endurance is increasingly held at cost. Recovery space contracts, emotional containment intensifies, and moral tension becomes more prominent. Fractured Endurance represents a threshold breach in which cumulative load exceeds what can be absorbed or repaired within prevailing conditions. At this point, harm becomes visible through withdrawal, sickness absence, moral injury, or exit.

The Endurance Gauge makes explicit that movement between states is not linear or individually driven. Endurance may stabilise or improve where relief is materially enabled through staffing support, ethical acknowledgement, and protected recovery. Conversely, where pressure is sustained and repair remains constrained, endurance tightens towards fracture. In this way, the Gauge translates what participants described as "*holding it together*," "*running on empty*", or "*reaching breaking*" point into an organizationally legible account of strain without reducing experience to a single outcome.

Figure 6.5. The Endurance Gauge: Visualising Threshold Movement in Organizational Endurance

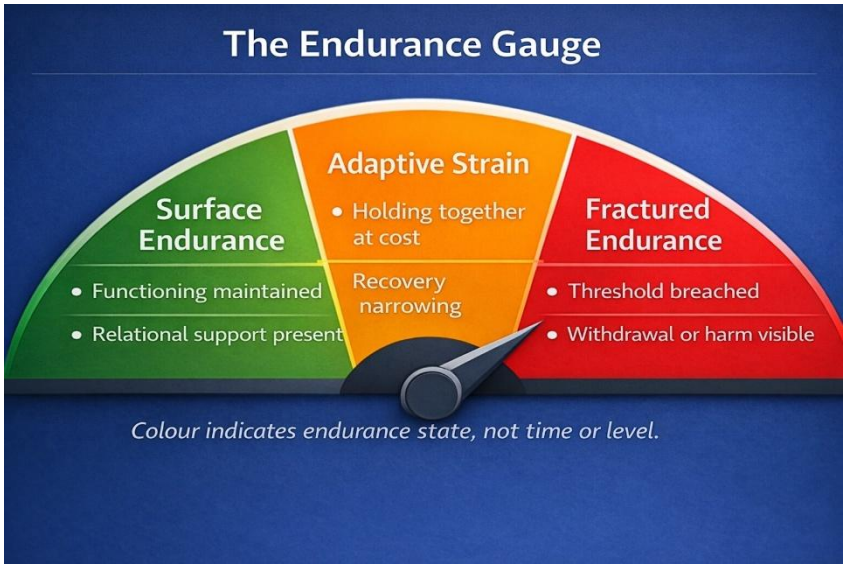


Figure 6.5 above presents The Endurance Gauge as a visual representation of endurance movement within organizational contexts. The Gauge illustrates how endurance can tighten towards fracture before deterioration becomes fully visible through conventional organizational indicators.

6.8.4 The Endurance Index: Mapping Patterned Organizational Endurance

Where The Endurance Gauge offers an interpretive snapshot of endurance movement, The Endurance Index extends the analytic work by mapping where endurance repeatedly settles under prevailing organizational conditions. In keeping with Constructivist Grounded Theory, The Endurance Index is not presented as a measurement instrument in a positivist sense. It functions as conceptual map that renders patterned organizational endurance visible across time by linking conditions, processes, and consequences at collective level.

Through constant comparison and memo development, it became evident that strain and fracture were not random. Endurance clustered predictably in relation to recurring organizational arrangements, including staffing instability, leadership presence or absence, access to recovery, and acknowledgement or denial of moral harm. The Endurance Index was developed to capture these patterned endurance locations without reducing the grounded theory to a score and without displacing responsibility onto individual nurses.

The Endurance Index builds directly from the threshold logic developed earlier in this chapter. It retains the three endurance states, Surface Endurance, Adaptive Strain, and Fractured Endurance, but shifts conceptual attention from fluctuation to patterned positioning. The Endurance Index therefore addresses a different conceptual question from The Endurance Gauge. It asks where endurance tends to reside when organizational conditions remain broadly unchanged and when pressures recur.

The Endurance Index is structured around four interrelated analytic domains, physical, psychological, moral, and ethical, and systemic. These domains reflect the architecture established in The Endurance Framework, while making explicit the organizational conditions that bind domains together in practice. Each domain is populated by indicators derived from the study categories and mechanisms, preserving the grounded theory logic of conditions shaping processes and processes giving rise to consequences (Charmaz, 2014, pp. 239 to 247).

Importantly, The Endurance Index does not assess individuals. It maps organizational climates and collective endurance states, locating endurance at team and organizational level rather than within personal coping capacity. This orientation aligns with the core argument of the study that endurance is socially produced and institutionally shaped. By mapping endurance in this way, The Endurance Index avoids pathologizing nurses and makes visible the structural and moral conditions that sustain, strain, or fracture endurance over time, consistent with Charmaz's emphasis on theorising social processes rather than individual attributes (Charmaz, 2014, pp. 260 to 263).

The Endurance Index also provides a bridge between theoretical integration interpretation and organizational governance. By translating qualitative patterning into theoretical integration structure, it enables endurance to be recognized as an organizational signal rather than an invisible labour absorbed by staff. This is a claim of recognition and accountability rather than prediction or managerial control. The Index creates a way for the organization to see when endurance is being relied upon as a substitute for repair, when strain is becoming normalised, and when fracture is likely to follow if conditions remain unchanged.

Figure 6.6. The Endurance Index: Mapping Patterned Organizational Endurance

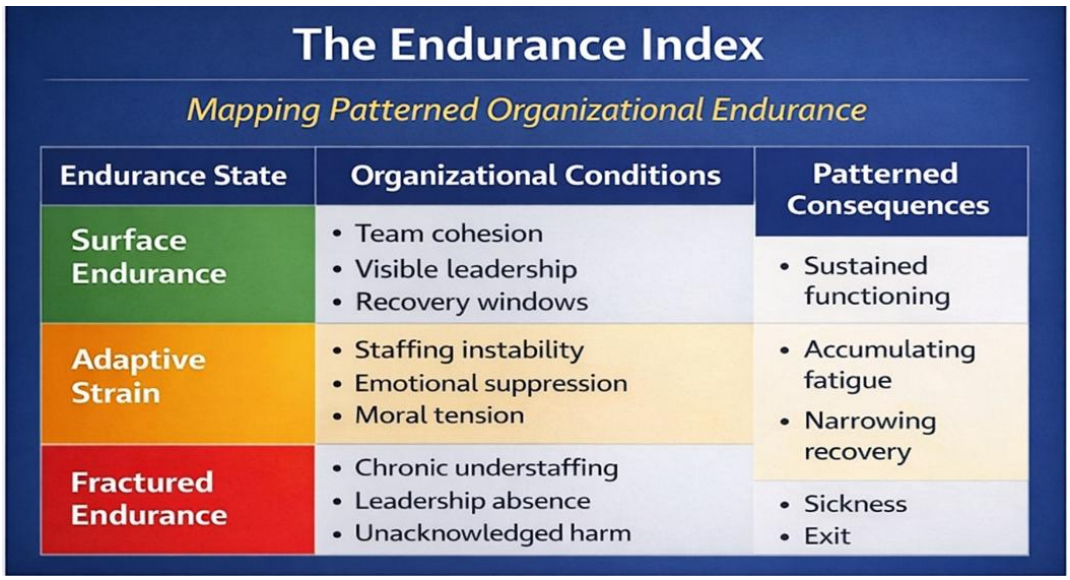


Figure 6.6 above presents the Endurance Index as conceptual map of organizational endurance, showing how endurance states cluster in relation to recurring structural and moral conditions. Read

alongside The Endurance Gauge, The Endurance Index demonstrates not only how endurance moves, but where it repeatedly settles.

Integrating the Applied System Across Organizational Cycles

Taken together, The Endurance Framework, The Endurance Gauge, and The Endurance Index form an integrated applied system derived from the grounded theory. Each component performs a distinct theoretical integration function. The Endurance Framework establishes the relational architecture of endurance. The Endurance Gauge renders threshold movement visible. The Endurance Index maps patterned positioning over time (Charmaz, 2014; Torraco, 2016; Weick, 1995).

This integrated system supports interpretation across routine organizational cycles without requiring individual disclosure or producing a new layer of surveillance (Braithwaite et al., 2017; ILO/WHO, 2021). The Endurance Index aligns with longer review rhythms, including annual workforce reporting, governance assurance processes, and quality or safety reviews, enabling reflective examination of cumulative endurance positioning. The Endurance Gauge aligns with interim reflection points throughout the year, particularly during periods of heightened pressure such as winter escalation, service reconfiguration, or system disruption, supporting earlier recognition of tightening endurance before fracture becomes organizationally visible through turnover or sickness (NHS England, 2023; WHO, 2021).

This dual temporal orientation reflects a core analytic finding of the study. Deterioration was rarely sudden. Instead, fracture developed through prolonged periods of suppressed strain, constrained recovery, and moral erosion that remained unrecognised or was reframed as individual coping. Locating endurance at team and organizational level therefore preserves the analytic integrity of the theory and reinforces organizational accountability for the conditions that shape nurses' physical and mental wellbeing.

6.8.5 From Categories to Theory: Theoretical Integration and Model Development

The preceding sections complete the theory development task of theoretical integration by demonstrating how the grounded theory *Enduring the System and Bearing the Weight* operate as a coherent explanatory system. In keeping with Constructivist Grounded Theory, theoretical integration requires sufficient conceptual density to explain the phenomenon under study, account for variation, and illuminate process in ways that remain grounded in participants' meanings (Charmaz, 2014).

The integrated model developed in this chapter demonstrates that endurance is a patterned organizational process shaped by identifiable structural conditions, mediated through relational and moral dynamics, and expressed through cumulative physical and psychological consequences. The core category Institutional Betrayal and Organizational Abandonment anchor this explanation by

showing how organizational actions and omissions shaped both the demand for endurance and its limits, particularly where moral repair and recovery were repeatedly constrained.

Importantly, the applied components do not function as interventions or evaluative instruments. They operate as theoretical integration translations that preserve interpretive depth while enabling organizational recognition of endurance as an ethical and structural signal. This concludes theoretical integration within the study. What follows is no longer a question of how the theory coheres, but how it contributes to existing knowledge and how it reframes understanding of nurses' physical and mental wellbeing within wider scholarly, policy, and practice debates. These questions are taken forward in Chapter 7.

Ethical and Governance Implications

Applied together, The Endurance Gauge and The Endurance Index reposition nurses' physical and mental wellbeing as an ethical and governance concern rather than an individual responsibility (Charmaz, 2014; Traynor, 2018; West et al., 2020). They make visible how organizational decisions shape endurance, and how sustained reliance on endurance can conceal harm until fracture becomes organizationally undeniable (Maben and Bridges, 2020; Smith and Freyd, 2014; WHO, 2021).

This reframing has direct implications for leadership practice. Instead of treating wellbeing as the management of individual coping, the applied system locates responsibility within organizational design, moral acknowledgement, and protected access to recovery and repair (Braithwaite et al., 2017; ILO/WHO, 2021; RCN, 2022). In this sense, the Gauge and Index support ethical sustainability by enabling earlier recognition of when endurance is being relied upon as a substitute for structural support, and by creating a shared language for addressing strain before thresholds are breached (Greenberg et al., 2020; West et al., 2020; WHO, 2021).

By rendering endurance visible as an organizational condition, the applied frameworks support a shift from reactive response to initiative-taking ethical stewardship (Weick, 1995; Torraco, 2016). Their use does not depend on new metrics, but on the willingness of organizations to interpret endurance as a governance signal and to act on the structural and moral conditions that sustain, strain, or fracture it (Charmaz, 2014; RCN, 2023; UK COVID-19 Inquiry, 2023).

6.9 Conclusion to Chapter 6

This chapter advanced synthesising and conceptualizing the work of the study from category construction and findings to theoretical integration and grounded theory development. Drawing on Constructivist Grounded Theory, I demonstrated how the four conceptual categories cohere through the core category Institutional Betrayal and Organizational Abandonment to explain nurses' experiences of working during and after the COVID-19 pandemic as a patterned process of Endurance.

Through theoretical integration, endurance was conceptualised as a threshold phenomenon shaped by organizational, moral, physical, and psychological conditions. It was theorised not as an individual capacity, but as a relational and systemic process governed by institutional arrangements, leadership practice, and the availability or absence of recovery and moral repair. This integration explains how conditions, processes, and consequences interacted to produce variation across nurses' trajectories, including the patterning captured through Surface Endurers and Fractured Endurers.

To translate theoretical explanation into organizationally intelligible form without reducing conceptual or moral complexity, the chapter developed three interconnected applied frameworks. The Endurance Framework consolidated the conceptual architecture of Endurance by integrating the core category, mechanisms, and threshold logic. The Endurance Gauge visualised endurance as movement between Surface Endurance, Adaptive Strain, and Fractured Endurance as organizational pressures intensified or relief became available. The Endurance Index mapped where endurance repeatedly settled under recurring conditions, rendering patterned organizational endurance visible over time.

Together, these frameworks form an integrated applied system that preserves interpretive depth while enabling endurance to be recognized, discussed, and reflected upon at team and organizational level. Importantly, the chapter maintained a clear boundary between theoretical translation and prescription. The Endurance Frameworks developed here function as conceptual tools for sense making and accountability rather than instruments of measurement or intervention.

This chapter completed theoretical integration by demonstrating how the grounded theory *Enduring the System and Bearing the Weight* cohere into a sufficient explanatory model. Moving beyond category description, I showed how nurses' experiences of working during and after the COVID-19 pandemic can be understood as endurance shaped by organizational conditions that governed recovery, recognition, and ethical reciprocity.

By integrating the four conceptual categories through the core category Institutional Betrayal and Organizational Abandonment, endurance was theorised as a threshold process rather than an expression of individual resilience. The chapter demonstrated how endurance was produced, sustained, and fractured within institutional contexts, shifting conceptual attention from individual coping to organizational responsibility.

The Endurance Framework, Endurance Gauge, and Endurance Index translated this explanation into a coherent applied system that makes visible the architecture, movement, and patterned consequences of endurance at team and organizational level without reducing moral or experiential complexity. In doing so, the chapter addressed theoretical integration invisibility of cumulative physical and mental strain described by participants and established a stable conceptual foundation for the next stage of the thesis. Chapter 7 builds on this foundation by placing the grounded theory in dialogue with wider scholarship and by articulating its contribution to knowledge, policy, and practice.

Chapter 7: DISCUSSION

7.1: Introduction

As the analysis brought together nurses' accounts of physical depletion, emotional holding, and moral strain, a broader concern began to surface how these experiences were noticed, interpreted, or at times overlooked within the organizations in which they worked. This raised questions not only about individual wellbeing, but about where responsibility sits when strain becomes routine and recovery remains uncertain. The applied concepts introduced in this chapter grow out of this concern, offering ways of thinking about how leadership, occupational health, and workforce functions might create shared spaces for reflection, acknowledgement, and response, rather than leaving endurance to be carried privately by nurses themselves. This chapter engages the grounded theory of *Enduring the System and Bearing the Weight* in conversation with broader organizational, professional, and empirical discussions around nurses' physical and mental wellbeing during and after COVID-19. Following the theoretical integration in Chapter 6, I synthesise the insights the theory provides on organizational responsibility, ethical sustainability, and the prolonged impact of worker injury that transcends the emergency period.

In Constructivist Grounded Theory, the discourse does not reiterate the findings. It elucidates the theory's explanations, its relationship with established knowledge, and the conceptual functions it serves (Charmaz, 2014). I use literary and policy materials as comparative reference points instead of evaluative criteria. This enables me to illustrate the alignment of the theory with previous literature, its extensions, and its reframing of prevailing notions regarding post-pandemic nursing wellbeing.

The chapter presents four interconnected arguments. Nurses' physical and mental wellbeing cannot be comprehensively understood as merely an individual psychological issue, since participants' narratives situate strain, recovery, and harm within organizational settings, fluctuating risks, and limited restorative opportunities. Secondly, endurance is conceptualised as a socially organized phenomenon rather than an individual virtue, manifesting in contexts where systems depend on nurses to endure structural instability. The conceptual categories Surface Endurers and Fractured Endurers enhance current worker narratives by elucidating how persistence and fracture can arise from analogous contexts yet progress along divergent paths. Ultimately, the theory presents a conceptual framework for synthesising ethical sustainability, focussing on the critical question of whether nurses can maintain safe practice and moral integrity throughout time.

I engage in discussions regarding worker wellbeing, moral harm, organizational ethics, and the tangible experiences of nursing work to further these views. The objective is not to assert that previous work has overlooked these domains, but to demonstrate that they are frequently addressed in isolation rather being included into a cohesive, organizationally based explanation of how harm

accumulates, stabilises, and endures. This is the intellectual framework within which *Enduring the System and Bearing the Weight* make its principal contribution.

7.2 NHS and Global Workforce Wellbeing Preceding and Following COVID-19

The wellbeing of the NHS workforce was influenced by persistent structural stress long before the onset of COVID-19. In the decade prior to the pandemic, austerity policies, increased service demand, and constrained workforce expansion established a pattern of chronic understaffing, heightened vacancy rates, and ongoing capacity pressures (The King's Fund, 2015; Buchan et al., 2019; Health Foundation, 2019). Nursing increasingly depends on prolonged hours, emotional labour, and the expansion of professional boundaries, framing coping as a standard practice rather than an indication of systemic failure (Ball et al., 2017; Bolton, 2010; Maben and Bridges, 2020).

Global evidence demonstrates analogous trends. Research in Europe, Australia, and Canada reveals escalating workloads, presenteeism, attrition risk, and perceptions of organizational unfairness associated with worker shortages and little institutional support (Aiken et al., 2012; ICN, 2019; OECD, 2020; Perry et al., 2021). Organizational literature interprets this dynamic as the transference of structural strain into employees' physical states, emotional responses, and ethical obligations, making organizational scarcity manageable through individual adaptability (Hochschild, 2012; Berlant, 2011; Theodosius, 2008; Allen, 2015).

COVID-19 did not create these vulnerabilities but rather exacerbated and worsened them. Initial pandemic assessments indicated significant rises in anxiety, sleep disturbances, moral distress, and trauma-related symptoms among healthcare professionals, coupled with policy volatility, erratic communication, and diminished leadership presence that undermined trust and intensified feelings of expendability (Chersich et al., 2020; Greenberg et al., 2020; Billings et al., 2021; Fernandez et al., 2020).

In addition to psychological injury, an expanding body of evidence reveals lasting physical consequences following COVID-19 infection, such as chronic fatigue, respiratory dysfunction, persistent pain, and diminished functional capacity, which have significant implications for long-term workforce sustainability (Gaber et al., 2021; Jack et al., 2023; ONS, 2023; WHO, 2022; Al Mandhari et al., 2023). Consequently, post-pandemic wellbeing is recognized as a persistent corporate risk rather than a finite recovery period.

Participants infrequently utilised concepts such as exhaustion or moral harm. They characterised a continual, corporeal weight, frequently expressed as harbouring the pandemic within the body. This explanation aligns with embodiment scholarship, which views extended organizational and moral pressure as becoming ingrained through limited agency and persistent demand (Csordas, 1994; Wainwright et al., 2018).

The conceptual distinction between Surface Endurers and Fractured Endurers enhances workforce discussions by revealing varied trajectories within common structural conditions. Surface Endurers exhibit persistent engagement and external performance despite chronic weariness, emotional depletion, and internalised ethical conflict, aligning with national data on presenteeism and subdued expression of distress (NHS England, 2022; RCN, 2023). Fractured Endurers exhibit patterns characterised by extended periods of sickness absence, diminished working hours, reassignment, or departure, sometimes linked to protracted COVID, psychological trauma, or significant moral dislocation (ICN, 2021; ONS, 2023; Dean et al., 2019).

By emphasising these regular trajectories, the theory transcends binary distinctions between wellbeing and burnout. It provides a procedural explanation in which organizational fragility, ethical tension, and embodied burden coalesce into distinct manifestations of endurance, reconceptualising worker harm as a structural and moral consequence rather than an individualistic shortcoming.

7.3 Historical Epidemics, Organizational Learning, and Pandemic Readiness

Data from previous infectious disease outbreaks consistently demonstrate that extensive epidemics produce lasting psychological, ethical, and physical repercussions for healthcare professionals. Studies after SARS recorded enduring discomfort, stigma, withdrawal from roles, and avoidance behaviours, especially in contexts of uneven organizational communication and delayed preventive actions (Chan and Huak, 2004; Maunder et al., 2006). Similar patterns were observed during H1N1, MERS, and Ebola, encompassing anxiety, somatic distress, moral dilemmas, and fear of infecting family members, exacerbated by unclear directives and inconsistent organizational support (Hewlett and Hewlett, 2005; Kim and Choi, 2016; Shanafelt et al., 2010). The occupational trauma scholarship indicates that suffering intensifies when exposure to risk exceeds institutional safeguards and containment (Hobfoll et al., 2007; Brooks et al., 2018).

Subsequent policy and system evaluations following outbreaks have consistently emphasised workforce protection priorities, such as secure reserves of personal protective equipment, stable infection prevention and control protocols, surge capacity planning, integrated psychological support, and enhanced occupational health infrastructures (World Health Organization, 2007; International Council of Nurses, 2015; Public Health England, 2017). Subsequent analyses of Ebola highlight the ethical aspects of preparedness, underscoring reciprocity, moral clarity, and the institutional obligation to care for staff facing heightened danger (World Health Organization, 2015; Adams and Walls, 2020).

In conjunction with these prescriptions, organizational study emphasises the vulnerability of institutional memory within intricate systems. Research on governance and safety culture reveals a persistent trend wherein lessons are recognized but not integrated into lasting frameworks, permitting previously highlighted weaknesses to resurface in future crises (Boin and Lodge, 2016; Wears and

Hunte, 2019). The issue lies not in the lack of data, but in the volatility of organizational learning when subjected to prolonged stress.

International research from Italy, Spain, Brazil, and the United States similarly identifies discrepancies between increasing clinical risk and organizational responsiveness, with healthcare professionals enduring uncertainty, moral dilemmas, and physical exposure amid rapidly changing guidelines and inconsistent protection (de Sousa et al., 2022; Sasso et al., 2022; Schwartz et al., 2022). This collection of research indicates that pandemic unpreparedness is a persistent structural issue rather than a failure peculiar to any institution.

In this framework, perseverance is conceptualised as a structured, structurally influenced process rather than a personal characteristic. Participants did not contextualise their experiences in terms of individual resilience or failure. They articulated ongoing emotional restraint, persistent labour despite physical exhaustion, and the burden of ethical ambiguity to uphold service provision. This explanation corresponds with embodiment scholarship, which posits that organizational and moral pressure becomes ingrained through repetition, exposure, and limited agency (Csordas, 1994; Wainwright et al., 2018).

By contextualising COVID-19 within a broader historical framework of pandemic response, the synthesis elucidates how endurance became a predominant organizing principle. This study aims not to contest the sufficiency of previous research or policy recommendations, but to deliver a substantive explanation of how persistent organizational conditions are integrated into routine nursing practice. According to Charmaz, endurance connects historical organizational patterns to current lived experiences by clarifying the relationship among conditions, acts, and consequences (Charmaz, 2014).

Tables 7.1 to 7.3 below serve as conceptual framework to facilitate this synthesis transition rather than as empirical reiteration. **Table 7.1** illustrates the recurrence of workforce effects over outbreaks, situating COVID-19 within a historically replicated framework. **Table 7.2** delineates pre-pandemic organizational weaknesses that influenced the circumstances participants encountered. **Table 7.3** synthesises these elements by illustrating how institutional forgetfulness manifests as organizational pressure and, eventually, results in patterned workforce endurance.

Table 7.1. Timeline of Global Epidemics and Recurrent Impacts on Healthcare Workers (2003–2023)

Epidemic	Recurrent Impacts on Healthcare Workers
SARS (2003)	Persistent PTSD symptoms Stigma, fear-based avoidance Delayed organizational protection Moral conflict under ambiguous guidance

H1N1 (2009)	Heightened anxiety & somatic strain Ethical ambiguity during rapid workload shifts Confusion in evolving IPC protocols
MERS (2012)	Fear of contagion & isolation Moral distress linked to risk exposure Perceived institutional neglect Inconsistent leadership communication
Ebola (2014–2016)	Trauma exposure and cumulative stress PPE scarcity & unsafe conditions Leadership gaps during crisis intensification Ethical strain around care restrictions
COVID-19 (2020–2023)	Chronic psychological strain Moral injury & institutional betrayal Long-COVID and embodied depletion Organizational dissonance & cumulative moral-physical harm

This timeline (**Table 7.1**) above establishes endurance as part of a longstanding organizational pattern, not a novel reaction to COVID-19. Across two decades of global outbreaks, the same constellation of psychosocial, moral, and organizational pressures is repeatedly documented: inconsistent protection, fluctuating guidance, leadership fragmentation, and escalating workloads outpacing institutional support. In this sense, COVID-19 did not create new vulnerabilities; it intensified vulnerabilities already structurally embedded into health systems.

Table 7.2. Conceptual Map of Pre-Pandemic Organizational Vulnerabilities

Domain of Vulnerability	**Core Organizational Weaknesses**	**Analytic Implications for Endurance**
Chronic Workforce Fragility	Long-standing nursing shortages High turnover and reliance on agency staff Escalating acuity without proportional staffing increases	Workforce gaps normalised into routine practice Staff compelled to absorb instability through emotional and physical labour
Weak Preparedness Infrastructures	Insufficient PPE stockpiles Fragmented emergency planning Limited Occupational Health capacity Absence of embedded psychosocial support	Risk escalates faster than institutional protection Safety becomes contingent on individual vigilance rather than systemic preparedness

Fragmented Leadership & Governance	Contradictory communication Leadership inaccessibility Disconnected decision-making Slow escalation pathways	Moral and procedural ambiguity intensifies strain Workers forced to "make sense" of incoherent expectations
Structural Underinvestment in Wellbeing	Wellbeing peripheral to governance Symbolic rather than substantive support Disconnected from staffing, workflow, and safety planning	Wellbeing becomes rhetorical rather than enacted Individuals compensate for organizational deficit through endurance
Erosion of Moral Organizational Reciprocity	Praise without protection Limited influence over decisions Inequitable support across teams and roles	Moral expectations exceed organizational reciprocity Staff carry ethical burden as part of everyday functioning

This conceptual **Table** (**7.2**) above demonstrates that the organizational pressures experienced during COVID-19 were not crisis-specific anomalies but extensions of pre-existing structural vulnerabilities. Chronic understaffing, weak preparedness infrastructures, and fragmented leadership systems were already embedded within the organizational fabric of the NHS and many international health systems. Participants entered the pandemic through these structural conditions, not despite them.

Table 7.3. Early Pandemic Organizational Conditions

Domain	**Early COVID-19 Conditions**	**Endurance Implications**
Operational Overload	Rapid escalation of patient acuity Redeployment without preparation Constantly shifting workflows	Staff forced into survival functioning Constant cognitive load consumes emotional reserves
Communication Volatility	Daily changing guidance Conflicting departmental messages Limited clarity on PPE, IPC, staff safety	Workers absorb ambiguity through emotional labour Increased moral anxiety and uncertainty
Leadership Absence	Minimal ward presence Remote or inconsistent	Silence interpreted as abandonment Emotional containment becomes a survival strategy

	visibility Delayed decision-making	
PPE Inconsistency & Safety Gaps	Variable PPE access Instructional contradictions Unequal risk distribution	Staff take on personal risk to maintain care Body becomes site of organizational failure
Psychosocial Dislocation	No protected debriefing time Loss of peer support Emotional isolation due to distancing	Suppression replaces processing Moral hurt accumulates without containment
Collapse of Recovery Structures	Cancelled leave No rest periods Pressure to "keep going"	Recovery deprivation accelerates exhaustion Endurance becomes the only viable mode of functioning

This synthesis enhances the literature on epidemic preparedness in five interrelated aspects, each demonstrating how structural deficiencies are consistently borne by nurses through physical, emotional, and moral labour. The findings redirect focus from specific psychological outcomes like anxiety, acute discomfort, or post-traumatic symptoms to a process-oriented comprehension of injury. Previous research on SARS, MERS, H1N1, and Ebola have identified episodic effects; however, participants in this study indicate the cumulative impact of strain when crises occur in already vulnerable organizational settings. Their narratives are more congruent with sociological research on embodied temporality (Wainwright et al., 2018; Kearns, 2017) than with acute trauma models. Exhaustion, ethical strain, and physiological dysregulation were characterised as accumulating across weeks and months, establishing a prolonged trajectory of endurance. In this regard, COVID-19 did not merely induce stress, but exacerbated pre-existing organizational conflicts and generated a complex type of injury that developed progressively.

Secondly, unpreparedness was perceived not as a technical deficiency, such as inadequate equipment or inconsistent infection control protocols, but as a moral and organizational fracture. When protective systems failed, participants reported compensating by increasing physical exertion, managing emotions, and engaging in ethical work. This illustrates Ahmed's (2014) assertion that institutional failure is experienced tangibly rather than conceptually, fostering an emotional environment in which individuals endure the repercussions of organizational voids. Preparedness thus manifests in the findings as an ethical imperative, wherein the existence or lack of moral reciprocity within organizational frameworks influences whether nurses perceive themselves as safeguarded by the system or compelled to serve as its buffer.

The findings demonstrate that lessons from prior crises are consistently lost due to what Huy (2002) refers to as structurally mediated forgetting. Participants faced the same issues recorded following previous outbreaks, such as inconsistent advice, disjointed leadership, and unequal access to psychological help. These connections indicate that unpreparedness is not coincidental, but rather historically structured. Vulnerabilities endure not due to oversight, but because they are not integrated into sustainable governance structures and institutional memory.

Fourth, organizational pressure was characterised not only in emotional or psychological terms but also as a physical manifestation. Narratives of pain, hypervigilance, interrupted sleep, physiological dysregulation, and enduring post-viral symptoms illustrate how structural and moral demands have been somatically encoded. The body manifested as a reservoir of organizational fragility, embodying a tangible record of institutional failure. Endurance is not merely a metaphor in these findings; it is a tangible response to sustained exposure to organizational inconsistencies and ethical strain.

Ultimately, endurance serves as the analytical pivot linking pandemic history to present organizational accountability. During outbreaks, it is nurses, rather than governance frameworks, who endure the lingering consequences of institutional fragmentation. Endurance serves as the connective element elucidating how past vulnerabilities are transformed into contemporary dependence on nurses' emotional, ethical, and physical labour. COVID-19 is therefore regarded not as an unusual disruption, but as the most recent manifestation of a persistent structural pattern wherein health systems maintain functionality through the hidden labour of resilience.

7.4 Endurance as a Moral Structural Indicator: Reevaluating System Integrity and Employee Accountability

This study reveals that endurance serves both as a behavioural reaction and as a moral structural indicator. It functions as a metric of system integrity by demonstrating the practical redistribution of organizational burden. Traditional workforce metrics, like burnout incidence, absenteeism, turnover rates, and employee surveys, typically assess damage in hindsight, frequently after significant thresholds have been surpassed. Endurance, in contrast, elucidates the ethical and structural shift of responsibility as it transpires, highlighting the erosion of moral reciprocity and the emergence of unsustainable organizational conditions.

Organizational sociology has demonstrated that when governance mechanisms under strain, risk is transferred to the frontline (Perrow, 1999; Hutter and Power, 2005). Lipsky's notion of street-level bureaucracy designates the frontline as the locus where institutional tensions are reconciled or assimilated (Lipsky, 2010). This study indicates that continuity during COVID-19 was maintained not only by organizational infrastructure but also through nurses enduring physical risk, moral ambiguity, and relational tension. This aligns with Mol's description of care as moral labour (Mol, 2008) and Baraitser's notion of duration labour, wherein persistence itself is work under constant demand

(Baraitser, 2017). Endurance thus serves as the conduit for the transference of organizational risk from institutional frameworks into physical, emotional, and moral realms.

Endurance also highlights ethical decline. Although moral injury literature frequently emphasises instances of severe ethical disruption (Dean et al., 2019), participants' narratives indicated a gradual decline in moral assurance influenced by erratic guidance, insufficient leadership engagement, and wellbeing practices perceived as symbolic rather than genuinely protective. This corresponds with Tronto's assertion that care organizations ethically falter when values are not systematically implemented (Tronto, 2013) and with examinations of policy inconsistency as a disruptive element in ethical practice (Greenhalgh, 2020). Assuming obligations that ought to have been managed by the organization exemplifies an ethical redistribution of load, as noted worldwide during COVID-19 (Bradley et al., 2022; Azzopardi Muscat et al., 2022).

Historical epidemics, such as SARS, Ebola, and COVID-19, indicate that detrimental effects intensify in the presence of organizational ambiguity and insufficient or non-existent recovery mechanisms (Maunder et al., 2006; Brooks et al., 2018). This grounded theory synthesises the evidence by conceptualizing endurance as a trajectory rather than a transient condition. Suppression leads to aftershocks, organizational dissonance, and moral degradation, resulting in cumulative harm rather than resolution. Distress gets ingrained in the body, ethical self-perception, and emotional control over time.

Modern health systems increasingly depend on unseen work to maintain organizational operations under stress (Bolton, 2010; Brown and Baker, 2012; Kearns, 2017). This study demonstrates that endurance serves as a form of organizational currency. Surface Endurers sustain continuity by internalising strain, but Fractured Endurers reveal the boundaries of this extraction when physical capacity or moral tolerance is surpassed. This pattern corresponds with global findings about protracted COVID-associated illness, diminished working hours, and workforce attrition after the pandemic (ICN, 2021; WHO, 2022; OECD, 2024). Endurance reveals the concealed cost of maintaining continuity.

From a governance standpoint, endurance serves as a metric of ethical sustainability. Systems defined by moral coherence, structural protection, and relational integrity produce diminished endurance labour due to the distribution of blame and the potential for recovery. Where these conditions diminish, endurance amplifies. This interpretation corresponds with the conclusions of the UK COVID-19 Inquiry, which identifies disjointed governance, ambiguity in decision-making, and inadequate prioritising of worker safety as factors contributing to workforce damage (UK COVID-19 Inquiry, 2024).

Endurance functions as a diagnostic tool for moral structure. It uncovers hidden organizational vulnerabilities, highlights discrepancies between moral standards and structural support, and indicates

instances when institutional accountability has been shifted onto the physical, ethical, and emotional capacity of nurses. In contrast to burnout or attrition metrics, endurance measures damage as it occurs rather than solely after limits are surpassed.

Thus, endurance reconceptualises labour sustainability as an ethical and structural concern rather than only a quantitative matter. While resilience frameworks view persistence as adaptive capacity, endurance perceives it as indicative of unresolved organizational contradictions. It demonstrates that continuity does not signify system robustness but frequently indicates that nurses have compensated for deficiencies that the system was structurally incapable or disinclined to address.

7.5 Surface and Fractured Endurers: Continuation of Harm in Post-Pandemic Contexts

The synthesises differentiation between Surface Endurers and Fractured Endurers illustrates that post-pandemic damage is neither sporadic nor uniformly allocated among the nursing workforce. International literature indicates an increase in psychological distress, moral harm, and lengthy COVID-19 related impairment among healthcare workers (Coimbra et al., 2023; Al Mandhari et al., 2023; Jack et al., 2023), however these effects are frequently regarded as separate events or endpoints. This grounded theory illustrates how harm endures through predictable pathways of resilience influenced by organizational settings, reconceptualising post-pandemic strain as structurally mediated rather than individually situated.

Global evidence substantiates that labour strain persists much after the acute phase of COVID-19. Reports from the World Health Organization, the Organization for Economic Co-operation and Development, and the International Council of Nurses indicate persistent fatigue, cognitive disruption, unresolved moral distress, functional impairment, and a continued risk of attrition within health systems (ICN, 2021; WHO, 2022; OECD, 2024). The reasons why certain nurses persist under these settings while others exhibit evident signs of distress remain insufficiently theorised.

This study fills that gap by demonstrating the emergence of two distinct endurance trajectories within common structural conditions. These trajectories do not denote immutable categories or personal characteristics. They illustrate dynamics influenced by the interplay of physical exhaustion, ethical anticipation, and institutional pressure.

Fractured Endurers signify the physical boundaries of sustained organizational stress. Participants reported enduring physical symptoms such as dyspnoea, pain, cognitive impairment, heart anomalies, and severe exhaustion, in addition to sleep disturbances, emotional instability, moral confusion, and deterioration of professional identity. These accounts align with global evidence regarding long COVID-related morbidity and trauma-induced affective disturbances (Al Mandhari et al., 2023; Coimbra et al., 2023), as well as research connecting institutional failure to persistent psychological and moral damage (Brewer, 2021; Weissinger et al., 2024). Fracture in this context does not denote

personal frailty. It signifies the juncture at which cumulative organizational stress surpasses the ability for physical and ethical restraint.

Surface Endurers, in contrast, exhibit external professional steadiness while interior experiencing exhaustion, ethical disquiet, and prolonged emotional repression. Their reports correspond with research on presenteeism and coping practices, indicating that visible functionality frequently masks considerable interior exhaustion (Kinman and Teoh, 2021; West et al., 2020). This work analytically demonstrates that surface endurance is distinct from resilience. Suppressed distress preserves organizational continuity by internalising tension.

Collectively, these trajectories uncover organizational dynamics that largely elude visibility in post-pandemic workforce study. Policy and reporting frameworks typically emphasise quantifiable measures such as burnout prevalence, absenteeism, or attrition rates (NHS England, 2022; OECD, 2024). Their analysis fails to account for how personnel persist in deteriorating organizational settings, nor does it address how resilience enables systems to operate while detrimental effects disproportionately affect the workforce.

Four implications ensue. Initially, endurance reveals how businesses allocate pressure to frontline employees. This corresponds with Lipsky's depiction of frontline work as the locus where institutional tensions are manifested (Lipsky, 2010) and with organizational risk literature about the diffusion of responsibility amid governance pressures (Perrow, 1999; Hutter and Power, 2005). Surface Endurers illustrate this process by stabilising teams and addressing leadership deficiencies through human rather than structural efforts.

Secondly, endurance demonstrates how organizational strain is manifested physically rather not solely psychologically. Fractured Endurers' narratives of physiological decline reflect sociological examinations of gradual, cumulative damage, wherein structural constraints accumulate into biological degradation over time (Berlant, 2011; Csordas, 1994; Wetherell, 2015). This study builds upon previous research by demonstrating how moral dissonance, persistent understaffing, and erratic leadership significantly impact nurses' physical and mental well-being.

Third, endurance offers a relational perspective on worker dynamics. Surface Endurers defined humour, emotional anchoring, and moral confinement as labour that supported teams under pressure, consistent with examinations of invisible emotional labour and relational care (Bolton, 2010; Mol, 2008). Fractured Endurers, conversely, highlight the juncture at which this relational labour disintegrates, elucidating how harm is disseminated, obscured, and ultimately rendered apparent within teams.

Fourth, endurance reinterprets worker indicators as manifestations of structural stress rather than personal inadequacy. Reduced hours, presenteeism, lengthy COVID-related absence, and workforce exit are not discrete outcomes but rather positions on an endurance continuum. Fractured Endurers

indicate the system's critical threshold, whereas Surface Endurers embody the concealed absorption of stress that postpones observable failure.

Table 7.4 below is presented as a comparative summary of the principal dimensions that delineate the divergences and intersections of Surface and Fractured Endurers.

Figure 7.4 Trajectory Map of Surface and Fractured Endurers

Dimension	Surface Endurers	Fractured Endurers
Outward Presentation	Stable appearance	Visible decline
Emotional Process	Suppression	Emotional overload
Embodied Experience	Hidden fatigue	Somatic deterioration
Moral Orientation	Values maintained	Moral disorientation
Organizational Conditions	Absorb system gaps	System strain exceeds capacity
Recovery Capacity	Delayed recovery	Minimal recovery
Risk Trajectory	Risk of later collapse	Elevated risk of exit
Organizational Meaning	Masks organizational fragility	Reveals organizational failure

Table 7.4 above illustrates a spectrum of endurance influenced by organizational conditions, ethical pressures, and inherent capabilities, clarifying that organizational continuity is frequently sustained by disproportionately allocated endurance labour rather than robust structures.

Organizational significance conceals vulnerability and exposes shortcomings. When considered together, Surface, and Fractured Endurers enhance existing frameworks by offering a procedural explanation of how suffering endures within ethically misaligned and structurally strained systems. Resilience literature encompasses adaptive ability, moral damage scholarship delineates ethical rupture, and institutional betrayal theory underscores organizational failure (Southwick et al., 2014; Fletcher and Sarkar, 2013). The endurance trajectories shown herein provide a critical connection by demonstrating how workers persist under adverse settings over time, until their capacity for endurance is surpassed.

Surface Endurers expose the hidden organizational dependence on employees who endure contradictions without acknowledgement or safeguarding. Fractured Endurers reveal the threshold at which this extraction becomes untenable. They collectively illustrate that endurance is not merely an individual trait but a systematic organizational necessity that unfairly allocates moral, emotional, and physical burdens throughout the workforce (Kahn, 1990; Maslach and Leiter, 2016).

This recontextualization characterises post-pandemic damage not as a lingering consequence of COVID-19, but as a manifestation of systemic reliance on unrecognised human support. Endurance serves as a diagnostic indicator of organizational conduct, highlighting areas of ambiguity, moral inconsistency, and structural instability, as well as instances where continuity is sustained to the detriment of nurses' physical and emotional well-being (Bakker and Demerouti, 2007; Maben and Bridges, 2020).

7.6 Endurance and Organizational Responsibility

In line with Charmaz's guidance that discussion should elevate categories to explain broader social and organizational processes, endurance functions as an interpretive lens for examining how healthcare systems maintain continuity when formal structures of protection, coordination, and recovery weaken (Charmaz, 2014). Endurance is not a coping strategy. It is a mechanism of organizational maintenance.

Organizational scholarship has long shown that when governance systems are fragile, responsibility and risk are redistributed downward. System vulnerabilities become absorbed at the frontline, where workers manage contradiction, uncertainty, and ethical ambiguity in practice (Perrow, 1999; Hutter and Power, 2005; Lipsky, 2010). Moral philosophy and care scholarship similarly demonstrate that when institutional values are articulated but not structurally enacted, moral labour shifts from organizations to individuals (Tronto, 2013; Mol, 2008; Bolton, 2010). The grounded theory developed in this study shows that endurance is the process through which these transfers are enacted in everyday nursing.

Participants' accounts illustrate how service continuity during and after COVID-19 was sustained through the absorption of organizational fragility. In the absence of consistent leadership presence, coherent guidance, and reliable recovery structures, nurses described carrying responsibility for managing risk, maintaining ethical standards, and stabilising care delivery. Endurance therefore reflects not internal fortitude but the externalisation of system instability onto nurses' bodies, emotions, and moral commitments.

Endurance also exposes processes of moral drift. Rather than arising from isolated ethical rupture, participants described a gradual erosion of moral confidence shaped by persistent misalignment between professional values and organizational realities. This pattern aligns with moral injury scholarship, which locates harm in systemic constraint rather than individual failure (Dean et al., 2019; Williamson et al., 2021). Endurance makes this contradiction visible by showing how nurses continue to enact the ethical identity of the organization while institutional structures fail to sustain it.

Within this framing, endurance operates as organizational currency. Stability is secured through the extraction of moral, emotional, and bodily labour, with costs deferred into long-term physical and

psychological consequence. This reflects analyses of moral economy in healthcare, where systems depend on workers' ethical commitment to compensate for structural deficiency (Berlant, 2011; Brown and Baker, 2012).

A central implication of this research is that endurance reframes duty of care as a structural obligation rather than an individual responsibility. Participants described compelled continuation rather than recovery, and moral obligation rather than choice. Endurance emerged where coping was structurally obstructed by lack of time, safety, and organizational repair capacity.

Endurance also clarifies why conventional governance metrics struggle to detect emerging harm. Workforce dashboards typically capture threshold breaches rather than the gradual accumulation of strain embedded in everyday practice (Power, 1997; Mannion and Braithwaite, 2012). Endurance instead reveals harm in process, showing how healthcare systems remain operational through the progressive depletion of embodied, emotional, and moral resources (Hochschild, 1983; Epstein and Hamric, 2009; Maslach and Leiter, 2016). Taken together, endurance functions as a diagnostic of organizational responsibility by exposing how vulnerability and ethical burden are distributed and how continuity of care is maintained under sustained conditions of strain (Tronto, 1993; Mol, 2008; Cribb, 2014). In this sense, endurance is not evidence that systems held during COVID-19, but that ethical design limits were exceeded, and organizational functioning was sustained through the absorption of moral and emotional deficit by nurses (Dean et al., 2019; Smith and Freyd, 2014; Billings et al., 2021).

7.7 Value Displacement, Ethical Drift, and Moral Numbing as Institutional Processes

This grounded theory demonstrates that value displacement, ethical drift, and moral numbing were not expressions of personal weakness or psychological fragility. They functioned as institutionally shaped processes that enabled continued professional functioning when organizational expectations exceeded structural support. Conceptualising these mechanisms as patterned adaptations extends understanding of how endurance is sustained over time and why distress persists beyond the acute phase of COVID-19 (Charmaz, 2014; Lamb et al., 2020).

Value displacement was evident in participants' accounts of a shift from relational, person-centred care towards task prioritisation driven by throughput, backlog reduction, and operational targets. This did not reflect abandonment of professional values, but a forced recalibration of purpose under constraint. Organizational scholarship shows how institutional logics redefine what counts as "good work" under performance and policy pressure, requiring frontline practitioners to reinterpret professional meaning to manage contradiction rather than exercise free moral choice (Hyde, 2017; Lipsky, 2010; Allen, 2015; Maben and Bridges, 2020).

Ethical drift emerged as a gradual normalization of compromise. Participants described skipping breaks, tolerating unsafe staffing, narrowing relational engagement, and accepting reduced standards of care as routine rather than exceptional. Rather than deliberate ethical failure, this erosion reflects systemic conditions in which prolonged organizational constraint reshapes moral thresholds and professional norms, making continued functioning possible under sustained strain (Kleinman, 2006; Lamb et al., 2020; Tronto, 2013; Wainwright et al., 2018).

Moral numbing constituted a further adaptive process. Participants described emotional dampening, detachment, and working on "autopilot." While often framed as psychological defence in moral injury literature, within this study it also functioned organizationally by enabling continued work in environments characterised by persistent ethical conflict and limited containment. This aligns with accounts of slow, cumulative harm in which chronic structural pressure pushes bodies and subjectivities into survival modes that obscure longer-term moral and physical costs (Berlant, 2011; Litz et al., 2009; Nash et al., 2013).

These processes formed an interlocking moral circuitry that sustained endurance. Value displacement rationalised compromised practice as organizational necessity. Ethical drift rendered repeated compromise routine. Moral numbing made such conditions tolerable enough to persist. This circuitry helps explain differentiated endurance trajectories. Surface Endurers often experienced these mechanisms as discomfort or moral dissonance that remained partially reversible. Fractured Endurers described more entrenched patterns in which moral recalibration contributed to identity rupture, moral injury, and embodied depletion over time (Dean et al., 2019; Williamson et al., 2021).

Interpreting these mechanisms as institutional processes shifts the locus of responsibility. Endurance did not arise because nurses coped effectively as individuals, but because organizational conditions shaped the moral adjustments required for continued functioning. This aligns with analyses showing how policy incoherence and governance strain transfer ethical and interpretive burden onto frontline staff, stabilising fragile systems through moral and emotional labour rather than structural repair (Greenhalgh, 2020; Bolton, 2010; Brown and Baker, 2012).

Viewed through the lens of moral economy, endurance emerges as an asymmetric exchange. Nurses described the continued expenditure of bodily, emotional, and ethical resources through physical depletion, emotional containment, and moral tension associated with compromised care. During the acute phase of the pandemic, this labour was framed through professional duty and solidarity. As recovery narratives took hold, participants described a withdrawal of reciprocal organizational support, leaving limited pathways for repair, leadership coherence, or sustained psychological care (Fassin, 2012; ICN, 2021; NHS England, 2022; WHO, 2022).

7.8 Endurance, Moral Economy, and Organizational Responsibility

Interpreting endurance through the lens of moral economy provides a deeper analytic foundation for understanding the organizational patterns identified in this study. Moral economy attends to how values, obligations, and reciprocal expectations structure institutional exchange (Thompson, 1971; Sayer, 2000; Fassin, 2012). Applied here, it clarifies what nurses gave to sustain care during and after COVID-19, what organizations reciprocated, and how imbalance in this exchange shaped enduring harm.

Across participants' accounts, endurance was sustained through the ongoing expenditure of bodily, emotional, and ethical resources. Nurses described working while physically depleted, extending shifts, managing pain, and, for some, continuing while symptomatic with long COVID. These experiences align with international evidence identifying chronic fatigue, reduced functional capacity, and persistent physical impairment as enduring workforce consequences rather than transient post-crisis effects (WHO, 2022; OECD, 2024; Jack et al., 2023). Emotional endurance was evident in the containment of fear, grief, and vicarious trauma alongside the emotional needs of patients, families, and colleagues. Literature on emotional labour in healthcare shows how such containment becomes structurally expected under sustained organizational pressure rather than confined to episodic crisis (Bolton, 2010; Kinman and Teoh, 2021).

During the acute phase of the pandemic, this expenditure of bodily, emotional, and ethical resources was widely framed as morally justified through professional duty, solidarity, and shared risk. As organizations moved into recovery narratives, participants described a shift in the moral economy. Organizational fragility persisted, while reciprocal structures such as leadership coherence, occupational health support, and psychological recovery pathways were described as limited, fragmented, or inaccessible. This reflects international evidence that post-pandemic recovery for healthcare workers has been uneven and under-resourced (ICN, 2021; WHO, 2022).

The grounded theory therefore reveals an increasingly asymmetric moral economy. Nurses continued to give bodily, emotional, and ethical labour, while organizational reciprocity diminished. In place of sustained structural protection, participants described reliance on wellbeing rhetoric and symbolic recognition rather than durable changes to staffing, workload, or recovery capacity. This asymmetry shaped the differentiated endurance trajectories identified earlier. Surface Endurers sustained the appearance of organizational stability by internalising strain and maintaining performance despite depletion, concealing fragility through continued functioning (Weick, 1995). Fractured Endurers marked the point at which this moral economy became unsustainable, reflected in prolonged sickness, reduced capacity, redeployment, or exit from the profession.

Understanding endurance as moral economy clarifies why institutional betrayal was not experienced simply as loss of trust, but as a structural breach of reciprocal obligation. Institutions continued to rely

on nurses' bodily, emotional, and ethical resources while providing diminishing structural support in return. Endurance thus became both the means through which systems continued to function, and the evidence of unresolved moral imbalance embedded within organizational design.

7.8.1 Why Endurance Could Be Understood As Organizational Endurance and Ethical Infrastructure

This grounded theory demonstrates that endurance is not a personal achievement or individual capacity, but a structural response to organizational instability. Participants' accounts of "*keeping going,*" "*running on empty,"* and carrying responsibility because there was no alternative articulate not resilience, but the absorption of institutional burden at the frontline. In this sense, endurance emerges where organizational protection is insufficient and responsibility is displaced onto the workforce, aligning with analyses of frontline labour as the site where organizational contradictions are managed and stabilised through embodied and emotional work (Lipsky, 2010; Bolton, 2010).

International evidence reinforces this interpretation. Studies across Europe, Canada, Brazil, Australia, and the United Kingdom show that nurses persisted during and after COVID-19 not because of exceptional personal resilience, but because organizational conditions constrained alternatives. Chronic understaffing, fragmented communication, inconsistent leadership visibility, unresolved moral conflict, and limited protective infrastructure repeatedly shaped the capacity to continue working (Azzopardi-Muscat et al., 2022; Bradley et al., 2022; Hu et al., 2023; Sasso et al., 2022). Early findings from the UK COVID-19 Inquiry similarly locate compromised workforce safety within governance fragmentation and delayed institutional response rather than individual failure (UK COVID-19 Inquiry, 2024). Endurance therefore functions as a marker of displaced institutional responsibility.

This interpretation reframes conventional workforce indicators. Measures such as sickness absence, presenteeism, burnout, and long COVID-related withdrawal are typically treated as discrete outcomes (ONS, 2023; RCN, 2023). The grounded theory positions them instead as points along a constant endurance trajectory shaped by organizational conditions. Surface Endurers sustain continuity through emotional suppression, moral compromise, and physical overextension, masking structural fragility and delaying recognition of harm (Kinman and Teoh, 2021; West et al., 2020). Fractured Endurers mark the point at which physical, psychological, or moral thresholds are exceeded, exposing the limits of organizational extraction (ICN, 2021; Jack et al., 2023).

Understanding endurance in this way challenges post-pandemic wellbeing strategies that prioritise individual resilience, mindfulness, or psychological flexibility. While such approaches may offer personal support, they risk obscuring the structural sources of harm, including workload intensification, leadership absence, unsafe staffing, and fragmented occupational health provision (Maslach and Leiter, 2016; Traynor, 2018; Rushton, 2018). The grounded theory therefore redirects conceptual attention from individual coping to organizational design and moral reciprocity.

Interpreted as ethical infrastructure, endurance reveals how institutions allocate responsibility and sustain continuity under strain. Participants' accounts show that moral and emotional labour became stabilising resources when governance arrangements failed to provide coherent leadership, recovery pathways, and meaningful protection. This aligns with scholarship locating ethical sustainability in the visibility, fairness, and reciprocity of organizational action rather than in workforce adaptability (Tyler, 2011; Maben and Bridges, 2020). This interpretation positions wellbeing as a matter of governance rather than individual adjustment and establishes endurance as a structural indicator of workforce viability, providing a conceptual bridge to Chapter 8's examination of leadership practice, policy reform, and system-level accountability.

7.9 Theoretical Implication: Endurance as Ethical Infrastructure

Interpreting endurance as a structural process exposes a deeper phenomenon within post-pandemic health systems: the ethical infrastructure through which institutions allocate responsibility, respond to harm, and sustain or erode moral reciprocity with their workforce. In line with Charmaz's guidance that grounded theory should extend analytic categories into wider social and institutional concerns, endurance is developed here as a lens for examining the moral architecture of contemporary healthcare rather than as an attribute of individual workers (Charmaz, 2014).

This interpretation emerged through constant comparison across the analytic categories, particularly organizational dissonance and fragmentation, moral suffering and ethical erosion, and the contrasting trajectories of Surface and Fractured Endurers. Memo writing traced how continued functioning was sustained through emotional suppression, moral recalibration, and embodied depletion. Through this analytic pathway, endurance was theoretically integrated as an organizational process rather than an individual capacity.

Across national and international wellbeing frameworks, distress is frequently framed through individual adaptation, emphasising resilience, psychological flexibility, and self-regulation, while the structural determinants of harm receive less attention (NHS England, 2021; WHO, 2022). Scholars in sociology and nursing ethics caution that such framings obscure the institutional production of distress by relocating responsibility from organizational systems onto individual workers (Brown and Baker, 2012; Maslach and Leiter, 2016; Traynor, 2018). Participants in this study did not describe coping or adaptation. They described compelled continuation shaped by organizational fragility, moral obligation, and limited alternatives.

This pattern resonates with Foucault's concept of governmentality, in which responsibility is displaced from institutional structures onto individual bodies, and with Ahmed's argument that organizations rely on workers to absorb affective and moral labour that remains structurally unacknowledged (Foucault, 1991; Ahmed, 2014). Comparable patterns documented across Canada, Australia, Italy, and

Brazil suggest that endurance reflects a broader transnational labour phenomenon embedded within contemporary health system governance rather than a context-specific response (Perry et al., 2021; Sasso et al., 2022; de Sousa et al., 2022).

While institutional betrayal frameworks describe intensified harm when trusted organizations fail to protect their workforce, this grounded theory extends that literature by showing how betrayal can become structurally embedded rather than episodic (Freyd, 2013; Weissinger et al., 2024). Participants described not only acute failures during COVID-19, such as inconsistent protection and staffing, but prolonged organizational withdrawal in the post-pandemic period, including fragmented occupational health pathways, limited recovery time, and the absence of moral repair. These accounts align with findings from the UK COVID-19 Inquiry and international evaluations identifying governance weaknesses that predated the pandemic, including underinvestment, leadership fragmentation, and erosion of ethical coherence (Royal Society, 2021; WHO, 2022; UK COVID-19 Inquiry, 2024).

Within this context, ethical sustainability becomes analytically central. Developed within public sector governance, ethical sustainability positions staff wellbeing as integral to institutional integrity rather than as a discretionary wellbeing enhancement (EU-OSHA, 2018; New Zealand Ministry of Health, 2020). The grounded theory strengthens this perspective by demonstrating that symbolic care alone does not restore moral balance when structural reciprocity is absent. Participants described temporary wellbeing initiatives as insufficient when staffing instability, leadership absence, and recovery deprivation remained unchanged (West et al., 2020).

Leadership visibility emerged as a stabilising moral anchor. Its absence accelerated the transition from surface endurance to fracture, intensifying ambiguity, and ethical dissonance. This finding aligns with international evidence linking leadership presence to psychological safety, moral coherence, and workforce retention (Aiken et al., 2012; Billings et al., 2021; Tyler, 2011).

Synthesised in this way, endurance functions as an ethical infrastructure embedded within healthcare governance. Surface Endurance conceals organizational fragility through suppressed distress, while Fractured Endurance exposes the moral and embodied limits of institutional extraction. Persistent endurance therefore signals ethical unsustainability rather than system strength. This reframing positions nurses' physical and mental wellbeing as a matter of governance and moral responsibility, providing a conceptual bridge to Chapter 8's focus on policy, leadership practice, and system-level reform.

Enduring the System and Bearing the Weight offers a conceptual reframing of wellbeing by theorising endurance as a structural, moral, and embodied process rather than an individual capacity. Instead of locating persistence within personal coping, resilience, or psychological flexibility, the grounded theory demonstrates that endurance emerges where organizational responsibility, ethical coherence, and structural protection are insufficient. In this sense, wellbeing is not enacted primarily through

individual adaptation, but through the alignment or misalignment between organizational values and material conditions.

Nursing and healthcare literature has long recognised that work-related harm may be experienced physically, psychologically, and morally. Mental health research documents elevated anxiety, depression, post-traumatic stress, and emotional exhaustion among nurses during and after COVID-19 (Kisely et al., 2020; Greenberg et al., 2020). Occupational health literature identifies chronic fatigue, musculoskeletal strain, sleep disturbance, and longer-term physiological sequelae, including long COVID, as major workforce risks (ICN, 2021; WHO, 2022; Jack et al., 2023). Moral injury scholarship highlights ethical conflict, compromised care, and institutional constraint as sources of enduring distress (Dean et al., 2019; Williamson et al., 2021). Organizational justice research further emphasises fairness, trust, and procedural integrity as central to workforce wellbeing (Tyler, 2006; Greenberg, 2011).

These domains, however, are frequently examined in parallel rather than theorised as dynamically interconnected processes shaped by shared organizational conditions (Maslach and Leiter, 2016; Traynor, 2018; Lamb et al., 2020). What remains underdeveloped is an integrated explanation of how physical, emotional, and moral harms accumulate together over time within structurally constrained healthcare environments.

Participants did not narrate physical, psychological, and moral distress as separate or sequential experiences. Instead, these dimensions were described as intertwined and mutually reinforcing, emerging through prolonged exposure to organizational instability, moral contradiction, and constrained opportunities for recovery. Wellbeing is therefore conceptualised as a moral–emotional–physical ecology shaped by organizational conditions rather than as a set of discrete outcomes (Papathanassoglou et al., 2012; Maben and Bridges, 2020; Tronto, 1993; Rushton, 2018; Bakker and Demerouti, 2007).

Participants themselves articulated this interconnection. Several located distress somatically while simultaneously describing emotional containment or ethical unease, for example carrying distress "*in my chest*" (P3, p.7), experiencing pain that had "*never left since COVID*" (P6, p.12), or describing moral discomfort as something that "*sat in my stomach*" (P10, p.9). These accounts do not suggest a simple causal relationship between emotions and symptoms. Rather, they reflect how bodily discomfort, emotional suppression, and moral strain were experienced as co-present within the same organizational context.

This interpretation aligns with embodiment scholarship, which conceptualises bodies as sites where institutional and emotional histories are sedimented under conditions of prolonged constraint and limited agency (Csordas, 1994; Berlant, 2011; Wetherell, 2015). Nursing research similarly shows that

moral distress and emotional labour may manifest somatically when organizational pressures remain unresolved (Theodosius, 2008; Rushton, 2018; Kelly, 2020).

Participants described delayed and contradictory guidance, leadership invisibility, fragmented support pathways, and inconsistent communication as enduring features rather than temporary disruptions. These conditions transformed distress into moral harm and coping into endurance. The analytic contribution of this study lies not in introducing institutional betrayal as a concept, but in demonstrating how betrayal becomes embodied and processual, shaping differentiated endurance trajectories over time.

Although institutional betrayal literature has frequently highlighted psychological injury (Freyd, 2013), participants in this study also articulated how organizational stress manifested physically in their bodies. They reported chronic weariness, impaired stress reactions, exacerbated extended COVID symptoms, musculoskeletal discomfort, and increased vigilance associated with prolonged emotional repression. In conjunction with research on gradual and cumulative harm, these narratives indicate that organizational injustice can manifest physically and emotionally, materialising through daily bodily experiences rather than existing solely in the realm of cognition or emotion (Berlant, 2011; Williamson et al., 2021).

Similarly, initial descriptions of moral discomfort have concentrated on specific ethical instances or difficulties (Jameton, 1984). The narratives of participants in this study indicate that moral disruption developed gradually, arising from persistent conflicts between professional values and organizational constraints, including inadequate staffing, limited care, and ambiguous accountability. This viewpoint corresponds with contemporary research that characterises moral distress as an organizational and relational phenomenon rather than a collection of discrete incidents (Epstein et al., 2020; Lamiani et al., 2021).

The grounded theory delineates the analytical progression from denial, via trauma and organizational dissonance, to moral disintegration, illustrating how endurance can influence daily practices amid persistent structural pressure. This approach redirects attention from personal deficiencies to the working conditions imposed on nurses, emphasising how organizational structures and ethical climates influence staff capabilities over time.

Participants frequently conveyed organizational and ethical pressure via nonverbal communication. Expressions like "*carrying it in my chest*" (P3, p.7), anguish that had "*never left since COVID*" (P6, p.12), or moral unease that "*sat in my stomach*" (P10, p.9) exemplify how prolonged organizational stress and ethical conflict were perceived in corporeal terms. These accounts do not indicate a direct or uncomplicated causal relationship between emotional state and physical manifestation. Instead, they illustrate how nurses conceptualised their wellbeing as an integrated embodiment of emotional and moral dimensions, influenced by the working conditions imposed upon them. This viewpoint

aligns with research on embodiment, which perceives bodies as repositories of social, institutional, and emotional histories, especially in situations of sustained stress and restricted agency (Csordas, 1994; Berlant, 2011; Wetherell, 2015).

The grounded theory does not displace established frameworks like burnout, moral harm, or occupational health; instead, it situates them inside an analytical discourse. These approaches provide various methods for engaging with a collective organizational environment, elucidating how diverse forms of strain can coalesce, intensify, and, in certain pathways, result in fragmentation when opportunities for recuperation, leadership alignment, and structural safeguards are constrained (Maslach and Leiter, 2016; Demerouti et al., 2001; Freyd, 2013; Epstein et al., 2020).

This does not imply a linear or universal causal relationship between moral conflict and specific physical symptoms. Rather, it highlights how prolonged exposure to unresolved ethical contradiction, constrained professional agency, and limited opportunities for recovery becomes entangled with embodied experience. In contexts where moral repair, reflection, and organizational containment were absent, participants described moral strain as something that accumulated within the body as well as within emotional and ethical self-understanding.

By theorising endurance as the connective process through which moral, emotional, and physical strain converge, the study advances occupational health perspectives in the post-pandemic context. International evidence has already established that long COVID, chronic fatigue, and psychological distress pose significant risks to workforce sustainability (ICN, 2021; WHO, 2022). The grounded theory extends this literature by showing how these risks are not merely co-occurring outcomes, but are structurally linked through organizational design, leadership practices, and moral expectations. Harm is therefore conceptualised as organizationally patterned rather than individually located.

Wellbeing is reframed not as a personal state to be restored, but as an organizational condition to be sustained. In line with Charmaz's emphasis on theorising process, conditionality, and analytic integration (Charmaz, 2014), the contribution of this study lies in demonstrating how constructivist grounded theory can link embodied experience, moral meaning, and organizational structure within a single explanatory account. Through constant comparison and sustained memo development, endurance emerged as the organising concept through which emotional suppression, bodily depletion, and ethical strain could be understood as mutually constitutive rather than coincidental (Demerouti et al., 2001; Epstein et al., 2020).

This processual framing moves beyond static or outcome-focused models of harm. It offers a temporally sensitive explanation of how distress develops, stabilises, and, for some, becomes untenable under cumulative organizational conditions that persist beyond the acute phases of COVID-19 (Maslach and Leiter, 2016; West et al., 2020; WHO, 2021). In doing so, the study reinforces

endurance as a structural indicator of workforce vulnerability and ethical sustainability rather than a marker of individual coping or resilience (Traynor, 2018).

Table 7.5 Methodological contributions of the study

Methodological Contribution	How This Study Extends CGT Practice
Embodied Data Integration	Treats breath, pauses, fatigue and somatic metaphors as analytic material, extending embodiment scholarship into CGT (Warin, 2019; Wetherell, 2015).
Visual–Conceptual Theory Building	Uses diagrams (Endurance Framework, Index, Sentinel Model) as analytic tools rather than illustrations, strengthening theoretical integration (Charmaz, 2014).
Reflexive Practitioner–Researcher Positioning	Uses insider knowledge of NHS systems as a source of theoretical sensitivity, consistent with situated CGT (Charmaz, 2014).
Processual Saturation of Mechanisms	Achieves saturation at the level of mechanism (suppression → erosion), not merely category, enhancing explanatory coherence.
Extension of CGT into Organizational Ethics	Demonstrates that CGT can theorise moral–structural processes such as institutional betrayal and organizational abandonment.

Table 7.5 above synthesises these methodological contributions by showing how embodied data integration, visual conceptual analysis, reflexive positioning, and mechanism-level saturation supported theoretical sensitivity and explanatory coherence. The figure functions as a transparency device, making visible the analytic pathway through which the grounded theory was constructed and integrated in line with Charmaz's constructivist criteria of credibility, resonance, originality, and usefulness.

Moral injury scholarship has argued that clinicians' suffering during COVID-19 is often better conceptualised as ethical and moral harm rather than burnout alone (Dean et al., 2019; Rushton, 2018; Greenberg et al., 2020). This study extends that terrain by framing endurance as a structural response to organizational contradiction, produced through leadership absence, institutional betrayal and weakened moral reciprocity (Smith and Freyd, 2014; Park et al., 2023). In this way, moral injury becomes legible not only as an internal psychological experience but as a condition shaped by organizational architecture and governance decisions.

Occupational health frameworks often emphasise exposure to stressors, workload, and hazards (Nielsen and Nielsen, 2023) and increasingly recognize the importance of psychosocial risk governance (WHO and ILO, 2021). This study strengthens that terrain by showing that organizational injustice, leadership invisibility and weakened ethical reciprocity function as structural determinants

of long-term harm. Endurance theorises how these determinants become embodied and sustained, linking workforce sustainability to organizational ethics and governance conditions rather than remaining at the level of abstract risk.

Affective theorists describe how people persist within harmful systems through obligation, hope, habituation, or attachment (Berlant, 2011; Ahmed, 2014). This study adds that nurses' persistence during COVID-19 was frequently experienced as institutionally compelled, shaped by professional duty within constrained organizational conditions. Endurance therefore functions as a sociological mechanism that reveals how systemic strain becomes absorbed into the moral and affective lives of workers rather than being understood only as an emotional state.

By engaging these theoretical terrains in an integrated way, the grounded theory meets Charmaz's (2014, pp. 262–268) expectation that discussion should locate the theory within broader conceptual landscapes and clarify originality. Endurance is theoretically significant here because it integrates moral, physical, and organizational dimensions of post-pandemic nursing work as a cumulative process rather than treating them as parallel concerns.

7.9.1 Contextualising the Theory Within Broader Theoretical Frameworks

This grounded theory engages with multiple recognised disciplines of inquiry, including moral psychology, organizational sociology, occupational health, and emotion theory. Each of these literatures illuminates significant facets of nurses' experiences during and after to COVID-19. An integrated account of how physical, emotional, and moral strain interconnects and persists over time under organizational contexts characterised by instability and limitation remains underdeveloped across these traditions. This section elucidates the theory's contribution to these fields by providing a process-oriented comprehension of endurance as a structural, embodied, and ethical phenomena.

Research on moral distress posits that nurses' pain during COVID-19 is more aptly interpreted through experiences of ethical conflict, compromised treatment, and value disruption, rather than solely through the lens of burnout (Dean et al., 2019; Rushton, 2018; Greenberg et al., 2020). This study situates moral strain within a broader organizational context, contrasting with the literature that mostly emphasises psychological and emotional repercussions. Endurance is understood as evolving through persistent organizational contradictions, such as leadership voids, perceived institutional betrayal, and the erosion of moral reciprocity. Moral damage is thus regarded not merely as an individual experience, but as a systemic condition influenced by routine organizational behaviours and structures (Smith and Freyd, 2014; Park et al., 2023).

Fundamental research on emotional labour and institutional affect has demonstrated that companies rely on employees' emotional abilities and affective performances to maintain care and service provision (Hochschild, 1983; Bolton, 2010; Berlant, 2011; Ahmed, 2014). This study expands these viewpoints by examining the progression of emotional labour during extended crisis and post-crisis

scenarios. Participants' narratives indicate that the ongoing management of anxiety, grief, and moral conflict becomes physically and ethically burdensome over time, manifested via exhaustion, disrupted sleep, increased vigilance, and chronic somatic symptoms. Endurance thus encapsulates the absorption of organizational dissonance not merely as a collection of "feeling rules," but as both embodied and moral effort within the daily practice of nursing (Maben and Bridges, 2020).

Occupational health frameworks have generally concentrated on exposure to stressors, workload, and physical risks as primary factors influencing workforce wellbeing (Nielsen & Nielsen, 2023). This study enhances that focus by emphasising the ethical and relational aspects of organizational life. Participants' experiences suggest that leadership invisibility, organizational unfairness, and limited access to support can function as structural factors contributing to prolonged physical and emotional distress. This viewpoint corresponds with the advocacy for enhanced integrated governance of psychosocial risk (WHO and ILO, 2021), while introducing a conceptual dimension by identifying endurance as the mechanism via which organizational constraints are internalised and perpetuated over time.

By integrating these literatures into a cohesive dialogue instead of addressing them in isolation, grounded theory adheres to Charmaz's (2014, pp. 262–268) recommendation that a discussion chapter situate theory within wider conceptual frameworks and elucidate its analytical contribution. Endurance serves as a cohesive concept that integrates the moral, physical, and organizational aspects of post-pandemic nursing work under a singular explanatory framework, enabling these components to be perceived as interconnected processes rather than separate issues.

Table 7.6 Positioning the Theory Across Four Theoretical Terrains

Theoretical Terrain	What the Literature Emphasises	What This Theory Adds
Moral Injury & Ethics	Psychological wounds; ethical conflict (Dean et al., 2019)	Reframes moral injury as organizationally produced through betrayal and dissonance.
Organizational Sociology & Emotional Labour	Emotional regulation as institutional necessity (Hochschild, 1983)	Shows emotional labour becoming somatic and moral under crisis; ties affect to organizational fragility.
Occupational Health	Stressors, hazards, workload (Nielsen & Nielsen, 2023)	Positions injustice, leadership absence, and ethical reciprocity as determinants of physical and psychological harm.

Emotion & Affect Theory	Persistence within harmful systems (Berlant, 2011)	Demonstrates endurance as compelled institutional labour, not just affective attachment.

Table 7.6 above positions the grounded theory across four theoretical terrains to show how endurance functions as an integrating concept connecting literatures often treated separately. It clarifies how this study reframes ethical, emotional, occupational, and affective accounts of nurses' work by theorising endurance as a cumulative organizational process with embodied and moral consequences.

Although rooted in UK nursing during and after COVID-19, the Endurance Framework is analytically abstract rather than context-bound. Its value lies not in direct equivalence between settings, but in its capacity to identify patterned processes through which organizational conditions shape endurance trajectories. This allows conceptual transfer to other high-strain environments such as disaster response, humanitarian practice, and emergency care, where constrained action, institutional contradiction, and moral strain similarly accumulate over time. Transferability is therefore located in the framework's usefulness for tracing how organizational design, leadership presence, and ethical reciprocity structure sustained endurance rather than in replicating empirical conditions.

7.9.2 The Endurance Framework, Endurance Gauge, and Endurance Index: Converting Theory into Organizational Understanding

The analytical progression of this grounded theory did not culminate solely in conceptual elucidation. As endurance became the primary mechanism connecting moral, bodily, and emotional stress, an additional analytical inquiry arose: how can this mechanism be made discernible and interpretable within organizational systems that predominantly depend on retroactive or outcome-based metrics? The Endurance Framework, Endurance Gauge, and Endurance Index were created to address this inquiry, each functioning at a distinct analytical level to convert lived experiences into forms comprehensible to organizations while remaining true to the interpretive principles of constructivist grounded theory.

The Endurance Framework offers the theoretical structure that elucidates the process by which endurance is built over time. It incorporates four interconnected mechanisms identified through constant comparison and memo development: affective-somatic control, cyclical threat exposure, structurally limited recuperation, and moral decay. These processes elucidate how nurses maintain their professional efficacy by managing fear, tiredness, and ethical dilemmas under organizational environments marked by volatility and restricted possibilities for recuperation.

This paradigm corresponds with process-oriented methodologies in grounded theory that highlight the conditional and temporal aspects of action and meaning (Charmaz, 2014). This perspective aligns with sociological and organizational research that attributes distress to work systems rather than only to individual coping abilities (Hochschild, 1983; Berlant, 2011; Maben and Bridges, 2020). By

synthesising physical depletion, emotional suppression, and moral strain into a unified explanatory framework, the model characterises endurance as an organizational phenomena rather than an individual trait.

The Endurance Gauge: Analysing Endurance in Application

The Endurance Gauge serves as a mediating instrument between theoretical concepts and practical evaluation. Instead, than serving as a diagnostic tool, it offers a systematic approach to understanding the reliance on endurance within specific teams, positions, or contexts. The Gauge is designed to identify the relative severity and direction of strain in three areas: physical capacity, emotional processing, and moral alignment. This emphasises whether organizational conditions facilitate healing and reciprocity or increasingly exploit staff members' ability to persist without rejuvenation.

This methodology embodies broader demands in occupational health and organizational governance to transcend limited metrics of illness and absenteeism, aiming for a more comprehensive comprehension of psychosocial risk and ethical climate (WHO and ILO, 2021; Nielsen and Nielsen, 2023). The Gauge serves as an interpretive instrument that facilitates thoughtful organizational discourse around work circumstances, rather than functioning as a meter for individual evaluation or performance management.

The Endurance Index: Making Cumulative Strain Apparent

The Endurance Index enhances this interpretive framework by providing a conceptual tool for quantifying accumulated moral, physical, and psychological burdens at an organizational level. The framework comprises three interconnected analytical domains: physical indicators such as fatigue, pain, dysregulation, and long COVID sequelae; psychological indicators including intrusion, emotional suppression, and sleep disturbances; and moral-ethical indicators encompassing moral residue, loss of trust, and perceived organizational withdrawal.

The Index potentially illuminates forms of strain that traditional labour metrics typically capture only after endurance has already deteriorated. Metrics such as turnover, sickness absence, and vacancy rates generally reflect outcomes rather than the cumulative depletion experienced by those who remain active and functional, including individuals whose sustained performance masks considerable physical and moral strain (NHS Digital, 2022; ONS, 2023). The Index associates endurance with a temporal and structurally organized process rather than a transient experience of suffering.

The Endurance Index reconceptualises wellbeing as an organizational and ethical issue by associating workforce sustainability with ethical sustainability, defined as the extent to which institutions uphold reciprocity, respect, and protection for employees. This viewpoint aligns with research on organizational justice and institutional accountability within health systems, highlighting the ethical

aspects of governance, leadership visibility, and structural support (Smith and Freyd, 2014; WHO and ILO, 2021; Park et al., 2023).

Incorporating The Endurance Framework, The Endurance Gauge, and The Endurance Index

The Endurance Framework, Endurance Gauge, and Endurance Index collectively constitute a multi-tiered analytical framework. The Framework elucidates the mechanisms by which endurance is generated and maintained within organizational contexts. The Gauge offers a method for assessing the practical manifestation of this process across various contexts and occupations. The Index visually represents accumulated strain at an organizational level, facilitating the analysis of patterns across time.

The implemented architecture is anchored in participants' narratives and constructivist grounded theory principles, while also addressing wider discussions on workforce sustainability, ethical governance, and psychosocial risks within modern healthcare systems (Charmaz, 2014; WHO and ILO, 2021; Nielsen and Nielsen, 2023).

In Chapter 7, these elements illustrate the contribution of grounded theory beyond mere conceptual explanation, revealing how an interpretive, process-oriented analysis can be transformed into forms that hold organizational significance. Chapter 8 elaborates on their comprehensive operationalization, governance responsibilities, and policy ramifications, transitioning from analytical contributions to system-level implementation, executive supervision, and workforce strategizing.

The PARC Index

Building on the integrated conceptualisation of endurance developed across this chapter, I introduce the PARC Index (**Figure 7.1**) as an analytic and governance tool derived from the grounded theory. While the Endurance Framework explains the organizational conditions through which endurance becomes necessary, the PARC Index translates these theoretical insights into a structured way of recognizing cumulative organizational harm as it is experienced and absorbed by the workforce.

The PARC Index was developed inductively through constant comparison across the analytic categories and the core category, Institutional Betrayal and Organizational Abandonment, and was refined through integrative memo writing. It responds to a recurring analytic problem identified during theoretical integration: organizational harm often became visible only once staff reached late-stage outcomes such as sickness absence, redeployment, or exit. By that point, endurance had already been depleted and harm had become embedded.

The PARC Index offers a way of recognizing strain earlier by focusing on indicators that may be overlooked in conventional workforce metrics. Rather than measuring failure, it captures patterns of strain, displacement, and depletion while staff remain present in practice. In this way, the PARC Index

reframes endurance as an early signal of organizational risk rather than as a marker of workforce robustness.

Conceptual Structure of the PARC Index

The PARC Index consists of four interrelated domains, each grounded in participants' accounts and linked to the analytic categories:

P: Presence under strain

This domain captures sustained attendance despite physical depletion, emotional suppression, constrained recovery, or ongoing distress. It reflects patterns described by Surface Endurers who remained operational while internally depleted.

A: Absorbed organizational risk

This domain identifies where risk that would ordinarily be held within organizational systems is displaced onto individuals. It includes absorbing unsafe workloads, compensating for leadership absence, managing contradictory guidance, and carrying responsibility for systemic gaps.

R: Recovery deprivation

This domain reflects the erosion of recovery opportunities. Participants described cancelled leave, limited rest, minimal debriefing, inaccessible occupational health pathways, and premature return to full workload following crisis or illness.

C: Cumulative load

This domain captures the layered accumulation of strain over time, including bodily symptoms, emotional suppression, and sustained psychological pressure. It reflects how strain can sediment rather than resolve when organizational conditions remain unchanged.

Together, these domains operationalize endurance as a process indicator rather than an individual attribute. They allow organizational strain to be read in real time rather than retrospectively through workforce loss.

Figure 7.1: The PARC Index as an Indicator of Organizational Endurance Load

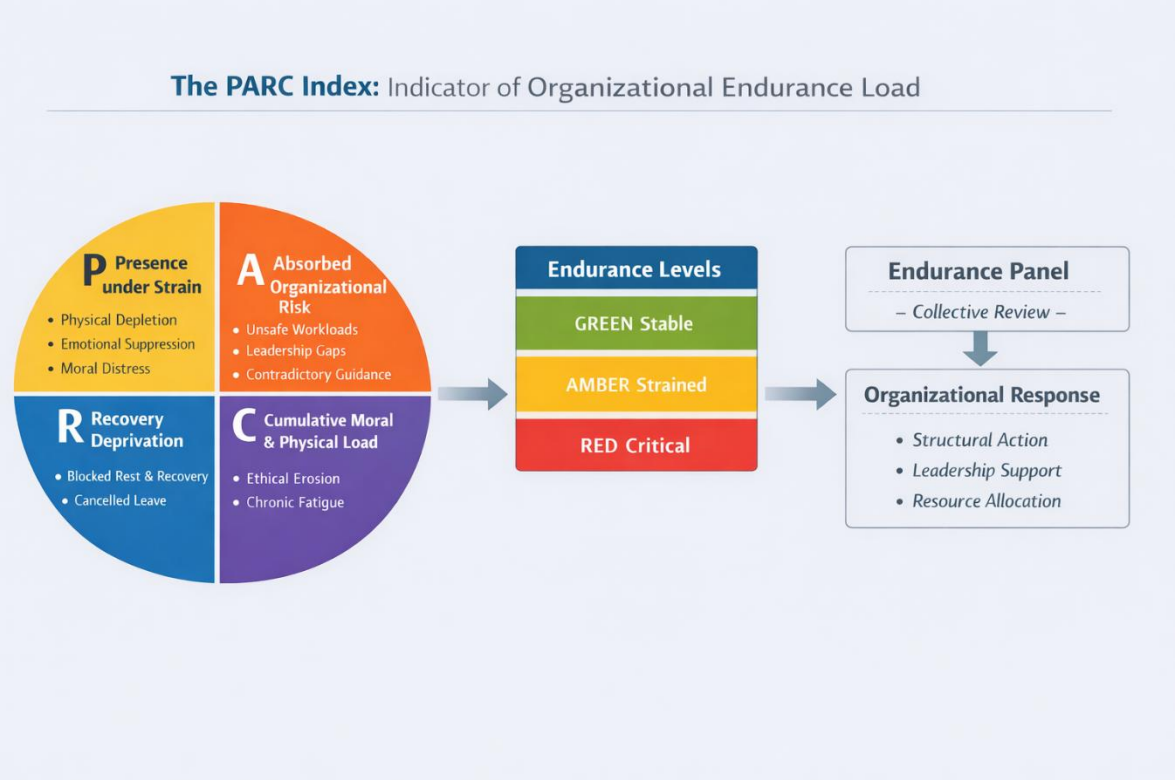


Figure 7.1 above illustrates how the PARC Index translates nurses' experiences of endurance into a governance signal that can be recognized within organizational oversight. It shows how workforce strain can be interpreted as a cumulative endurance load while staff remain visibly present at work. The figure therefore makes explicit a pathway from hidden endurance to organizational interpretation and structured review, supporting the central argument that endurance should not be misread as resilience or professional robustness.

At this stage of the thesis, the grounded theory has been fully developed and theoretically integrated. The purpose of introducing the PARC Index here is not to add a new theoretical construct, but to clarify how the theory operates beyond interpretation by making visible how endurance can become legible to organizations as a signal of strain and risk. Detailed operationalization and system-level implications are intentionally developed in Chapter 8, where I extend this governance logic into applied considerations, scope, and future evaluation without presenting prescriptive or nationally validated solutions.

7.10 Contribution to Knowledge and Post-Pandemic Nursing and Organizational Scholarship

This study aimed at exploring the experiences of nurses during and after the COVID-19 pandemic and the influence of organizational settings on their physical and mental well-being. This emphasis was shaped by my practitioner-researcher experience in NHS research and workforce environments, where I noted enduring post-pandemic stress, unresolved physical ailments, disturbed professional identity, and restricted access to organized recovery and support. These insights did not serve as analytical

catalysts but intensified my interests in formulating a theory that demonstrates how such experiences are structured across organizational contexts rather than being confined by individuals solely.

Charmaz (2014, pp. 263–271) argues that grounded theory must progress beyond thematic description to provide an analytical examination of how social and structural processes influence experience. The grounded theory established in this work, "*Enduring the System and Bearing the Weight*", addresses this assumption by conceptualizing wellbeing as a structural, embodied, and moral process rather than merely a psychological state or individual potential. Endurance is posited as a systematic reaction to organizational conditions marked by accumulating stress, restricted recovery, and minimal institutional reciprocity.

To organize and assess the study's contribution, I use the 'Five Pillars of Grace', which are articulated as a heuristic framework for theoretical integration rather than a formal model of the phenomenon. The pillars, established through constant memo-writing and integrative analysis, serve as an analytical tool to elucidate the transition from lived experience to empirical evidence, from evidence to theory, and from theory to organizational and policy significance. The term 'grace' is analytically employed to denote equilibrium among conceptual clarity, empirical foundation, methodological transparency, applied innovation, and ethical accountability, rather than as a stylistic or normative assertion.

The subsequent sections detail each pillar in turn, illustrating how the study enhances understanding in post-pandemic nursing scholarship, occupational health, organizational well-being, and health system governance.

Pillar One

Theoretical Contribution: Endurance as a Structural, Embodied, and Ethical Framework

This study's primary theoretical contribution is the establishment of endurance as a conceptual framework for comprehending nurse well-being in the post-pandemic context. This study conceptualises endurance not merely as an individual psychological issue, but as a process influenced by organizational settings, ethical dilemmas, and limited options for recuperation.

Through continual comparison and theoretical synthesis, endurance surfaced as the term that encompassed both prolonged professional performance and ultimate breakdown. Participants reported persisting in their work despite physical exhaustion, emotional repression, and ethical unease, frequently in environments where organizational support and institutional recognition were scarce or non-existent. This framework expands current research on moral damage and institutional harm, which has mostly concentrated on psychological and ethical consequences, by contextualising harm within the structural and relational dynamics of healthcare institutions (Dean et al., 2019; Freyd, 2014; Smith and Freyd, 2014).

In this study, Endurance is characterised as:

‘The enforced persistence of professional duties amid cumulative ethical pressure, physical exhaustion, and emotional repression, taking place in environments where organizational support and recuperation are limited’.

This definition differentiates endurance from resilience, coping, and burnout by situating the process within organizational and ethical frameworks rather than inside human ability or temperament. Endurance serves as a diagnostic indicator of systemic stress, demonstrating how professional labour is maintained in the absence of adequate institutional support.

This theoretical shift interacts with research on embodiment and social pain, emphasising how organizational and moral conditions are manifested in the body rather than staying abstract or symbolic (Scheper-Hughes and Lock, 1987; Berlant, 2011). Endurance is understood not merely as a moral or emotional condition but as a lived, corporeal, and systematically structured activity that develops over time.

Pillar Two

Empirical Contribution: Illuminating Post-Pandemic Resilience and Reverberations

This study empirically demonstrates that the physical, mental, and moral effects of the COVID-19 pandemic endure beyond the immediate crisis and become ingrained in daily professional operations. Participants reported enduring exhaustion, chronic discomfort, interrupted sleep, hypervigilance, moral dissonance, and reduced trust in leadership, frequently persisting well beyond the conclusion of formal emergency protocols.

This contribution corresponds with national and international evidence that illustrates long-term workforce impacts, including attrition, absenteeism, and psychological distress (Greenberg et al., 2020; RCN, 2023; WHO, 2021). This study enhances the literature by illustrating how harm is often obscured by ongoing functionality. Nurses articulated their ability to function under significant, frequently unacknowledged stress, illustrating a nuanced equilibrium between perceived wellbeing and evident deterioration.

The analytical classifications Surface Endurers and Fractured Endurers offer empirical clarity for comprehending this landscape. Surface Endurers maintained professional functionality despite enduring cumulative depletion. Fractured Endurers encountered junctures where ongoing performance became unsustainable, leading to disengagement, absenteeism, or departure from positions. The transition between these places illustrates how organizational factors influence endurance trajectories over time, rather than yielding static results.

This empirical study reconceptualises employee wellbeing as a longitudinal, contextually embedded process rather than a collection of discrete reactions to crisis situations.

Pillar Three

Methodological Contribution: Enhancing Constructivist Grounded Theory via Embodied and Insider-Led Analysis

This study methodologically enhances Constructivist Grounded Theory by illustrating how prolonged, manual, and reflective analysis can be employed to theorise organizational processes rather than solely individual experiences. Consistent with Charmaz's (2014) focus on theoretical integration and researcher positioning, coding, memo-writing, and diagramming were regarded as embodied analytic practices rather than just technical procedures.

By maintaining a close physical and analytical proximity to the data through constant comparison and iterative memo generation, I was able to identify shifts in meaning, contradictions, and embodied expressions that facilitated the transition from categories to an integrated process model. This methodology corresponds with interpretive and creative interpretations of grounded theory as an analytical activity rather than a procedural technique (Charmaz, 2014; Dey, 1999; Birks and Mills, 2015).

My role as a practitioner-researcher facilitated an awareness of organizational frameworks, leadership dynamics, and occupational health systems that influenced participants' narratives. Instead of regarding context as mere backdrop, organizational factors were deemed analytically central, so expanding grounded theory into the domain of institutional analysis and ethical governance.

Pillar Four

Practical Conceptual Contribution: Converting Endurance into Organizational Indicators

A further contribution involves translating the grounded theory into forms comprehensible to organizations without diminishing it to decontextualized measurements. The Endurance Framework delineates four interconnected systems that generate and maintain endurance: Affective–Somatic Regulation, Cycling Threat Exposure, Structurally Constrained Recovery, and Moral Erosion. These mechanisms link micro-level experiences with meso- and macro-level organizational settings, illustrating how harm is normalized in routine practices.

The PARC Index advances this research by conceptualizing wellbeing through Physical, Affective, Relational, and Cognitive dimensions, redefining suffering as multidimensional rather than predominantly psychological. The Endurance Index consolidates these dimensions at the team or organizational level, framing accumulating strain as a systemic indicator rather than an individual shortcoming.

This contribution addresses organizational safety and governance literature that highlights the recognition of latent circumstances and structural risks prior to the manifestation of visible failures

(Reason, 1997; Dekker, 2011). Instead of depending on retroactive metrics like turnover or absenteeism, the study presents endurance as a primary measure of worker susceptibility and ethical stress. These tools are presented conceptually here and are detailed operationally in Chapter 8.

Pillar Five

Policy and Governance Contribution: Establishing Wellbeing as an Ethical and Institutional Obligation

This study reframes workforce wellbeing as an ethical and institutional obligation, rather than merely an issue of individual adaptation, within the context of policy and governance. This corresponds with global appeals to see psychological risk and employee protection as fundamental components of health system governance rather than optional assistance (WHO and ILO, 2021; ICN, 2021).

The study frames endurance as an indicator of moral and organizational stress, placing nurse wellbeing within the larger discussions of institutional accountability, leadership responsibility, and system design. This stance aligns with national and international assessments highlighting systemic deficiencies in worker safeguarding and post-crisis recuperation during the COVID-19 pandemic (UK COVID-19 Inquiry, 2023; RCN, 2023).

To make this integrative structure analytically transparent, **Figure 7.2** below presents the Five Pillars of Grace as a theory-derived heuristic that visually synthesizes how participant accounts were translated through analytic categories, constant comparison, and theoretical integration into conceptual, applied, and policy-relevant contributions. The figure functions as a conceptual map linking the grounded theory Enduring the System and Bearing the Weight to its organizational, methodological, and governance implications.

Figure 7.2: The Five Pillars of Grace-Theory-Derived Contributions from the Study

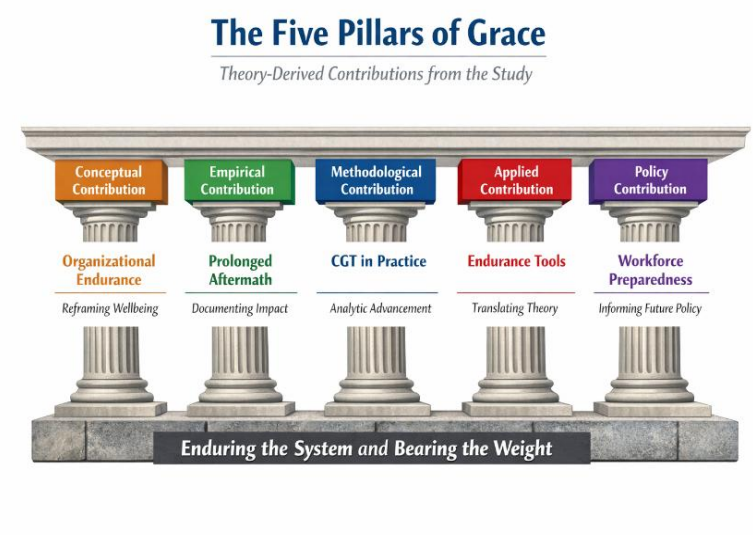


Figure 7.2 above presents the Five Pillars of Grace as a heuristic framework developed through integrative memo writing and theoretical comparison within Constructivist Grounded Theory. The central foundation, Enduring the System and Bearing the Weight, represents the grounded theory derived from participants' accounts of physical and mental wellbeing during and after the COVID-19 pandemic. Each pillar delineates an interdependent domain of contribution: (1) conceptual reframing of wellbeing as an organizational process of endurance, (2) empirical documentation of sustained physical and psychological aftermath, (3) methodological advancement of Constructivist Grounded Theory in organizational health contexts, (4) applied translation into proposed governance and workforce tools, and (5) policy-relevant implications for workforce preparedness and organizational accountability.

Analytically, the figure situates this structure within Charmaz's Constructivist Grounded Theory process by showing the progression from initial and focused coding, through constant comparison and memo-based theoretical integration, to the development of a coherent explanatory framework linking experience, theory, and organizational application. The Five Pillars are presented as a theory-derived heuristic rather than a validated model, indicating their role in guiding interpretation, organizational learning, and future empirical testing rather than prescribing standardized intervention.

Building on these integrated contributions, the following section clarifies the applied purpose of the grounded theory and its role in informing practice and governance without moving into prescriptive recommendations.

The Local and National Wellbeing Response Frameworks translate theory into the domain of future pandemic preparedness, framing structured debriefing, safeguarded recovery periods, acknowledgement of moral injury, and governance-level escalation as essential components of ethical

workforce systems rather than mere optional measures. These frameworks are elaborated upon in Chapter 8.

In line with Charmaz's (2014, p. 262) emphasis on theorising complexity, process and conditionality, this study demonstrates how constructivist grounded theory can be used to integrate embodied experience, moral meaning, and organizational structure without reducing them to a single explanatory frame. The analytic contribution lies not in asserting conceptual novelty over existing literature, but in showing how endurance functions as a connective process that links domains which are often examined separately within qualitative health research.

Through constant comparison, memo writing and theoretical integration, endurance emerged as the organising concept through which emotional suppression, bodily depletion and moral strain could be understood as mutually constitutive rather than coincidental. This processual account enables a more nuanced understanding of how nurses' wellbeing was shaped not by isolated stressors or discrete events, but by cumulative organizational conditions that persisted during and after the acute phases of COVID-19. In this sense, the theory moves beyond static or outcome-focused models and offers a temporally sensitive explanation of how harm develops, stabilises and, for some, becomes untenable.

By integrating multiple dimensions of experience within a coherent analytic framework, the study illustrates the capacity of constructivist grounded theory to theorise complex organizational environments where ethical, emotional, and physical processes intersect. This integration provides a robust conceptual foundation for rethinking workforce sustainability and organizational responsibility in post-pandemic healthcare, shifting the analytic focus away from individualised models of distress and towards the structural conditions that shape how wellbeing is lived, embodied and endured over time.

7.11 From Theory to Governance: Locating the Applied Contribution

The analytic trajectory developed in this chapter does not conclude with theoretical explanation alone. As the relationships between endurance, organizational conditions, and cumulative physical and psychological strain became clearer through theoretical integration, a further analytic question emerged: how might this grounded theory be positioned so that endurance is recognized as an organizational responsibility rather than an individual burden.

In this study, governance is understood as the way organizations notice, interpret, and take responsibility for patterns of strain, care, and vulnerability within their workforce, rather than simply as a set of formal policies or performance systems. The concepts introduced here are intended to create shared spaces for reflection and ethical deliberation across leadership, occupational health, and workforce functions, drawing attention to how physical and mental strain accumulates and becomes normalised within everyday organizational life. Their purpose is not to prescribe solutions, but to

support collective sense-making about where responsibility lies, what forms of support are visible or absent, and how organizational responses shape nurses' capacity to continue working overtime. This question informed the initial development of Endurance Panels and the Local and National Wellbeing Response Frameworks as proposed governance mechanisms intended to situate endurance within organizational accountability structures. At this stage of the thesis, these mechanisms are introduced to demonstrate the scope and reach of the grounded theory beyond interpretation. Their inclusion here signals that the theory generated has the capacity to inform structured organizational response, without yet moving into questions of operational design or implementation.

The detailed articulation, operationalization, and governance implications of these mechanisms are intentionally developed in Chapter 8, where the analytic focus shifts from contribution to formal translation into organizational and system-level contexts. Within Chapter 7, these applied elements therefore function as indicators of theoretical extension, demonstrating how a Constructivist Grounded Theory can move from lived experience and conceptual explanation toward ethically grounded organizational application.

Positioning the Endurance Framework, PARC Index, and Endurance Index as Contributions to Knowledge

The constructs established in this work enhance knowledge not as measurement tools but as theory-driven conceptual interpretations. Charmaz (2014, pp. 306–318) contends that grounded theory must preserve analytic abstraction while being anchored in lived experience and social processes. The Endurance Framework, PARC Index, and Endurance Index address this need by transforming theoretical categories into forms comprehensible to organizations while maintaining their moral, relational, and embodied significance.

In the literature on occupational health and workforce wellbeing, organizational tools frequently emphasise exposure and outcomes at the expense of ethics, meaning, and relational context (Nielsen and Noblet, 2018; WHO and ILO, 2021). This applied system presents a process-oriented paradigm that emphasises the accumulation of harm through organizational settings, leadership practices, and moral ties over time.

The Endurance Framework provides a theoretical structure that connects embodied experience, organizational conflict, and ethical pressure into a unified explanatory paradigm. The PARC Index offers a multifaceted understanding of wellbeing that contests resilience-focused and deficit-driven frameworks (Traynor, 2018; Maben and Bridges, 2020). The Endurance Index reinterprets accumulated strain as a primary indicator of organizational risk, broadening the scope of institutional betrayal and governance research into worker sustainability (Smith and Freyd, 2014).

Collectively, these ideas illustrate how interpretive and reflexive grounded theory can produce practical conceptual frameworks while maintaining analytical rigour and empirical foundation.

This chapter examines the primary research question of the study:

Nurses' experiences of working during and after the COVID-19 pandemic; views on physical and mental well-being?

Nurses' viewpoints consistently positioned wellbeing within the interaction of physical exhaustion, emotional repression, and ethical distress influenced by organizational contexts rather than individual susceptibility. The four analytical categories illustrated the convergence of suppression, trauma and aftershocks, organizational dissonance, and moral suffering within the central category of Institutional Betrayal and Organizational Abandonment, highlighting endurance as the process through which these conditions were experienced and perpetuated over time.

The study satisfies Charmaz's (2014, pp. 337–350) assessment criteria in the following respects.

Credibility was established through constant interaction with the data, ongoing comparisons across contexts and roles, and clear documenting of analytical choices via memo-writing and diagramming.

Originality resides in conceptualizing endurance as a structural, embodied, and moral phenomenon rather than merely an individual attribute, and in presenting analytical classifications that uncover the gap between ostensible functionality and breakdown.

Resonance is demonstrated by the congruence between the theory and participants' narratives of their experiences of the pandemic in relation to their bodies, identities, and professional obligations, as well as its alignment with national and international workforce data. The utility is evidenced by the creation of practical conceptual instruments that convert theory into organizational and governance significance without diminishing it to mere prescription.

This chapter has delineated the study's conceptual, empirical, methodological, and scholarly contributions. The subsequent chapter transitions from theoretical integration to practical resolution. Chapter 8 delineates the operational framework, governance alignment, and policy ramifications of the Endurance Framework, PARC Index, Endurance Index, and Endurance Panels, elucidating how these analytically derived instruments can enhance NHS workforce governance, organizational accountability, and preparedness for future pandemics.

7.12 Conclusion to Chapter 7

This chapter has brought together the theoretical, empirical, and analytic components of the study to contextualise the grounded theory *Enduring the System and Bearing the Weight* within broader conceptual, organizational, and ethical frameworks. Following Charmaz's constructivist grounded theory approach, I moved beyond the presentation of analytic categories to evaluate how nurses' experiences of working during and after the COVID-19 pandemic were shaped by patterned organizational conditions, moral tensions, and structurally constrained opportunities for recovery.

This integration illustrates that endurance is neither an individual psychological characteristic nor a particular ability to cope. It is, instead, a structural, embodied, and ethical process generated within organizational systems that rely on sustained professional operation while providing minimal reciprocity, visibility, and remediation. The physical and mental wellbeing of nurses is intrinsically linked to leadership practices, institutional responsiveness, and the ethical framework of the care environments.

The chapter demonstrated the theory's originality by redefining post-pandemic wellbeing in terms of endurance instead of resilience or burnout. This research enhances the study on moral injury, institutional betrayal, and organizational ethics by providing a process-oriented analysis of how suffering accumulates, stabilises, and, for certain individuals, becomes intolerable over time. The analytical differentiation between Surface Endurers and Fractured Endurers elucidated the frequently obscured gap between visible functionality and organizational disintegration, demonstrating how employee vulnerability may remain hidden within traditional wellbeing and performance metrics.

The theory's credibility and resonance were bolstered by constant interaction with participants' narratives and ongoing comparisons across various contexts, roles, and endurance trajectories. Nurses frequently attributed their experiences of distress, exhaustion, and moral conflict to organizational contexts rather than to personal weakness or failure. Their accounts of embodying the pandemic through their identities and professional obligations highlighted the necessity for a theoretical framework that can simultaneously articulate persistence and harm. This chapter elucidated the study's contribution to post-pandemic nursing and organizational scholarship by promoting an embodied, relational, and temporal comprehension of worker wellbeing. Endurance was framed as a means by which organizational strain is experienced, articulated, and perpetuated, linking physical exhaustion, emotional repression, and ethical decline within a unified analytical framework. This theory enhances the expanding corpus of research that contests personalised wellbeing paradigms and advocates for structural and ethical accountability in healthcare systems.

The chapter presented the Endurance Framework, the PARC Index, the Endurance Index, and the concept of Endurance Panels as analytically derived instruments that convert theoretical insights into comprehensible organizational formats. These features were introduced to illustrate the practical applicability of grounded theory, whilst its operationalization, governance implications, and policy significance are elaborated upon in Chapter 8. This distinction maintains the analytical integrity of Chapter 7 as a domain for theorisation, assessment, and conceptual contribution rather than prescription.

Chapter 8: Recommendations and Conclusion

8.1 Introduction

In this chapter, I consolidate the study's principal contributions, return explicitly to the research question, and outline the implications of the grounded theory for practice, organizational governance, policy, and future crisis preparedness. A central argument developed across this thesis is that nurses' physical and mental wellbeing cannot be adequately understood through isolated framings of resilience, burnout, or coping. Participants' accounts instead revealed a systemic process through which nurses sustained professional functioning by enduring organizational instability and absorbing the physical and psychological consequences of structural fragility. The grounded theory that emerged, *Enduring the System and Bearing the Weight*, addresses the research question by conceptualizing wellbeing as a structural and embodied process shaped by organizational conditions rather than as an individual attribute or deficit.

In line with Charmaz's interpretive stance, this chapter also reflects on how my role as a practitioner-researcher informed the analytic process. My insider knowledge of NHS organizational contexts and workforce dynamics enhanced theoretical sensitivity and supported the development of a theory that is both conceptually robust and practice relevant. At the same time, reflexive engagement with this positionality constitutes a methodological contribution, demonstrating how practitioner insight can be integrated into Constructivist Grounded Theory while maintaining analytic transparency and rigor.

This chapter proceeds in five sections. First, I present a concise synthesis of the grounded theory and its core analytic architecture. Second, I summarize the study's principal contributions, including the Endurance Framework, the Endurance Gauge, the PARC Index, the Endurance Index, the Endurance Panels, and the proposed Local and National Wellbeing Response Frameworks, clarifying their status as theory derived, applied outputs requiring empirical testing and organizational evaluation. Third, I outline the implications of the study for practice, organizational leadership, occupational health, workforce governance, and future crisis preparedness. Fourth, I revisit the study's limitations and identify generative directions for further research. Finally, I outline the broader significance of this work for understanding and safeguarding nurses' physical and mental wellbeing.

Taken together, this chapter marks the culmination of a study that began with a practitioner-researcher concern about unresolved post-pandemic harm within a single NHS Trust and developed into a grounded conceptual explanation of cumulative workforce strain with wider organizational and policy implications. It represents both an academic contribution and an ethical commitment to ensuring that participants' experiences are translated into theoretically grounded and empirically accountable pathways for organizational learning and improvement.

8.2 Revisiting the Research Aim and Research Question (s)

The overarching aim of this study was to develop a grounded, theoretically robust, and practice relevant explanation of how nurses understood and experienced their physical and mental wellbeing during and after the COVID-19 pandemic. This aim emerged from my practitioner-researcher observations within NHS clinical and research contexts, where I encountered persistent fatigue, long COVID symptoms, disrupted recovery pathways, and fragmented organizational support that continued well beyond the acute phase of the pandemic. These observations align with national and international evidence highlighting systemic gaps in workforce protection, post-crisis care, and wellbeing governance (Royal College of Nursing, 2021; UK COVID-19 Inquiry, 2023; World Health Organization, 2021).

Guided by Constructivist Grounded Theory, the study was structured around the following central research question:

Nurses' experiences of working during and after the COVID-19 pandemic; Views on physical and mental wellbeing?

This question positioned wellbeing not as an individual psychological outcome, but as a process shaped within organizational, professional, and structural contexts. It directed analytic attention toward how working conditions, leadership practices, communication systems, and recovery infrastructures influenced nurses' physical and psychological trajectories over time.

To address this question, I pursued three interrelated research objectives.

First, I sought to explore how nurses described the physical and psychological consequences of working during and after the COVID-19 pandemic. This objective was informed by evidence indicating that healthcare workers experienced persistent somatic symptoms, sleep disturbance, autonomic dysregulation, and psychological strain following prolonged crisis exposure, including among those affected by long COVID (Greenhalgh et al., 2020; Billings et al., 2021). Rather than treating these outcomes as discrete or episodic, the analysis examined how participants narrated them as cumulative and interconnected.

Second, I aimed to theorize the processes through which nurses navigated, managed, or absorbed organizational strain across both crisis and post-crisis conditions. In keeping with Charmaz's emphasis on grounded theory as a method for explicating process rather than categorization, this objective focused on tracing how early strategies of suppression, adaptation, and professional containment were linked to later patterns of deterioration, fragmentation, or withdrawal. The analytic task was therefore not simply to document impact, but to explain how organizational conditions shaped wellbeing trajectories over time.

Third, I sought to develop a conceptual and applied framework capable of informing organizational and policy-level responses to workforce wellbeing in both routine practice and future health emergencies. This objective aligned with international calls for structured wellbeing governance, integrated occupational surveillance, and crisis responsive workforce systems in the aftermath of COVID-19 (World Health Organization, 2021; International Labour Organization and World Health Organization, 2022).

8.3 How the Grounded Theory Addresses the Research Aim

Through iterative coding, constant comparison, theoretical sampling, and integrative memo writing, I developed the grounded theory *Enduring the System and Bearing the Weight*. This theory extends beyond individualized interpretations of wellbeing by demonstrating that nurses' physical and mental wellbeing were shaped through a structural and organizational process of sustained endurance rather than through personal resilience or coping capacity alone. This position aligns with critiques of resilience-oriented frameworks in healthcare, which argue that such approaches risk displacing responsibility for wellbeing from organizations onto individuals (Traynor, 2018; West et al., 2020).

The theory integrates four major analytic categories: Physical and Emotional Suppression and Delayed Processing, Physical and Psychological Trauma and Aftershocks, Organizational Dissonance and Fragmentation, and Moral Suffering and Ethical Erosion, which together generate the core category Institutional Betrayal and Organizational Abandonment. While analytically distinct, these categories function as interdependent mechanisms that shape how nurses experience and interpret physical and psychological strain within complex organizational environments.

These analytic patterns extend findings reported in the UK COVID-19 Inquiry, which documented leadership invisibility, inconsistent communication, insufficient protective infrastructure, and the absence of structured workforce aftercare as systemic failures in the national response (UK COVID-19 Inquiry, 2023). The grounded theory contributes to this evidence base by explaining how such organizational conditions become embodied in nurses' physical and mental wellbeing over time.

The analytic groupings Surface Endurers and Fractured Endurers further demonstrate that variation in wellbeing trajectories was shaped less by individual disposition than by differential exposure to organizational instability, access to recovery opportunities, and cumulative strain. This interpretation is consistent with research on workforce distress and moral injury, which identifies sustained organizational misalignment as a driver of psychological deterioration and workforce attrition (Williamson et al., 2020; Dean et al., 2022).

Taken together, this study demonstrates that its research aims and objectives have been met. Nurses' experiences of physical and mental wellbeing during and after the COVID-19 pandemic are best understood as the outcome of a structural and organizational process of endurance rather than as

isolated psychological or individual phenomena. By moving analytically from participant accounts to integrated conceptual explanation and applied organizational implications, the grounded theory establishes a coherent pathway linking experience to theory and theory to governance.

8.4 Summary of Principal Contributions

The Five Pillars of Grace as a Theory-Based Heuristic

This study contributes to nursing scholarship, organizational studies, and workforce wellbeing research by offering a grounded, process-oriented explanation of how nurses' physical and mental wellbeing is shaped within healthcare organizations during and after prolonged crisis conditions. Rather than presenting isolated findings or applied tools, the thesis advances an integrative, theory-based heuristic that links conceptual, empirical, methodological, applied, and policy dimensions within a coherent analytic structure.

The Five Pillars of Grace emerged through integrative memo writing and theoretical comparison as a means of preserving analytic coherence while translating the grounded theory *Enduring the System and Bearing the Weight* into organizationally meaningful form. In this context, 'Grace' denotes conceptual alignment and ethical balance rather than stylistic framing. The heuristic clarifies the movement from participant experience to theoretical integration and onward to governance and policy relevance.

At a conceptual level, the study advances endurance as an organizational construct for understanding how sustained professional functioning is produced under conditions of prolonged systemic strain. This reframes wellbeing away from individual coping capacity and toward leadership practices, staffing design, communication systems, and recovery infrastructures as organizational determinants of physical and psychological trajectories over time.

Empirically, the study documents the prolonged physical and psychological aftermath of pandemic work, including fatigue, disrupted sleep, cognitive depletion, and emotional strain, and demonstrates how recovery trajectories were shaped by the visibility, accessibility, and legitimacy of organizational support systems rather than by individual health status alone.

Methodologically, the thesis extends Constructivist Grounded Theory into the domain of organizational health by developing a transparent analytic pathway from manual coding and constant comparison to integrative, mechanism-based explanation, supported by visual analytic devices and reflexive engagement with practitioner-researcher positionality.

At an applied and governance level, the study introduces a suite of theory-derived interpretive tools, including the Endurance Framework, Endurance Gauge, PARC Index, Endurance Index, and Endurance Panels. These are positioned as heuristic devices rather than prescriptive instruments,

intended to support organizational reflection, ethical deliberation, and governance-level interpretation of cumulative workforce strain.

Finally, the study contributes to policy-relevant scholarship by situating nurses' physical and mental wellbeing within broader systems of institutional responsibility, aligning organizational processes of endurance, recovery, and protection with national and international discussions on workforce safeguarding and post-crisis preparedness.

Taken together, the Five Pillars of Grace function as an integrative structure that connects participant experience to theory, and theory to organizational and policy relevance, without displacing the grounded and interpretive foundations of the study.

8.5 Workforce Governance: Interpreting Endurance as Organizational Information

The grounded theory positions endurance as an organizational outcome rather than an individual attribute. Within this framing, the Endurance Framework, Endurance Gauge, PARC Index, and Endurance Index function as complementary, theory-derived interpretive structures through which leadership, occupational health, and workforce governance teams may reflect on how organizational conditions shape cumulative physical and mental strain.

The Endurance Framework maps the organizational processes through which strain is produced and sustained across staffing configurations, communication practices, and recovery provision. The Endurance Gauge introduces a temporal lens, making visible how physical and psychological strain stabilises, escalates, or shifts over time, thereby supporting earlier recognition of gradual deterioration that may remain obscured within existing governance systems (Royal College of Nursing, 2022; International Labour Organization and World Health Organization, 2022).

The PARC Index provides a multidimensional, governance-oriented integrative space for examining how cumulative strain is composed across four empirically intertwined domains: Physical, Affective, Relational, and Cognitive. Abstracted through constant comparison rather than imposed a priori, these domains translate the process model of Enduring the System and Bearing the Weight into an interpretive structure that holds together complexity without reducing experience to discrete indicators, aligning with multidimensional approaches to occupational health and psychosocial risk assessment (Cox et al., 2000; World Health Organization, 2021).

The Endurance Index draws these analytic dimensions together into an overall reflective profile of organizational capacity, recovery provision, and emerging vulnerability. Rather than functioning as a quantitative measure, it operates as a governance-facing heuristic that supports structured deliberation about how endurance and recovery are shaped within organizational systems.

Endurance Panels are positioned as a coordinating governance mechanism for collectively interpreting insights generated across the Endurance Framework, Endurance Gauge, PARC Index, and Endurance Index, enabling aligned reflection and response across occupational health, leadership, and workforce management functions. This approach responds to governance literature emphasizing cross-functional oversight in the management of complex organizational risk and accountability within health systems (Ferlie and Shortell, 2001; UK COVID-19 Inquiry, 2023).

Collectively, these tools extend qualitative grounded theory into the domain of organizational governance as theory-derived, proposed instruments requiring empirical testing, validation, and contextual adaptation, consistent with international calls for integrated occupational surveillance and workforce accountability (International Labour Organization and World Health Organization, 2022; Royal College of Nursing, 2022).

8.6 Summary of Key Contributions

This study emerged from a practitioner-researcher concern that critical dimensions of nurses' physical and mental wellbeing had been insufficiently recognized within national and organizational responses to COVID-19. Observations made during the SIREN study, including the persistence of long COVID symptoms, moral strain, unresolved trauma, emotional depletion, and structural fragmentation, suggested that prevailing wellbeing frameworks lacked both conceptual coherence and explanatory depth.

Through the application of Constructivist Grounded Theory, I developed Enduring the System and Bearing the Weight, a grounded theory that illuminates how nurses' physical and psychological wellbeing is shaped through the sustained moral, emotional, and organizational labour required to remain operational within conditions of prolonged systemic pressure during and after the pandemic.

To articulate the full contribution of this work, I developed the Five Pillars of Grace as a conceptual structure that synthesises how the study moves from experience to evidence, from evidence to theory, and from theory to governance and policy. In this context, *grace* does not denote gentleness or stylistic framing; rather, it signifies balance, integrity, and ethical clarity. It reflects the disciplined alignment of conceptual, empirical, methodological, applied, and policy contributions.

The five pillars therefore represent the underlying architecture of the study's contribution to knowledge and its significance for nursing, organizational studies, occupational health, and pandemic governance.

The conceptual contribution is twofold. First, endurance is advanced as an analytic category within nursing and organizational scholarship for understanding how sustained functionality is produced under conditions of prolonged systemic strain. Second, the analytic groupings Surface Endurers and

Fractured Endurers, developed in this study, provide a nuanced vocabulary for examining differential wellbeing trajectories and patterns of continued professional functioning.

Taken together, these concepts explain how organizational systems remained operational while individuals bore the physical and psychological weight of that functionality.

8.7 Recommendations

Theory-Informed Considerations for Organizational and Policy Development

Consistent with the interpretive and theory-generating orientation of Constructivist Grounded Theory, the considerations outlined in this section are presented as theory-informed propositions rather than prescriptive recommendations. They emerge from the analytic integration of participant accounts, constant comparison, and memo-based theoretical development (Charmaz, 2014). Their purpose is to invite reflection, dialogue, and further inquiry among practitioners, leaders, and policymakers, rather than to establish definitive standards of practice.

Given that this study was conducted within a single NHS Trust, these considerations are offered as context-sensitive and exploratory. Their relevance and applicability across other organizational and policy environments therefore remain matters for empirical examination, adaptation, and collaborative evaluation (Lincoln and Guba, 1985; Polit and Beck, 2021).

These reflections are grounded in the four analytic categories and the core category of Institutional Betrayal and Organizational Abandonment and are positioned as extensions of the governance logic articulated through the Endurance Framework, Endurance Gauge, PARC Index, Endurance Index, and Endurance Panels.

8.7.1 Analytic Foundations

Across the analytic categories, participants' accounts consistently pointed to an organizational context in which physical and mental wellbeing was shaped by sustained workload intensity, constrained opportunities for recovery, variable leadership presence, and fragmented access to occupational health and wellbeing support. Comparable patterns have been identified in national and international reviews of post-pandemic workforce conditions, which highlight the relationship between staffing pressure, leadership practices, and prolonged strain among healthcare workers (Royal College of Nursing, 2022; World Health Organization, 2021).

These conditions generated cumulative strain that was managed primarily through individual endurance rather than through coordinated organizational processes, reflecting wider critiques of resilience-oriented approaches that risk shifting responsibility from institutions to individuals (Traynor, 2018; West et al., 2020).

Each category highlights a distinct but interconnected organizational pattern that informs the considerations that follow.

Physical and Emotional Suppression and Delayed Processing

Participants described continuing to work through physical exhaustion and emotional strain in the absence of formalized recovery opportunities. This suggests a context in which wellbeing becomes reliant on individual self-regulation rather than being structurally embedded within workforce design.

This study invites reflection on how opportunities for physical and psychological recovery are recognized, legitimized, and made visible within everyday staffing, workload, and rostering arrangements, consistent with evidence that predictable recovery time is associated with reduced burnout and improved workforce sustainability (West et al., 2020; World Health Organization, 2021).

Physical and Psychological Trauma and Aftershocks

Ongoing fatigue, disrupted sleep, and cognitive and emotional strain were frequently reported beyond the acute phase of the pandemic, often without structured follow-up or sustained support pathways. This points to a pattern in which post-crisis recovery is experienced as episodic rather than constant.

Organizations may therefore wish to consider how continuity between occupational health, psychological support, and return-to-work processes can be strengthened to support longer-term recovery trajectories, reflecting findings that coordinated aftercare and trauma-informed services are central to workforce retention and rehabilitation (Greenberg et al., 2020; Billings et al., 2021).

Organizational Dissonance and Fragmentation

Inconsistent communication and variable leadership presence were associated with heightened uncertainty and reduced confidence in organizational systems. These conditions shaped how participants interpreted organizational intent, stability, and support.

This study suggests that alignment between leadership visibility, communication practices, and recovery planning may play a role in shaping wellbeing trajectories across both crisis and post-crisis phases, consistent with research linking leadership behaviour to psychological safety and trust in healthcare teams (West et al., 2020; Shanafelt et al., 2020).

Moral Suffering and Ethical Erosion

Participants described strain linked to constrained professional judgment and perceived withdrawal of organizational support. Although analytically distinct, this category intersected with physical and psychological wellbeing by shaping motivation, engagement, and willingness to remain within the system.

This invites reflection on how ethical concerns are acknowledged and addressed at a system level, rather than being managed primarily through individual coping or professional resilience, aligning

with scholarship on moral injury and institutional responsibility in healthcare settings (Dean et al., 2019; Williamson et al., 2020).

Core Category: Institutional Betrayal and Organizational Abandonment

Taken together, these patterns suggest that cumulative strain was experienced because of organizational conditions rather than individual vulnerability alone. This study therefore foregrounds organizational responsibility for how wellbeing is communicated, enacted, and sustained over time, in line with institutional betrayal theory and organizational ethics literature (Smith and Freyd, 2014; Traynor, 2018).

8.7.2 Organizational Practice: Supporting Recovery and Coordination

Recovery Pathways within Workforce Design

Participants' accounts indicated that recovery was often informal and dependent on local arrangements rather than embedded within formal organizational processes.

Organizations may wish to reflect on whether opportunities for physical and psychological recovery are structurally integrated into staffing models, rostering systems, and workload planning, rather than being contingent on discretionary or ad hoc provision. This reflects evidence linking protected recovery time to reduced burnout and improved staff retention (West et al., 2020; Royal College of Nursing, 2022).

Coordination Between Occupational Health and Psychological Support

Experiences of fragmented support suggested that physical and mental health services were not always experienced as connected or coherent.

This study invites consideration of models that promote closer coordination between occupational health provision and psychological support, particularly in relation to return-to-work planning and longer-term follow-up, reflecting international guidance on integrated workforce health systems (World Health Organization, 2021; International Labour Organization and World Health Organization, 2022).

Leadership Presence and Communication

Leadership visibility and communication were frequently linked to participants' sense of stability, trust, and organizational legitimacy.

Organizations may therefore wish to reflect on how leadership presence and communication strategies are maintained across both high-pressure operational periods and subsequent recovery phases, consistent with evidence that visible leadership is associated with improved workforce morale and psychological safety (Shanafelt et al., 2020; UK COVID-19 Inquiry, 2023).

8.7.3 National Policy and Pandemic Preparedness

The grounded theory developed in this study situates nurses' physical and mental wellbeing within broader systems of organizational and policy responsibility. The core category of Institutional Betrayal and Organizational Abandonment highlights that cumulative strain was not only experienced at the level of local leadership and workplace design but also shaped by the presence or absence of national mechanisms for recognition, protection, and long-term recovery.

Recognition of Pandemic-Related Injury and Long-Term Occupational Impact

Participants' accounts indicated that long COVID and sustained functional impairment were experienced as personal misfortune rather than as occupationally recognized harm, with implications for financial security, professional identity, and future working life. Comparative policy approaches in other national contexts, including the classification of COVID-19 as an occupational disease, suggest alternative ways of locating responsibility for pandemic-related injury within system-level governance rather than individual circumstance.

From a theory-informed perspective, national bodies may wish to examine whether formal mechanisms for recognizing pandemic-related occupational harm, including pathways for income protection, pension safeguarding, and early retirement, could contribute to processes of moral repair and institutional accountability. This aligns with workforce protection recommendations articulated by the Royal College of Nursing (2023) and the UK COVID-19 Inquiry (2024).

Post-Pandemic Workforce Health Surveillance and Recovery Infrastructure

Despite growing evidence of long COVID prevalence and prolonged psychological impact among healthcare workers (Office for National Statistics, 2023; World Health Organization, 2021), participants described an absence of coordinated, system-level follow-up beyond local occupational health provision. International experience following previous infectious disease outbreaks has highlighted the potential value of structured health surveillance and rehabilitation pathways for healthcare workers exposed to sustained crisis conditions (Maunder et al., 2006; Chan, 2004).

This study invites consideration of whether national health surveillance mechanisms could function as a governance response to endurance load by supporting longer-term physical and psychological monitoring, rehabilitation planning, and occupational reintegration.

National Frameworks for Wellbeing Response in Future Health Emergencies

The Local and National Wellbeing Response Frameworks are shaped by the question of how organizations can remain present to the long afterlife of crisis, rather than only to its most visible moments. They draw attention to the need for spaces where experiences of loss, fatigue, moral conflict, and recovery can be acknowledged over time, and where responsibility for wellbeing is shared rather than assumed to rest with individuals alone. In this sense, the frameworks are offered as

ways of holding together learning, care, and accountability across organizational and system levels, particularly in preparation for future periods of sustained pressure. Participants consistently described the absence of structured aftercare, formal debriefing, and coordinated recovery following the acute phase of the pandemic. This pattern resonates with the UK COVID-19 Inquiry's characterization of institutional unpreparedness in relation to workforce protection and post-crisis care (UK COVID-19 Inquiry, 2023).

Building on this analytic insight, the proposed National Wellbeing Response Framework is positioned within this thesis as a theory-derived, exploratory construct rather than a validated policy instrument. It is intended to illustrate how the grounded theory might be extended into system-level governance by linking early psychological support, leadership visibility, occupational surveillance, and recovery provision within a coordinated national response architecture, consistent with international guidance on health workforce protection (World Health Organization, 2021).

These considerations are derived from qualitative data generated within a single NHS Trust and are presented as theory-informed and exploratory. They are intended to support reflection, dialogue, and further research rather than to define standards of practice. Their applicability across other organizational and policy contexts therefore remains a matter for empirical testing, collaborative development, and ongoing theoretical refinement (Lincoln and Guba, 1985; Polit and Beck, 2021).

Introduce a National Pandemic Injury Compensation and Early-Retirement Scheme

Participants' accounts indicated that nurses experiencing long COVID and sustained functional impairment faced reduced work capacity, pension vulnerability, and limited formal recognition of pandemic-related occupational harm. Comparative policy approaches in other national contexts, including Sweden and Canada, classify COVID-19 acquired at work as an occupational disease, thereby situating responsibility for pandemic injury within system-level governance rather than individual circumstance (Swedish Work Environment Authority, 2020; Government of Canada, 2021; International Labour Organization, 2021).

Recommendation: Establishing a National Pandemic Injury Scheme that provides:

- Early retirement pathways
- Enhanced pension protection
- Income support for those below the minimum retirement age
- Specific protections for internationally recruited nurses
- Formal recognition of COVID-19 as an occupational exposure for future pandemics

This recommendation aligns with calls for national-level wellbeing reform and workforce protection articulated by the Royal College of Nursing (2023) and the UK COVID-19 Inquiry (2023; 2024) and

reflects the core category of Institutional Betrayal and Organizational Abandonment by situating recovery, recognition, and protection as matters of institutional responsibility rather than individual endurance.

Create a National Post-Pandemic Health Surveillance Programme for Healthcare Workers

Despite documented prevalence of long COVID and prolonged psychological impact among NHS staff (Office for National Statistics, 2023; World Health Organization, 2021), participants described an absence of coordinated, national-level tracking and structured follow-up beyond local occupational health provision.

Recommendation: Establishing a National Workforce Health Surveillance System responsible for:

- Long COVID screening
- Psychological follow-up
- Rehabilitation pathways
- Occupational reintegration planning

This recommendation mirrors international practice following SARS and MERS, where structured monitoring and recovery systems were used to support healthcare workers exposed to sustained crisis conditions (Chan, 2004; Maunder et al., 2006). It also reflects World Health Organization (2021) guidance on sustained workforce monitoring and recovery as components of health system resilience.

Adopt a National Wellbeing Response Framework for Future Crises

Participants consistently described a complete absence of structured aftercare, formal debriefing, and coordinated recovery following the acute phase of the pandemic. This pattern resonates with the UK COVID-19 Inquiry's conclusion that the national response was institutionally unprepared for the longer-term protection and recovery of the healthcare workforce (UK COVID-19 Inquiry, 2023; 2024).

Recommendation: Implementing the National Wellbeing Response Framework incorporating:

- Mandatory psychological first aid within 72 hours of major incidents
- Structured debriefing processes for all staff
- Real-time occupational surveillance during crises
- National PPE governance mechanisms
- Formal leadership presence expectations
- Protected time for recovery

Cross-Trust mutual aid systems

This framework is positioned within this thesis as a theory-derived and exploratory governance structure rather than a validated policy instrument. It is intended to demonstrate how the grounded theory may be extended into coordinated system-level responsibility for workforce protection, consistent with international guidance on health workforce safeguarding during and after public health emergencies (World Health Organization, 2021).

Extend Wellbeing Services Beyond Standard Working Hours

Participants' accounts indicated that existing wellbeing and support services were frequently inaccessible to staff working nights, weekends, and rotating shifts, reinforcing inequities in access to recovery and support across the workforce. This pattern reflects national concerns regarding the alignment of wellbeing provision with the 24-hour operational reality of the NHS (Royal College of Nursing, 2022).

Recommendation: Extending wellbeing and support services beyond standard working hours to ensure equitable access for staff across all shift patterns and clinical settings.

Introduce Leadership Crisis-Response Training

Participants described leadership paralysis and limited senior presence during critical phases of the pandemic, experiences that were intricately linked to perceptions of abandonment, moral strain, and organizational disconnection.

Recommendation: The introduction of mandatory crisis-response training for senior leaders, informed by preparedness models used in military and emergency-service contexts. Such training may support decision-making under uncertainty, leadership visibility, and recovery-focused governance during major incidents.

Mandate Integrated Occupational Health and Psychological Services Across Trusts

Fragmentation between occupational health and psychological support services was identified as exacerbating physical and psychological harm, particularly during recovery and return-to-work phases. International guidance advocates integrated psychosocial and physical health models as a core component of workforce protection during and after crises (World Health Organization, 2021).

Recommendation: Formalizing integrated occupational health and psychological support pathways across NHS Trusts, with clear coordination for assessment, follow-up, rehabilitation, and reintegration.

Formalise National Standards for Redeployment, Return-to-Work, and Staff Support

Participants' accounts indicated that inconsistent redeployment practices and variable

return-to-work pathways intensified both moral and physical strain, contributing to perceptions of inequity and organizational fragmentation.

Recommendation: The development of national minimum standards for redeployment, return-to-work planning, and staff support during and after major incidents, to promote consistency, reduce inter-organizational variation, and strengthen continuity of recovery provision.

8.8 Implications for Future Research

Academic and Theory-Extending Directions

This study offers a grounded, process-oriented explanation of how nurses' physical and mental wellbeing is shaped within organizational contexts during and after prolonged crisis. As a qualitative inquiry conducted within a single NHS Trust, it opens a set of generative directions for further research aimed at examining the transferability, scope, and analytic refinement of the grounded theory Enduring the System and Bearing the Weight.

8.8.1 Multi-Site and Comparative Studies

Future research may examine how the processes identified in this study operate across different organizational settings, including acute, community, mental health, and primary care environments. Comparative, multi-site studies could explore whether the analytic categories and the core category Institutional Betrayal and Organizational Abandonment manifest similarly across diverse staffing models, leadership structures, and resource conditions. Such work may help to clarify the extent to which endurance functions as a general organizational process or as a context-dependent pattern shaped by local governance arrangements.

8.8.2 Longitudinal Designs and Wellbeing Trajectories

The findings highlight that physical and mental wellbeing trajectories often extended well beyond the formal end of crisis conditions. Longitudinal research designs may therefore be particularly well suited to examining how suppression, aftershocks, organizational dissonance, and recovery unfold over time. Repeated engagement with participants across extended periods could support a more detailed understanding of how individuals move between the analytic groupings Surface Endurers and Fractured Endurers, and how organizational interventions, leadership changes, or policy shifts shape these transitions.

8.8.3 Methodological Development within Constructivist Grounded Theory

This study demonstrates the value of applying Constructivist Grounded Theory to organizational and occupational health contexts characterized by sustained strain. Future research may build on this approach by exploring the use of visual analytic devices, constant comparison matrices, and reflexive memo writing in other complex system settings. Comparative methodological studies may also

examine how practitioner-researcher positionality influences theoretical sensitivity, category development, and theoretical integration across different professional and institutional contexts.

8.8.4 Integration with Quantitative and Mixed Methods Approaches

While this study is grounded in qualitative analysis, future research may consider mixed methods designs that examine how the processes identified here relate to quantitative indicators of workforce health, such as sickness absence, staff turnover, and occupational health utilization. Such work could explore whether patterns associated with endurance, suppression, and organizational dissonance are reflected in organizational metrics, thereby extending the analytic reach of the grounded theory without reducing it to a set of standardized measures.

8.8.5 Policy-Oriented and Governance-Focused Research

Further research may investigate how organizational and policy environments shape the enactment of workforce wellbeing strategies in different health systems. Studies examining leadership accountability, governance structures, and the implementation of occupational health frameworks could provide additional insight into how institutional conditions influence physical and mental wellbeing across organizational levels. This line of inquiry may be particularly relevant in the context of future public health emergencies and large-scale system reform.

8.8.6 Conceptual Refinement of Endurance and Organizational Responsibility

Future theoretical work may seek to refine the conceptual boundaries of endurance as an organizational construct. Comparative studies across professions, including allied health, social care, and emergency services, could examine whether similar processes of organizational endurance and cumulative strain emerge in other high-demand, high-risk occupational contexts. Such research may contribute to broader debates on organizational responsibility, workforce protection, and the governance of wellbeing within contemporary public service systems.

8.8.7 Evaluation of Theory-Derived Frameworks and Tools

Future research may also focus on the empirical evaluation of the theory-derived applied outputs developed within this study, including the Endurance Framework, Endurance Gauge, PARC Index, Endurance Index, and Endurance Panels. At present, these tools function as conceptual and heuristic extensions of the grounded theory rather than as validated instruments.

Further work may examine how the PARC Index operates as a governance-oriented interpretive structure in practice, exploring how leadership, occupational health, and workforce governance teams understand and use its four domains of physical, affective, relational, and cognitive wellbeing when reflecting on organizational strain and recovery provision.

Multi-site pilot studies could examine the feasibility, acceptability, and interpretive value of these tools within different organizational contexts, including acute, community, and specialist care settings. Mixed methods designs may be particularly well suited to exploring whether their application contributes to earlier recognition of cumulative physical and mental strain, improved coordination of recovery pathways, or enhanced organizational dialogue about workforce wellbeing.

Such work would support the refinement of these tools, clarify their scope of applicability, and contribute to the development of empirically grounded approaches to integrating qualitative theory into organizational monitoring and decision-making processes.

8.9 Strengths and Limitations

This study's strengths and limitations are best understood in relation to its methodological positioning within Constructivist Grounded Theory and its focus on nurses' physical and mental wellbeing within a single NHS Trust. Rather than functioning as a binary evaluation of quality, this section situates the study's contributions and constraints within the interpretive and context-sensitive nature of qualitative inquiry.

8.9.1 Strengths

Depth of Analytic Engagement

A central strength of this study lies in the depth of its analytic engagement with participants' accounts. The use of manual coding, constant comparison, and sustained memo writing supported close attention to language, pacing, and embodied expression, enabling the development of a mechanism-based explanation of how organizational conditions shape physical and mental wellbeing over time.

Theoretical Integration and Conceptual Coherence

The study achieved an important level of theoretical integration by linking analytic categories to a core category and an overarching grounded theory. This structure provides a coherent conceptual framework that connects individual experience to organizational processes and governance implications, supporting analytic rather than descriptive explanation.

Practitioner-Researcher Positionality

My positioning as a practitioner-researcher within NHS contexts enhanced theoretical sensitivity and facilitated access to contextual knowledge regarding workforce structures, leadership practices, and occupational health processes. Reflexive engagement with this positionality, through memo writing and supervisory dialogue, supported transparency in how interpretations were developed and challenged.

Transparency of the Analytic Process

The use of visual analytic tools, including category maps, comparison matrices, and integrative diagrams, contributed to a clear audit trail linking raw data to theoretical constructs. This transparency strengthens the credibility and trustworthiness of the grounded theory.

8.9.2 Limitations

Single-Organization Context

The study was conducted within a single NHS Trust, which necessarily shapes the organizational, leadership, and policy environment in which participants' experiences were situated. While the grounded theory offers analytic insights that may resonate beyond this setting, its transferability to other organizational contexts require careful consideration and empirical examination.

Scope of Professional Representation

Although participants represented a range of nursing roles and settings within the Trust, the study does not encompass the full diversity of healthcare professions or interprofessional dynamics. Future research may extend this analytic framework to include allied health professionals, support staff, and managerial perspectives.

Temporal Context

Data collection captured experiences during and in the period following the COVID-19 pandemic. Organizational conditions, leadership practices, and workforce policies continue to evolve, and the grounded theory reflects a particular historical and institutional moment. Longitudinal research is therefore required to examine how these processes develop under different system pressures.

Interpretive Nature of the Analysis

As a Constructivist Grounded Theory study, the analysis is inherently interpretive and shaped through the interaction between researcher and participants. While reflexive practices and constant comparison were used to enhance analytic rigor, alternative interpretations remain possible and constitute a productive avenue for further theoretical engagement.

Status of Theory-Derived Applied Outputs

While this study developed a set of applied outputs, including the Endurance Framework, Endurance Gauge, PARC Index, Endurance Index, and Endurance Panels, these remain conceptual and theory-derived. They have not been empirically evaluated, validated, or implemented within organizational systems. Their inclusion in this thesis reflects an effort to translate grounded theory into potential governance- and practice-relevant forms rather than to present finalized instruments. More research is needed to evaluate how practical, dependable, and influential these methods are in different healthcare settings.

8.10 Conclusion

This thesis set out to examine nurses' perspectives of their experiences of working during and after the COVID-19 pandemic, with particular focus on how their physical and mental wellbeing was shaped within organizational contexts. Through the application of Constructivist Grounded Theory, the study developed a grounded explanation of the processes through which organizational conditions, professional demands, and recovery infrastructures interacted to influence wellbeing trajectories over time.

The grounded theory Enduring the System and Bearing the Weight offer a conceptual account of how nurses remained operational within environments characterized by uncertainty, fragmented support, and variable leadership presence. Rather than locating wellbeing primarily within individual coping capacity, the theory demonstrates how physical and mental strain accumulated through organizational processes of deferred recovery, inconsistent communication, and limited institutional reciprocity. These processes were synthesized through the core category Institutional Betrayal and Organizational Abandonment, which captures the structural conditions under which endurance became necessary rather than chosen.

As a practitioner-researcher, my engagement with participants' accounts was shaped by both professional proximity and analytic discipline. Reflexive memo writing and supervisory dialogue were used to interrogate how insider knowledge informed theoretical sensitivity without displacing critical distance. This approach supported the development of a theory that is grounded in participants' experiences while remaining open to reinterpretation and further testing.

The study contributes to nursing and organizational scholarship by offering a process-oriented understanding of wellbeing that connects individual experience to organizational design and governance. It suggests that nurses' physical and mental wellbeing during and after large-scale health crises may be better understood through attention to recovery pathways, leadership practices, and occupational health infrastructures rather than through individual-level frameworks alone.

In closing, this thesis offers a grounded, theory-informed account that invites continued inquiry into how healthcare organizations can learn from the experiences of nurses and reflect on the conditions that shape workforce wellbeing during and after pandemics. The experiences shared by participants form the basis for an ongoing scholarly and professional conversation about organizational responsibility, protection, and care within contemporary health systems.

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APPENDICES

APPENDIX A: Participant Information Sheet (PIS)

A constructivist grounded theory qualitative study to determine nurses' experiences of working during the Covid-19 pandemic and their perspectives on physical and mental wellbeing beyond, while working for an NHS organization

Participant Information Sheet

(One-on-one Interviews)

What is the purpose of the study?

I am a PhD candidate at Birmingham City University, who is being sponsored by [redacted] NHS Trust. We would like to understand better the experiences of nurses working within [redacted] NHS Trust's during the COVID-19 pandemic and their perspectives on physical and mental wellbeing beyond the pandemic. I would really want to know about your experience of working during the pandemic. This includes all registered nurses from a diversity of disciplines as well as nursing associates from across the organization. I am hoping that this understanding will help future services to provide better physical and mental health wellbeing support for nurses.

Who is involved in the research?

Patience Domingos (Lead Researcher - PhD candidate)

Dr Kate Thomson (Supervisor)

Dr Maria Clark (Supervisor)

Dr Kathrina Connabeer (Supervisor)

An Invitation to participate.

We would like to invite you to participate in our research study. Before deciding whether or not to participate, you should understand why the research is being conducted and what it will entail. Please read the following information carefully and contact us if you require any additional information or if you have any questions. Please feel free to share this with your friends, family, and anyone else you want.

Am I eligible to take part in the study?

You have been asked to participate because you work for [redacted] NHS Trust and worked there during the COVID-19 pandemic. Your knowledge and experience of working during the pandemic, as well as your perspectives on physical and mental wellbeing, will be greatly appreciated in helping to shape this topic.

Do I have to take part?

It is completely up to you whether or not you agree to take part in the study. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part but then change your mind, you are free to do so at any time without giving a reason.

What will happen if I take part?

You will be asked to take part in a one-on one interview or with the researcher, Patience: about your experience of working during the COVID-19 pandemic and your views on mental health and wellbeing. The interviews will last approximately 45-60mins and might be longer, or as long as you would like to talk about your experience. We are offering options of one-on-one, telephone or online interviews, however, we are prioritizing one-on-one interviews. With your permission, the interview will be audio-recorded. You can stop the interview at any time, and you do not have to answer a particular question if you don't want to.

What will happen if I agree to take part and later change my mind?

You have the right to withdraw from the interview at any time, including during the interview and up to seven days after the interview.

What are the benefits of taking part?

The Trust is supporting this research to make sure they are doing their best to support staff during, after and future pandemics. This study will enable your voice to be heard and allow you to contribute to shaping up interventions and support for NHS staff during, after and future pandemics. Although there are no immediate advantages to participating, you will have the option to share your experience and views of working during the COVID-19 pandemic. Making sense of your experiences may be facilitated by discussing them with a neutral party. Additionally, participating in a growing field of study that could affect nurses in the future could have psychological advantages and aid in the implementation of measures that would support nurses during, after, and in future pandemics.

What happens after interviews?

You will have no further involvement in the study after the interview; however, participants will be given the opportunity to comment, provide further clarity, and review transcripts should you wish. If you require additional assistance, you will be given a leaflet listing some relevant support networks. You are welcome to request a copy of your transcript for use for revalidation.

Are there any potential risks in taking part?

There are no known risks; however, there is a possibility that the interviews will be emotionally distressing for some people, either during or after the interviews. If the researcher suspects you are becoming distressed, she may ask you to pause for a moment to ensure you are not becoming overly anxious. The researcher may ask clarifying questions but not questions involving specifics about an event. You will be reminded that you should only talk about experiences that you are willing to talk about in a manageable way. The researcher will follow BSA code of conduct and signpost participants to Occupational Health and Wellbeing for further support.

Will my information be kept confidential?

We will keep all of the information you provide us strictly confidential. The procedures for handling, processing, storing, and destroying data will be in accordance with the Data Protection Act (1998).

This means that only the researcher and her supervisors will be able to see what you said. Only a pseudonym will be used to identify the audio recording of your interview. These audio recordings will be transcribed, and identifying information such as place names and people's names will be removed. We will use quotes from the interviews and focus groups on the study's write-up, but we will ensure that these quotes cannot be used to identify anyone.

At the end of the study, the research data, including consent forms, anonymised interview transcripts, field notes and your contact details, will be kept in locked filling cabinets and/or password-protected university computers for up to 10 years.

How will you use this information?

The findings of the study will be documented in a report for Patience's Doctorate in Health. This may include annotated quotes from interviews. The study will be written up and submitted to peer-reviewed academic journals and conferences so that other health professionals can benefit from it.

Are there any situations when information I tell you will be shared?

Any personal information obtained from interviews would be disclosed only in exceptional circumstances, such as if you revealed information that may indicate a risk to yourself or others. This information will be shared with Occupational Health and Wellbeing services and participants will be informed of this.

What options do you have for how your information is used?

- You can withdraw from the study at any time without giving a reason, but we will keep any information we already have about you.

Who is funding this study?

The study is being funded by Birmingham City University and [redacted]

Where can I find out information if I need to make a complaint?

- You can contact Birmingham City University Data Protection Officer on informationmanagement@bcu.ac.uk or +44(0)121 331 5288 or Data Protection Officer, information management team, Birmingham City University, University house, 15 Bartholomew Row, Birmingham B5 5JU.
- HELS_Ethics@bcu.ac.uk
- Health Research Authority (HRA) www.hra,nhs.uk/information-about -patients/
- They can complain directly to the Information Commissioner at Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9.
- You can send an email to the research team; Patience on patience.domingo@mail.bcu.ac.uk; Dr Kate Thomson on kate.thomson@bcu.ac.uk; Dr Maria Clark on maria.clark@nottingham.ac.uk and Dr Kathrina Connabeer on kathrina.connabeer@bcu.ac.uk

Who is in the research team?

Patience Domingos	Lead researcher for the project. PhD candidate Birmingham City University	Patience.domingo@mail.bcu.ac.uk
Dr Kate Thomson	Director of studies-PhD (Health) Birmingham City University PhD supervisor	Kate.thomson@bcu.ac.uk
Dr Kathrina Connabeer	Birmingham City University PhD supervisor	Kathrina.connabeer@bcu.ac.uk
Dr Maria Clark	Nottingham University PhD supervisor	Maria.clark@nottingham.ac.uk

What do I do if I am interested in taking part?

Participation is completely voluntary, so we first encourage you to have some time and space to think about whether you would like to take part.

If you would like to take part, and you have read the Participant Information Sheet, please email a completed Expression of Interest Form to [TBC].

A constructivist grounded theory qualitative study to determine nurses' experiences of working during the Covid-19 pandemic and their perspectives on physical and mental wellbeing beyond, while working for an NHS organization

Participant Information Sheet

(Focus Groups)

What is the purpose of the study?

I am a PhD candidate at Birmingham City University, who is being sponsored by Sandwell and [redacted]. We would like to understand better the experiences of nurses working within [redacted] NHS Trust's during the COVID-19 pandemic and their perspectives on physical and mental wellbeing. I would really want to know about your experience of working during the pandemic. This includes all registered nurses from a diversity of disciplines as well as nursing associates from across the organization. I am hoping that this understanding will help future services to provide better physical and mental wellbeing support for nurses.

Who is involved in the research?

Patience Domingos (Lead Researcher - PhD candidate)

Dr Kate Thomson (Supervisor)

Dr Maria Clark (Supervisor)

Dr Kathrina Connabeer (Supervisor)

An Invitation to participate.

We would like to invite you to participate in our research study. Before deciding whether or not to participate, you should understand why the research is being conducted and what it will entail. Please read the following information carefully and contact us if you require any additional information or if you have any questions. Please feel free to share this with your friends, family, and anyone else you want.

Am I eligible to take part in the study?

You have been asked to participate because you work for [redacted] NHS Trust and worked there during the COVID-19 pandemic. Your knowledge and experience of working during the pandemic, as well as your perspectives on physical and mental health wellbeing, will be greatly appreciated in helping to shape this topic.

Do I have to take part?

It is completely up to you whether or not you agree to take part in the study. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part but then change your mind, you are free to do so at any time without giving a reason.

What will happen if I take part?

You will be asked to take part in focus group discussion with the researcher, Patience; about your experience of working during the COVID-19 pandemic and your views on mental health and wellbeing. The focus groups will last approximately 50-60mins and might be longer than or as long as you would like to talk about your experience. With your permission, the focus groups will be audio-recorded. You can stop your participation in the focus groups at any time, and you do not have to answer a particular question if you don't want to. We are offering options of face-to-face groups or online, however, we are prioritizing face to face groups.

What will happen if I agree to take part and later change my mind?

You have the right to withdraw from the focus group at any time, including during the focus group and up to seven days after the focus group discussions.

What are the benefits of taking part?

The Trust is supporting this research to make sure they are doing their best to support staff during and after the pandemic. This study will enable your voice to be heard and allow you to contribute to shaping up interventions and support for NHS staff during future pandemic. Although there are no immediate advantages to participating, you will have the option to share your experience and views of working during the COVID-19 pandemic. Making sense of your experiences may be facilitated by discussing them with a neutral party. Additionally, participating in a growing field of study that could affect nurses in the future could have psychological advantages and aid in the implementation of measures that would support nurses during, after, and in future pandemics.

What happens after focus groups?

You will have no further involvement in the study after the focus group discussions. If you require additional assistance, you will be given a leaflet listing some relevant support networks.

Are there any potential risks in taking part?

There are no known risks; however, there is a possibility that the interviews will be emotionally distressing for some people, either during or after the interviews. If the researcher suspects you are becoming distressed, she may ask you to pause for a moment to ensure you are not becoming overly anxious. The researcher may ask clarifying questions but not questions involving specifics about an event. You will be reminded that you should only talk about experiences that you are willing to talk

about in a manageable way. The researcher will follow BSA code of conduct and signpost participants to Occupational Health and Wellbeing for further support.

Will my information be kept confidential?

We will keep all of the information you provide us strictly confidential. The procedures for handling, processing, storing, and destroying data will be in accordance with the Data Protection Act (1998).

This means that only the researcher and her supervisors will be able to see what you said. Only a pseudonym will be used to identify the audio recording of your interview. These audio recordings will be transcribed, and identifying information such as place names and people's names will be removed. We will use quotes from the interviews and focus groups on the study's write-up, but we will ensure that these quotes cannot be used to identify anyone.

At the end of the study, the research data, including consent forms, anonymised interview transcripts, field notes and your contact details, will be kept in locked filling cabinets and/or password-protected university computers for up to 10 years.

How will you use this information?

The findings of the study will be documented in a report for Patience's Doctorate in Health. This may include annotated quotes from focus groups. The study will be written up and submitted to peer-reviewed academic journals and conferences so that other health professionals can benefit from it.

Are there any situations when information I tell you will be shared?

Any personal information obtained from interviews would be disclosed only in exceptional circumstances, such as if you revealed information that may indicate a risk to yourself or others. This information will be shared with Occupational Health and Wellbeing services and participants will be informed of this.

What options do you have for how your information is used?

- You can withdraw from the study at any time without giving a reason, but we will keep any information we already have about you.

Who is funding this study?

The study is being funded by Birmingham City University and [redacted] NHS Trust.

Where can I find out information if I need to make a complaint?

- You can contact Birmingham City University Data Protection Officer on informationmanagement@bcu.ac.uk or +44(0)121 331 5288 or Data Protection Officer, information management team, Birmingham City University, University house, 15 Bartholomew Row, Birmingham B5 5JU.

- HELS_Ethics@bcu.ac.uk
- Health Research Authority (HRA) www.hra,nhs.uk/information-about -patients/
- They can complain directly to the Information Commissioner at Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9.
- You can send an email to the research team; Patience on patience.domingo@mail.bcu.ac.uk; Dr Kate Thomson on kate.thomson@bcu.ac.uk; Dr Maria Clark on maria.clark@nottingham.ac.uk and Dr Kathrina Connabeer on kathrina.connabeer@bcu.ac.uk

Who is in the research team?

Patience Domingos	Lead Researcher for the project. PhD candidate Birmingham City University	Patience.domingo@mail.bcu.ac.uk
Dr Kate Thomson	Director of studies-PhD (Health) Birmingham City University PhD supervisor	Kate.thomson@bcu.ac.uk
Dr Kathrina Connabeer	Birmingham City University PhD supervisor	Kathrina.connabeer@bcu.ac.uk
Dr Maria Clark	Nottingham University PhD supervisor	Maria.clark@nottingham.ac.uk

What do I do if I am interested in taking part?

Participation is completely voluntary, so we first encourage you to have some time and space to think about whether you would like to take part.

If you would like to take part, and you have read the Participant Information Sheet, please email a completed Expression of Interest Form to [TBC].

Appendix B: Participant Consent Form

A constructivist grounded theory qualitative study to determine nurses' experiences of working during the Covid-19 pandemic and their perspectives on physical and mental wellbeing beyond, while working for an NHS organization

Summary of Project

I would like to understand better the experiences of nurses working within [redacted] NHS Trust's during the COVID-19 pandemic and their perspectives on physical and mental wellbeing. This includes all registered nurses as well as nursing associates from across the organization. I am hoping that this understanding will help future services to provide better physical and mental wellbeing support for nurses.

An Invitation to Participate

We would like to invite you to participate in our research study. Before deciding whether or not to participate, you should understand why the research is being conducted and what it will entail. Please read the following information carefully and contact us if you require any additional information or if you have any questions. Please feel free to share this with your friends, family, and anyone else you want.

Why have I been chosen to take part?

You have been asked to participate because you work for [redacted] NHS Trust and worked there during the COVID-19 pandemic. Your knowledge and experience working during the pandemic, as well as your views and perspectives on mental health and wellbeing support, will be greatly appreciated in helping to shape this topic.

Do I have to take part?

It is completely up to you whether or not you agree to take part in the study. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part but then change your mind, you are free to do so at any time without giving a reason.

CONFIDENTIAL WHEN COMPLETE

	Please initial each box to confirm consent ↓

1) I confirm that I have read and understood the Participant Information Sheet dated: D D / M M M / Y Y Y Y for the above study. I have had the opportunity to think about the information, ask questions, and have had these answered to my satisfaction.	
2) I understand that my interview/focus group discussion will be audio recorded.	
3) I understand that my participation is entirely voluntary, that I may withdraw at any time without explanation, and that my job role and legal rights will not be affected.	
4) I understand that my data, collected as part of this research, will be stored securely for up to 10 years and that during this time it may be looked at again by research personnel in relation to the Exploring of Nurses' experiences working during the COVID-19 pandemic: Their views on mental health support.	
5) I have been told how information relating to me (data obtained during the course of the study and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.	
6) I understand that my participation in this study may reveal findings that could indicate that I might require further advice and support. In that event, I will be invited to consult Occupational Health and Wellbeing Services at [redacted] NHS Trust, who can redirect me to appropriate support contacts, or my GP. I am also aware that I will be emailed a list of contact details for support following the interview or focus group.	
7) I understand that quotes/sentences from my interview/focus group discussion may be used in a report about the study, but all identifying information will be removed or changed. I give permission for these anonymous quotes to be published.	
8) I understand that if there is evidence of illegal activity or non-medical circumstances that would or have put others in danger, the Birmingham City University may refer the matter to the appropriate authorities.	
9) I understand that I have 7 days after the interview or focus group discussion to withdraw, as it may not be possible to isolate individual participants' data.	
10) I give agreement to take part in the above study.	

_____	_____	_____	**Chosen Pseudonym**
Participant name	Date	Signature	
_____	_____	_____	
Name of person taking consent	Date	Signature	
_____	_____	_____	
Researcher	Date	Signature	

Appendix C: Express of Interest Form (EoI)

EXPRESSION OF INTEREST FORM

Exploring nurses' experiences of working for an NHS Trust within Birmingham during the COVID-19 pandemic: Physical and Mental wellbeing.

This study is part of Patience's doctoral degree, and therefore there are time limits to complete the research study. More than the required number of participants may express an interest in participating. It is possible that not everyone who expresses an interest will be able to participate in the study. I would like to be certain that I recruit nurses from a variety of socioeconomic and cultural backgrounds. My goal is that this will contribute to the body of knowledge and help nurses receive better physical and mental wellbeing support during and after future pandemics.

PLEASE MAKE SURE YOU HAVE READ THE PARTICIPANT INFORMATION SHEET BEFORE COMPLETING THIS FORM. THANK YOU.

PLEASE COMPLETE SECTIONS BELOW

NAME AND SURNAME:	
GENDER:	
HOW WOULD YOU DESCRIBE YOUR ETHNIC BACKGROUND?	
JOB TITLE:	
LENGTH OF EXPERIENCE OF WORKING IN ROLE (include years & months):	
LENGTH AND EXPERIENCE OF BEING A NURSE OR OTHER HEALTHCARE WORKER (include years & months):	
NHS BAND **(e.g.,4/5/6/7/8)**	
Which department are you based at within the Trust?	
Which location? [redacted] ☐ [redacted] City ☐ [redacted] Rowley Regis ☐ Other ☐ (please specify):	
Are you employed full time or part-time? *Full Time* ☐ Yes Part time ☐ Yes	
Are you on substantial contract with the Trust? ☐ Yes ☐ No	
What is your email address and telephone number? Which is the best way to contact you? (please specify)	

APPENDIX D: Topic Guides- One-On-One Interview And Focus Group

Semi-Structured One-0n-One Interview Topic Guide

Introduction

Thank you for agreeing to do this one-on-one interview. I am interviewing you to learn more about what nurses and nursing associates from band 4 to band 8 from various departments and cultural backgrounds think about their experiences working during the Covid-19 pandemic and their perspectives on physical and mental wellbeing in the future, as well as how the Trust can improve and provide interventions for staff's physical and mental wellbeing.

I have a few interview questions for you about your experiences working during the Covid-19 pandemic, as well as your thoughts on physical and mental wellbeing beyond. There are no correct or incorrect answers to any of my questions, as I am interested in your individual experiences and thoughts.

Participation in this study is voluntary and your decision to participate or not participate will have no effect on your professional standing. The interview should last roughly 45 minutes to an hour, depending on how much information you want to provide. With your permission, I would like to audio record the interview so that I don't miss any of your comments; and all responses will remain confidential. This means that your de-identified interview responses will only be shared with research team members, and the information I include in my report will not identify you as the respondent; you may use a pseudonym. You may decline to answer any question or terminate the interview at any point and for any reason. Do you have any questions about what I have just explained?

May I turn on the audio recorder?

Please note that this guide only represents the main themes to be discussed with the participants and as such does not include the various prompts that may also be used (examples given for each question). Non-leading and general prompts will also be used, such as "Can you please tell me a bit more about that?

Establishing Rapport

Before we begin, it would be nice if you could tell me a little bit about yourself.

1. **What are nurses' and nursing associates' experiences of working for an NHS organization during the Covid-19 pandemic?**

How are you finding your work as a nurse?

Prompts: How has your role changed during and beyond the Covid-19 pandemic?

Prompts: What kind of support did you get from managers to enhance the occupational safety and wellbeing during the Covid-19 pandemic?

2. **How do NHS nurses and nursing associates describe their experiences of working during the Covid-19 pandemic?**

How would you describe your experiences of working during the Covid-19 pandemic?

Prompts: How did the pandemic affect you and your work?

Prompts: What is your experience with respect to physical and mental wellbeing beyond the Covid-19 pandemic?

3. **What identities do they construct based on their accounts of their experiences?**

How was the work pressure in your ward/department during the Covid-19 pandemic?

Prompts: How did you cope with the difficulties and stress during this period?

Prompts: Has the experience of the Covid-19 pandemic had an impact on your personal and professional skills? If so, how? If so, why?

4. **What impacted nurses' capacity for self-care and their related capacity to deliver patient care during the pandemic?**

How did you balance your time and workload during the Covid-19 pandemic?

Prompts: What coping strategies did you and your colleagues adopt during these difficult Covid-19 pandemic?

Prompts: How did your workload affect you during and beyond the Covid-19 pandemic?

5. **How can we learn from this knowledge to support nurses now and into the future?**

How have your unit/ward/floor operation changed beyond the Covid-19 pandemic?

Prompts: Could you tell me what you have learned from this experience?

Prompts: Can you tell about the main areas for improvement emerging beyond the Covid-19 pandemic?

6. **Insights into questions 1, 2,3,4,5 and how this knowledge could be implemented to support nurses?**

According to your experiences, what suggestions can you give in regard to enhance the well-being of nurses during the Covid-19 pandemic?

Prompts: How did organizational strategies help you build resilience at workplace during the Covid-19 pandemic?

Prompts: Is there anything else you would like to share about your time working and living during the Covid-19 pandemic and beyond?

Prompts: What comments or questions do you have for me? Is there anything you would like me to explain?

Prompts: What would you like to tell me that you have thought about during this interview?

Thank you for participating in this study.

Focus Group Interview Questions

Focus group questions.

How can we learn from this knowledge to support nurses and nursing associates now and into the future?

Topics	**Central Questions**
Topic 1 Experiences and challenges related to the pandemic; physical and mental wellbeing beyond	1. I have done some individual interviews, and some people spoke about increased stress and even having depression as a result of their experiences of working during the Covid-19 pandemic; what do you think about that, does that resonate with you? 2. How do you or your department currently evaluate your stress, fatigue, and/or burnout levels? 3. What lessons have we learnt from the Covid-19 pandemic? 4. What do you think about the impact of the pandemic since the first wave in 2020?
Topic 2 New environment for work; major contributors on physical and mental wellbeing (Covid-19 as well as non-Covid-19 related).	1. Let us define physical and mental wellbeing….given this definition, do you think you have experienced or are currently experiencing challenges on your physical or mental wellbeing? 2. What do you think are some of the most important contributors to physical and mental wellbeing? 3. What are your thoughts on working in another environment/context than usual? 4. Have you ever considered quitting your job because of Covid-19 related physical and mental health challenges? Can you please elaborate?
Topic 3 Strategies or practical interventions to deal with physical and mental wellbeing related resources at your workplace?	1. What do you think about current resources for wellbeing services offered by the Trust? 2. Do you think you have adequate access to physical and mental wellbeing related resources at your workplace? 3. What outside resources do you use to address physical and mental health issues? 4. What other interventions, policy changes or support would you like to see to help you manage your stress, physical and mental wellbeing? 5. What would you like to see as good wellbeing service? 6. What would you expect to be offered as a basic standard for wellbeing services for the staff?

APPENDIX E: Study Approvals Documentation

Dear Patience,

Study Title:	**Nurses' Experience of Working During the Covid-19 Pandemic**
REC Ref:	**23/HRA/2549**
IRAS ID:	**317563**
R&D Ref:	**23EDUC89**

Thank you for submitting your request to conduct this research in the Trust.

Please accept this email as confirmation of Capacity and Capability of the above-named study to commence at [redacted].

Once the sponsor issues greenlight the research may commence in accordance with the Protocol, fully executed contract/organization information document (attached) and subject to the following conditions:

Conditions of Approval

1. That you keep an up to date and accurate record of your research in a study file, and that you make this file and other records available for audit by the Research and Development Office when requested.
2. That you inform the R&D office of any changes to the study, related documentation, or study personnel.
3. That you notify the R&D office of any serious adverse events arising from this research in accordance with Trust Procedure for safety reporting in research.
4. That where the research continues for more than 1 year, you provide the R&D office with an annual report of your research progress, when approval will be reviewed.
5. Recruitment will be monitored with the expectation that the first participant will be recruited within 30 days of this email, and the study will be delivered to time and target.
6. Provide monthly recruitment figures to Research & Development at [redacted]

***Please send updates and documents to [redacted]**

Documents approved by Research & Development Department

Documents	**Version**	**Date**

Summary PIS	1.0	24 July 2023
BCU Insurance certificate	-	10 August 2023
BCU Ethics Approval Letter	-	13 February 2023
Focus Group PIS	1.1	03 August 2023
IRAS_Form_22062023	-	22 June 2023
Access letter support for PhD	-	06 January 2023
Express of Interest form	1.0	15 June 2023
Consent Form	1.0	15 June 2023
Participant Information Sheet one-on-one interviews	1.1	03 August 2023
Nurses' experiences of working during the Covid-19 pandemic	1.1	03 August 2023
HRA Approval Letter – Reissue	-	08 January 2024
IRAS Form	-	26 June 2023

Study Title:	**Nurse's experiences of working during the Covid-19 pandemic**
IRAS ID:	**317563**
R&D Ref:	**23EDUC89**
Non-Substantial Amendment:	**NSA03 15/10/2024**

Thank you for notifying R&D of the above study amendments.

Documents reviewed by Research & Development Department

Document	**Version**	**Date**
Amendment tool	NSA03	15/10/2024
Protocol	V1.4	03/09/2024
HRA Approval email	NSA03	13/11/2024

We are pleased to confirm continued capacity and capability to deliver this study at [redacted] The study record has been updated accordingly.

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

MISS PATIENCE DOMINGOS
Projects and Research Associate-PhD candidate

15 November 2023
Reissue 23 November 2023
Correction to document checklist

Dear MISS DOMINGOS

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	A constructivist grounded theory qualitative study to determine nurses' experiences of working during the Covid-19 pandemic and their perspectives on physical and mental wellbeing beyond, while working for an NHS organization
IRAS project ID:	317563
Protocol number:	10745
REC reference:	23/HRA/2549
Sponsor	BIRMINGHAM CITY UNIVERSITY

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

Faculty of Health, Education & Life Sciences Research Office
Seacole Building, 8 Westbourne Road
Birmingham
B15 3TN

HELS_Ethics@bcu.ac.uk

13/Feb/2023

Miss PATIENCE DOMINGOS

patience.domingo@mail.bcu.ac.uk

Dear PATIENCE ,

Re: DOMINGOS /#10745 /sub2 /R(C) /2023 /Feb /HELS FAEC - Exploring nurses' experiences of working for an NHS Trust within Birmingham during the COVID-19 pandemic: Mental health and wellbeing.

Thank you for your application and documentation regarding the above study. I am pleased to confirm that Birmingham City University has agreed to take on the role of Sponsor for BCU's part in the research.

The Faculty Academic Ethics Committee has approved this activity for review by the external ethics committee(s) stated in the application.

Birmingham City University can confirm that our insurance indemnity cover includes the actions of researchers working in suitable premises and under appropriate supervision. Our policy cover will not apply to liability that is more specifically insured under any policy covering medical negligence, malpractice or indemnity, professional errors, omissions or negligence.

A copy of BCU's insurance details is available at:
https://icity.bcu.ac.uk/Legal-Services-and-Compliance/Insurance/Index

If you wish to make any changes to your proposed study (by request or otherwise), then you must submit an Amendment application to us. Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead.

Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact HELS_Ethics@bcu.ac.uk

If you would like to provide feedback on the ethics process, please complete the feedback form using this link.

I wish you every success with your study.

Yours Sincerely,

Mrs. Clair Zawada

On behalf of the Health, Education and Life Sciences Faculty Academic Ethics Committee

APPENDIX F: Initial And Focused Codes For Categories 1,2,3 And 4

First Codes for Group 1 (n = 31)

Selective Code	Participants	Initial Code (In-Vivo)
Bottling Emotions	P02, P04, FG1	*"I held it in all shifts."*
Masking Distress	P06, P08	*"Had to put a brave face on."*
Pushing Down Anxiety	P07	*"Couldn't let myself think about it."*
Deferred Grief	P04	*"I just parked it until I got home."*
Surface Acting	FG2	*"Smiled for the patients, cried later."*
Emotional Numbness	P07	*"Felt nothing by the end."*
Suppressed Anger	P03	*"Couldn't say anything just swallowed it."*
Delayed Processing	P06	*"Only hit me a week later."*
Somatic Ignoring	P09	*"Even when dizzy, told myself to finish the round."*
Skipping Meals	P08	*"No time to eat patients came first."*
Missed Breaks	FG2	*"Breaks were a luxury."*
Working Through Pain	P05	*"Leg was killing me, but I couldn't stop."*
Post-COVID Breathlessness	P03	*"Still breathless but had to work."*
Fatigue Signals	P09	*"Just pushed past tiredness."*
Physical Collapse Post-Shift	P04	*"Collapsed on the sofa, uniform still on."*
Emotional Collapse Post-Shift	P02	*"Sobbed uncontrollably after shift."*
Self-Medicating	P07	*"Took painkillers just to keep going."*
Normalising Discomfort	FG1	*"We all just got on with it."*
Peer Endurance Pressure	P06	*"Didn't want to be the one to sit out."*
Professional Identity Pressure	P03	*"Felt I had to keep strong for others."*

Compartmentalising	P04	*"Put it in a box until later."*
Emotional Dissociation	P07	*"It was like I wasn't there."*
Hyper-Focus on Tasks	P06	*"Just kept doing the obs to distract myself."*
Delay in Help-Seeking	P05	*"Didn't tell anyone until it was bad."*
Suppression as Coping	FG2	*"It was the only way to survive the shift."*
Normalising Overwork	P03	*"Everyone was exhausted it was normal."*
Suppression Pride	P08	*"Felt proud I didn't cry at work."*
Self-Silencing	P05	*"Didn't want to make a fuss."*
Accumulation Effect	P04	*"It all came out later, like a dam bursting."*
Repeated Suppression Cycle	FG1	*"Day after day, same thing."*
Embodied Suppression	P09	*"Felt it in my chest, tightness."*

Progression from Initial 31 Codes to 19 Focused Codes

Initial Codes (Examples)	**Refined Focused Codes (n = 19)**
Bottling emotions, pushing down anxiety, holding it in	Emotional Suppression
Masking distress, "wearing a mask"	Surface Acting / Professional Front
Deferred grief, postponing feelings, emotional release at home	Temporal Deferral
Emotional numbness, shutting down, going on autopilot	Emotional Numbing / Protective Detachment
Skipping meals, missed hydration, bathroom suppression	Somatic Signal Silencing
Working through pain, post-COVID breathlessness	Physical Endurance / Presenteeism
Collapsing post-shift, sitting in silence, staring into space	Post-Shift Emotional & Physical Collapse
Staying late to finish, no time to pause	Task Completion Priority / Role Overload

Anticipatory anxiety, survival mode	Chronic Stress and Hyperarousal
Reassuring juniors, concealing fear	Role-Modelling / Professional Identity Work
Avoiding sickness absence	Presenteeism
Normalising overload, reframing fatigue as routine	Overwork as Norm / Cultural Acceptance
Apologising for needing help	Guilt for Prioritising Self
Fear of being judged as weak	Fear of Stigma / Image Management
Silence culture, no safe space to talk	Organizational Silence
Lack of breaks, no recovery time	Workplace Constraints / Resource Scarcity
Moral pressure to endure	Professional Duty and Obligation
Emotional collapse after shift	Emotional Decompression
Use of self-talk to push through	Cognitive Coping / Self-Directive Endurance

Initial Codes (n = 30) – Physical and Psychological Trauma and Aftershocks

Selective Code	Participants	Initial Code
Reliving Events	P03, P06, P08, FG2	Flashbacks when hearing alarms
Reliving Events	P03, P06, FG1	Dreams and nightmares of COVID wards
Triggered Reminders	P04, P06, P09	Distress triggered by PPE smell, news
Panic & Hyperarousal	P05, P10, FG2	Heart racing, breathlessness when reminded
Anxiety Aftershocks	P01, P03, FG1	Sudden anxiety spikes months later
Sleep Disturbances	P02, P04, FG2	Insomnia, early waking, night sweats
Emotional Flooding	P03, P07, FG2	Crying suddenly when reminded
Avoidance Behaviour	P06, P09, FG1	Avoiding wards, avoiding conversations

Long COVID Symptoms	P03, P08	Chronic fatigue, breathlessness
Physical Pain	P04, P05	Back pain, joint pain post-shift
Gastrointestinal Issues	P07	Stress-related stomach pain
Headaches & Migraines	P06, P10	Persistent headaches post-pandemic
Sickness Absence	P05, FG1	Time off due to health deterioration
Reduced Functionality	P08, P12	Needing reduced hours or redeployment

Focused Codes for Category 2 (n = 17)

Focused Code	Participants	Representative Initial Codes
Triggered Flashbacks	8	Flashbacks, dreams, intrusive memories
Panic & Hyperarousal	7	Heart racing, breathlessness, sweating
Emotional Flooding	6	Sudden crying, waves of grief
Sleep Disturbance	5	Nightmares, insomnia, night sweats
Avoidance	4	Avoiding wards, avoiding triggers
Long COVID Symptoms	5	Fatigue, breathlessness, “never recovered”
Chronic Pain	4	Back pain, musculoskeletal strain
Migraines & Headaches	3	Persistent headaches post-pandemic
Stress-Related GI Issues	2	Stomach pain, nausea
Collapse Post-Shift	3	“Too tired to speak,” lying down in uniform
Redeployment Limitations	3	Unable to return to pre-COVID roles
Anxiety Spikes	4	Hypervigilance, startle response
Survivor’s Guilt	3	Guilt about colleagues/patients who died
Emotional Numbness Breaking	2	Sudden release after long period
Increased Absence	3	Time off for recovery
Reduced Work Capacity	2	Needing part-time work
Occupational Health Referrals	2	Seeking support after physical decline

Initial Codes for Category 3: Organizational Dissonance & Fragmentation (n=29)

Selective Code	Participants	Initial Code
Policy–Practice Gap	P01, P06, FG1	"Guidance kept changing, we were told one thing then another."
Conflicting Messages	P03, P04, FG2	Mixed communication from managers and Trust.
Leadership Disconnect	P02, P10	Senior management "invisible" during crisis.
Lack of Consultation	P07, FG1	Staff not asked about redeployment decisions.
Staffing Gaps	P03, P08	Unsafe ratios, "constantly firefighting."
Resource Failures	P04, P05	Lack of PPE early on, equipment shortages.
Emotional Impact	P06, FG2	Feeling abandoned, undervalued.
Wellbeing Offer Limitations	P08, FG1	Support only 9–5, "not for night staff."
Self-Referral Fatigue	P05	Burden to seek help placed on staff.
Lack of Follow-up	P07	No check-in after sickness absence.
Peer Fragmentation	FG2	Team split by redeployment.
Policy Rigidity	P01	No flexibility for special circumstances.
Managerial Inconsistency	P03, FG1	Different managers giving conflicting instructions.
Escalation Barriers	P02, P06	"Didn't know who to go to when things went wrong."
No Safe Space for Feedback	P04, FG2	Fear of speaking up, risk of being labelled a troublemaker.
Perceived Organizational Neglect	P08, P10	"Felt like we were left to get on with it."
Inadequate Debrief	FG1, FG2	No psychological debrief or reflection time after shifts.
Overreliance on Goodwill	P05, P07	Expectation to work extra hours without support.
Shift Pattern Instability	P06, P09	Frequent rota changes, loss of predictability.
Redeployment Anxiety	FG2	Fear and stress around sudden redeployment.
Loss of Team Cohesion	P03, P08	Disbanded teams led to feelings of isolation.
Unsupported Return-to-Work	P05, P07	"Thrown back in with no adjustments."
Occupational Health Delays	P08	Long waits for OH appointments or referrals.
Inflexible Sickness Policies	P04, FG1	Feeling penalised for taking sick leave.
Emotional Exhaustion from System	P06, FG2	"It wasn't just the patients – it was the system breaking us."
Moral Distress Over Resource Allocation	P10, FG2	Stress from deciding who got equipment, prioritising care.
No Cover for Breaks	P03, P09	Skipping meals, no time to rest.
Wellbeing Seen as Tokenistic	FG2	"Free fruit doesn't fix burnout."
Cultural Expectation to Cope	P01, P07	"We were told just to get on with it."

Focused Codes for category 3(n = 15)

Focused Code	Supporting Initial Codes	Participants
Policy–Practice Dissonance	Changing guidance, last-minute policy shifts	P01, P03
Leadership Invisibility	Lack of senior presence, poor visibility	P02, P10

Conflicting Messaging	Mixed instructions from Trust/managers	FG2
Resource Shortages	PPE lack, staff shortages	P03, P04
Safety Concerns	Unsafe ratios, patient risk	P03, FG1
Communication Breakdown	Information not filtering down	P01, FG1
Emotional Fallout	Feeling abandoned/undervalued	P06
Wellbeing Gaps	Limited hours, mismatch with shifts	P08
Self-Referral Burden	Staff expected to initiate help	P05
Lack of Follow-Up	No post-absence support	P07
Fragmented Team Identity	Redeployment dividing colleagues	FG2
Procedural Rigidity	Lack of flexibility in redeployment	P01
Morale Decline	Demotivation, disengagement	P04
Loss of Trust	Disbelief in leadership promises	P02
Systemic Fatigue	Normalisation of broken systems	FG1

Initial Codes for Category 4 Moral Suffering and Ethical Erosion (n = 26)

Selective Code	Participants	Initial Code
Moral Distress	P02, P08, FG1	"Couldn't give the care I knew patients deserved."
Guilt & Shame	P05, P07, FG2	Feeling responsible for negative outcomes.
Witnessing Suffering	P03, FG1	"We watched people die alone."
Prioritisation Dilemmas	P04, FG2	Having to choose which patient to attend first.
Compromised Care Standards	P01, P06	"Rushed through care — no time for basics."
Fear of Causing Harm	P06, FG1	"Terrified I'd miss something and harm a patient."
Policy Conflict	P03	Having to enforce visiting bans despite distress.

Loss of Professional Pride	P05, P09	"Felt like a task robot, not a nurse."
Emotional Breakdown	P02, FG2	Crying during or after shifts from moral pressure.
Withdrawal/Numbing	P07	"Just shut down to get through it."
Survivor's Guilt	P10	Feeling guilty for being safe when colleagues died.
Physical Symptoms	P08, FG2	Headaches, IBS flare-ups, palpitations during moral stress.
Fatigue & Insomnia	P04, FG2	Couldn't sleep after complex decisions.
Somatic Stress Reactions	P06	Shaking, sweating after ethically distressing events.
Spiritual Strain	P09	Questioning faith, asking "why did this happen?"
Loss of Empathy	P07	Feeling emotionally detached as a survival tactic.
Resentment Toward System	P05, FG2	Anger at management for putting them in impossible situations.
Questioning Career	P03, FG1	Considering leaving nursing after repeated moral injury.
Emotional Exhaustion	P06, P10	"Completely drained by end of shift."
Hyper-vigilance	P08	Over-checking patients out of fear of missing harm.
Disengagement	P04	"Stopped caring — just did the minimum."
Suppressed Voice	FG1	Afraid to raise concerns, feared retaliation.
Peer Conflict	P09, FG2	Tension between colleagues over ethical decisions.
Self-Blame	P05	Felt personally responsible for systemic failings.
Moral Coping Strategies	P06	Prayer, peer debrief, compartmentalisation.
Long-Term Psychological Impact	P07, P10	Persistent intrusive thoughts, avoidance of similar wards.

Focused Codes for Category 4 (n = 14)

Focused Code	Supporting Initial Codes	Participants
Moral Distress	Moral distress, fear of harm, self-blame	P02, P06, FG1
Guilt & Shame	Guilt, survivor's guilt, spiritual strain	P05, P10
Compromised Care Standards	Rushed care, lack of time for basics	P01, P06
Ethical Dilemmas	Prioritisation, policy conflict	P03, FG2
Emotional Breakdown	Crying, emotional collapse	P02, FG2
Withdrawal & Emotional Numbing	Disengagement, loss of empathy	P07, P04
Anger & Resentment	Resentment toward system, peer conflict	P05, FG2
Professional Identity Threat	Loss of pride, questioning career	P05, P09
Psychological After-Effects	Intrusive thoughts, hyper-vigilance	P07, P08
Fatigue & Insomnia	Physical exhaustion, sleep disruption	P04, FG2
Somatic Stress Responses	Palpitations, IBS, sweating	P06
Suppressed Moral Voice	Silence culture, fear of raising issues	FG1
Moral Coping Strategies	Prayer, peer debriefing, reframing	P06
Long-Term Impact on Retention	Considering leaving, disengagement	P03

Appendix G: Core Category Development Map

Core Category: Institutional Betrayal and Organizational Abandonment

This appendix documents the analytic pathway through which the core category was developed from initial codes, through focused codes and categories, to theoretical integration.

Table 5.7: Analytic Pathway to the Core Category

Analytic Stage	Analytic Input	Key Analytic Questions (Memo-Led)	Analytic Output	Link to Core Category
Initial Coding (Feb–Jun 2024)	In-vivo accounts of suppression, fear, exhaustion, silence, and organizational confusion	What are participants doing to keep working? What is being held in, deferred, or absorbed? Where is responsibility located?	130 Initial Codes across four domains of experience	Early signals of being relied upon without reciprocal protection
Focused Coding (Jun–Sep 2024)	Consolidation of recurring processes (suppression, aftershocks, dissonance, moral strain)	What processes recur across participants and settings? What sustains continued functioning? What produces rupture?	60 Focused Codes organised within four analytic categories	Endurance emerges as a patterned organizational condition
Category Construction (Sep–Dec 2024)	Integration of focused codes into four categories	How do categories relate? Which category explains the others?	Four Categories: Suppression; Trauma; Organizational Dissonance; Moral Suffering	Organizational conditions link directly to moral and physical consequences
Comparative Grouping	Surface and Fractured Endurers	How do endurance trajectories differ?	Two analytic groupings used as	System reliance becomes visible through fracture

(Jun–Sep 2024)		What reveals system limits?	comparative lenses	
Core Category Testing (Jan–May 2025)	Cross-category mapping and memo comparison	What single process integrates all categories? What is the system doing through these processes?	Core process of reliance without reciprocity	Institutional Betrayal and Organizational Abandonment stabilised as integrative concept
Theoretical Integration (Oct 2025–Jan 2026)	Theory naming and abstraction	How does this process extend beyond this setting? What level of abstraction is warranted?	Grounded Theory: Enduring the System and Bearing the Weight	Core category anchors the theory ethically and organizationally

Figure 5.5: Development of the Core Category

This figure traces the analytic progression from initial and focused coding through category construction and comparative grouping (Surface Endurers and Fractured Endurers) to the development of the core category, *Institutional Betrayal and Organizational Abandonment*, and its integration into the grounded theory *Enduring the System and Bearing the Weight*, consistent with Charmaz's constructivist grounded theory process of constant comparison and theoretical integration.

Figure 5.5: Analytic Development of the Core Category