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Inclusion Instead of Management: The Association Between the Applicability of Character Strengths, Socio-Moral Climate, Work Engagement, Well-Being and Patient Safety

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Innsbruck, den 15.01.2022

Letter of Gratitude

Auch wenn die gesamte Arbeit in Englisch verfasst ist, ist Dankbarkeit eine Angelegenheit des Herzens und soll daher auch in der Sprache meines Herzens verfasst werden. Zuerst möchte ich mich bei Bernhard bedanken, der mir die Angst am Schreiben genommen hat und mir so geholfen hat, anfangen zu können, jeden Tag wieder. Außerdem möchte ich mich bei der wundervollen Betreuung von Cornelia bedanken, die mir immer mit Rat und Tat zur Seite stand, egal, was bei ihr auch gerade anstand. Ein besonderer Dank gilt Carla, die meine Arbeit durchgelesen hat und mich mit neuen Ideen, konstruktiven Kritiken und dem richtigen Maß an aufbauendem Lob bereichert hat. Ich möchte auch all meinen Freundinnen und Freunden, insbesondere Dada, Chiara, Sandra und Laurenz, danken, die mir immer das Vertrauen geschenkt haben, was mir manchmal gefehlt hat. Vielleicht ungewöhnlicherweise möchte ich zuletzt auch dem Prozess des Schreibens und mir selbst danken. Diese Arbeit hat mir geholfen, mehr Vertrauen in mich zu fassen und es auch zu akzeptieren, falls etwas mal nicht ganz rund läuft sowie herauszufinden, was mir dann guttut. In einer Weise habe ich durch diese Arbeit somit auch Ressourcen für mich gefunden, um besser mit anspruchsvollen Aufgaben umgehen zu können.

Abstract

The working conditions of a nurse are highly demanding threatening the health status of nurses as well as the quality of care provided. Within this study it is aimed to gain greater insights in the nursing context and the impact of resources at work such as a socio-moral climate and the applicability of character strengths on well-being, work engagement and the safety of patients.

Therefore, a mixed-methods study design was implemented including an online questionnaire filled out by *n* = 66 nurses regarding the socio-moral climate at work, applicability of character strengths, well-being, work engagement and patient safety. Additionally, two interviews with nurses were carried out to get a deeper understanding of the respective constructs as well as the working conditions.

Analyses show that a socio-moral climate was positively related to well-being and work engagement, but, against the expectation, not to applicability of character strengths. Applicability of character strengths was positively associated with well-being and work engagement. No mediation was found between socio-moral climate, the applicability of character strengths and well-being or work engagement, respectively. Patient safety was positively connected to socio-moral climate and well-being. Exploratory findings from the interviews further underlined the role of a proactive personality for applying one's character strengths and the importance of the character strengths self-regulation within the nursing context for being able to empathize with and care for a patient without getting emotionally involved.

The results indicate the importance of an integrative and holistic approach including strengthening resources and still striving for better working conditions within the medical context.

Key Words:

Socio-Moral Climate, Character Strengths, Well-Being, Work Engagement, Patient Safety

Table of Contents

Background

"Nobody wants to be managed but included."

~ Sadhguru

We all want to be valued. We all want to be valued for what we are good at and especially for who we are. As Sadhguru said, we do not want to be managed. We do not want someone to keep correcting our weaknesses. On the contrary, we would like to be included and appreciated as the person we are, with all our qualities and strengths. However, this approach is often neglected, especially within the working context. Often companies try to manage the weaknesses of an individual and lose sight of the appreciation of his or her strengths (Buckingham & Clifton, 2001), even though it is the inclusion of the strengths of an individual that promotes personal growth (Linley et al., 2009; Roberts et al., 2005).

Especially the medical context is a demanding professional field. Due to a constant shortage of staff and the immense patient loads, there is a constant lack of time, which ends in long and irregular working hours with many involuntary overtime (Letvak, 2001). Often, working shifts are stretched over several days without having a day off (Geiger-Brown et al., 2004). However, it is still important to provide proper quality of care even when being tired, exhausted or stressed, because of working with human beings and their health (Letvak, 2001). Involuntary work overtime and shift work, in particular, lead to reduced well-being and poorer mental health, sleep problems or substance use to deal with the stressful work rhythm (Brown et al., 2020; Watanabe & Yamauchi, 2018). This endangers not only the well-being of medical staff but also the safety of patients (Brown et al., 2020). Often, medical staff consider changing jobs as the only solution, which in the end would worsen the workload of the remaining employees, indicating a downwards spiraling situation (Geiger-Brown et al., 2004). For several decades, a large number of studies have dealt with this problem (e.g. Engkvist et al., 2001; Schalk et al., 2010; Mihdawi et al., 2020), which suggests that these problems persist and that working conditions in this field are very difficult to change. Therefore, recently, a lot of research has evolved around increasing personal resources of an individual or a working team especially within the background of positive psychology (Harzer & Ruch, 2013; Seligman & Csikszentmihalyi, 2000). This seems to be a promising, more holistic approach as it is not excluding issues but is rather shifting the focus from fixing

problematic working conditions that appear difficult to change to improving individual abilities, resources and resilience to deal with increasing job demands (Macfarlane & Carson, 2019).

Positive psychology is a science focusing on what makes life worth living, what makes us happy, and what makes us thrive and flourish. It arose around the 1990s as a response to the pathology-oriented psychology, which mainly concentrated on curing and repairing diseases. What was totally neglected, however, is that not only the absence of illness makes us happy, "but [also] nurturing what is best" (Seligman & Csikszentmihalyi, 2000, p. 7). Positive psychology tries to create a vision of a fulfilled life by paying attention to three levels: the *subjective level*, referring to subjective experiences such as well-being, hope or flow, the *individual level*, concentrating on positive individual traits such as courage, perseverance or forgiveness, and the *group level* that focuses on institutions that nurture individual development and better citizenship. Therefore, positive psychology focuses, inter alia, on an essential point: disease prevention (Seligman & Csikszentmihalyi, 2000).

Combining these three levels of positive psychology, there has been research focusing on the relationship between character strengths (*individual level*), work engagement and well-being (both *subjective level*) and a positive work atmosphere such as the socio-moral climate (*group level*) within a sample consisting of physicians or medical students. The results indicate positive associations between these constructs and evaluated applicability of character strengths as a mediator between the relationship of socio-moral climate and work engagement as well as well-being (e.g. Höge et al., 2020; Hausler et al., 2017a; Huber et al., 2020). However, considering the broad range of research examined for this study, these relationships have not yet been studied among nurses.

With 59% of the health sector, nurses make up the largest occupational group in this field and is also the one working closest to the patient. Since nurses play such an important role in our health care system, it is even more alarming that the shortage of nurses is a global problem affecting most countries (World Health Organization, 2020). Hospitals are affected by high employee turnover and high levels of employee absenteeism, which make frequent overtime inevitable (NSI Nursing Solutions, 2020). This results in difficult working conditions for this occupational group. Among other things, high emotional demands such as dealing with difficult patients or the

compulsion to be kind (Freimann & Merisalu, 2015), as well as a high workload (Dwinijanti et al., 2020) lead to high perceived stress (Masa'Deh et al., 2016) and high burnout and depression rates among nurses (Lee & Kim, 2006; Melnyk et al., 2018; Shanafelt et al., 2015). In addition to the shortage of staff, the perception of a low and unfair wage leads the staff to not being very motivated resulting in less willingness to support each other proceeding to higher perceived stress and feeling left alone (Geiger-Brown et al., 2004). And this, in turn, favors the shortage of nurses, as this increases the tendency to quit the job (Pienaar & Bester, 2011). However, this vicious cycle is not only affecting the health of nurses, but also the safety of patients as due to insomnia and depression their cognitive performance suffers (Kaliyaperumal et al., 2017; Melnyk et al., 2018; review: Wagstaff & Lie, 2011). Additionally, nurses are missing an important resource in the working context (for a closer look on important resources at the work place refer to Strecker et al., 2019), since their autonomy depends to a great deal on the collaboration with physicians, as decisions in treatment usually have to be discussed with the responsible physician first, making independent working less possible (Papathanassoglou et al., 2012).

In summary, nurses work within highly detrimental conditions. With making up the largest professional group in the medical context and working closest to the patient it is very important to focus on nurses, in addition to physicians, in terms of enhancing their personal resources to resist problematic working conditions. For these reasons, this paper strives to replicate the effects of character strengths and especially their applicability, the socio-moral climate, work engagement and well-being that have already been studied among physicians and medical students (see Höge et al., 2020) among nurses and further addresses the safety of patients in a hospital. In consequence, the focus lies on all three levels of positive psychology, namely the *subjective*, the *individual* and the *group level*, and also includes the impact on the individuals, nurses work with: the patients. In order to be able to put these results in a broader context with a deeper understanding, a mixed methods design was chosen using a combination of a survey and interviews. With getting more in-depth insights in the working conditions of nurses in combination with the impact of applicability of character strengths and a socio-moral climate, the study aims to help nurses strengthen their well-being and work-engagement as well as the safety of their patients.

Character Strengths

Character strengths are naturally present within an individual and are seen similar to personality traits as defined by Allport in 1961. Character strengths are characterized as fulfilling by contributing to a good life as they are morally valuable and lead to positive, desirable consequences for oneself and others (Peterson & Seligman, 2004). They are relatively stable but can still be actively developed over time (Biswas-Diener et al., 2011; Peterson & Seligman, 2004). Peterson and Seligman (2004) named 24 character strengths in their Values in Action (VIA) classification, which, in turn, are assigned to six virtues (for a detailed description, please refer to table 1). In addition, they assumed that everyone has three to seven so-called *signature character strengths* which are typical for that specific person.

As important as the possession of a character strength is its application (Huber et al., 2020). The use of character strengths, especially of signature character strengths, is associated with a flow-like state with being energized, losing track of time, being absorbed in an activity and a feeling of authenticity (Peterson & Seligman, 2004). Their application mostly feels effortless and just as the "right thing to do" (Miglianico et al., 2020, p. 3). Some studies even suggest a neural basis for character strengths (Johnstone et al., 2021), which possibly makes it so easy for us to use them.

Studies show numerous associations between the application of character strengths and positive work-related outcomes. On the side of the individual, the application of character strengths is associated with well-being and harmonious passion (Dubreuil et al., 2014), calling and life satisfaction (Harzer & Ruch, 2016), work engagement as well as job satisfaction and performance (Lavy & Littman-Ovadia, 2017). Being able to apply one's character strengths at work is further associated with a more efficient way of handling the workload as well as being less absent (van Woerkom et al., 2016). On the organizational side, higher applicability of character strengths is associated with higher productivity, sales and profit (Hodges & Asplund, 2010) accompanied by more commitment shown by the employees (Harzer & Ruch, 2013). These work-related outcomes of using character strengths are mainly mediated by work engagement (Lavy & Littman-Ovadia, 2017).

Wisdom & Knowledge Cognitive strengths that entail the acquisition and use of knowledge.	*Creativity*	Thinking of novel & productive ways to do things
	Curiosity	Interest, exploring, discovering, finding things fascinating
	Open-Mindedness	Thinking things through, not jumping into conclusions, change one's mind in light of evidence, considering fairly
	Love of Learning	Tendency to add systematically to what one knows, mastering new skills
	Perspective	Being able to provide wise counsel to others, having ways of looking at the world that makes sense to oneself and to other people
Courage Emotional strengths that involve the exercise of will to accomplish goals in the face of opposition, external or internal.	*Bravery*	Speaking up for what is right even when opposition, face challenge & threat
	Perseverance	Finishing what one starts even when obstacles occur
	Honesty	Presenting oneself in a genuine and authentic way
	Zest	Approaching life with excitement and energy
Humanity Interpersonal Strengths that involve tending and befriending others.	*Love*	Valuing close relations with others especially when caring is reciprocated
	Kindness	Doing favors for others, taking care, helping
	Social Intelligence	Being aware of motives and feelings of other people and oneself
Justice Civic strengths that underlie healthy community life	*Teamwork*	Working well as a member of a group, being loyal

	Fairness	Treating all people the same according to notions of fairness and justice, not letting personal feelings bias decisions about others, giving everyone a fair chance
	Leadership	Encouraging a group of which one is a member to get things done, organizing activities
Temperance Strengths that protect against excess.	*Forgiveness*	Forgiving those who have done wrong, giving second chances
	Modesty	Letting one's accomplishments speak for themselves, not regarding oneself as more special
	Prudence	Being careful about one's choices, not taking undue risks, not do things regretted later
	Self-Regulation	Regulating what one feels and does, being disciplined, controlling one's appetites and emotions
Transcendence Strengths that forge connections to the larger universe and provide meaning.	*Appreciation of Beauty and Excellence*	Noticing and appreciating beauty and skilled performance
	Gratitude	Being aware of and thankful for good things that happen
	Hope	Expecting the best in the future and working to achieve it
	Humor	Liking to laugh and tease, bringing smiles to other people
	Spirituality	Having coherent beliefs about the higher purpose and meaning of the universe and life, knowing where one fits within the larger scheme

Table 1. *Description of the six virtues and the 24 character strengths used in the VIA classification adapted from Peterson and Seligman (2004, p. 29-39).*

Especially in the clinical context, in which many working conditions are difficult to change (e.g. shift work or working with seriously ill or demanding patients), it makes sense to additionally rely on personal resources such as character strengths.

Even though the individual perception and appraisal of these stressors can play a role (Kerr et al., 2020), studies have often shown that specific work stress can have a negative impact on the health of individuals (e.g. Darr & Johns, 2008). However, in their Job Demands Resources Model, Bakker and Demerouti (2007) went one step further and assumed that certain resources can buffer the effects of stress on health. They proposed that resources mainly promote recovery processes, which can subsequently lead to a reduction in job strain. At the same time, they go hand in hand with work motivation and commitment. Such resources include, among other things, physical (e.g. working conditions such as work time or equipment), psychological (e.g. frustration tolerance or self-esteem) and social (e.g. positive working climate) aspects of a certain job or workplace that either reduce stress, make it easier to complete the task or stimulate personal development (Bakker & Demerouti, 2007). Certainly, resources never completely outweigh difficult working conditions. Nevertheless, such resources can buffer the negative effects of a detrimental working situation. Therefore, character strengths can be seen as a personal resource in the working context enabling an individual to cope more effectively with job demands (Bakker & Demerouti, 2007; van Woerkom et al., 2016). However, character strengths are not only in themselves a resource in a professional context, but their application is associated with higher values in other valuable resources such as psychological capital (Meyers et al., 2015), a psychological state with positive effects on the development of an individual, consisting of self-efficacy, optimism, hope and resilience (Luthans et al., 2007) as well as on work-related outcomes, namely work engagement, performance and well-being (Alessandri et al., 2018; Darvishmotevali & Ali, 2020).

In consequence, it is even more important to create a positive climate at work that promotes the development and display of character strengths helping employees to cope better with a demanding working situation.

Socio-Moral Climate

The organizational climate is defined as the shared perception of working conditions in a company by the people working there (Rosenstiel & Nerdinger, 2011). The positive consequences of a good organizational climate are numerous, such as better health, more active leisure time behavior, more motivation, commitment to the respective organization as well as well-being and job satisfaction (Rosenstiel, 1992). However, especially the social aspect of a positive working atmosphere seems to be an important resource in everyday working life. Carr et al. (2003) have shown in their meta-analysis studying the effects of working climate that the affective facet characterized by social relationships, compared to the cognitive (e.g. personal growth or autonomy) and instrumental (e.g. company structure or extrinsic reward system) facet of a working climate, had the strongest connection to well-being, work-related performance and withdrawal behavior, mediated by job satisfaction and commitment. Nahrgang et al. (2011) revealed a supportive environment to be the most stable job resource in terms of burnout, engagement and patient safety and, therefore, also being highly important in the working context of nurses.

The socio-moral climate represents a special form of the organizational climate. It is characterized by its appreciative and open communication and can therefore be seen as a social context factor at work (Höge et al., 2020; Verdorfer et al., 2013a; Weber et al., 2008).

In the working context, the socio-moral climate was described by Weber et al. (2008) derived from the "just community approach" by Kohlberg (1984) aiming to promote moral competencies in children and adolescents, especially in the school context. Therefore, the socio-moral climate is not just following a social approach but also focuses on the development of moral competencies at work (Weber et al., 2008). The socio-moral climate contains five components (Verdorfer et al., 2013a, p. 428; Weber et al., 2008):

1. Open confrontation of the employees with conflict and constructive conflict resolution
2. Reliable and constant appreciation, care, and support by supervisors and colleagues
3. Open communication and participative cooperation
4. Trust-based assignment and allocation of responsibility corresponding to the respective employees' capabilities
5. Organizational concern for the individual

The socio-moral climate can be described by a supportive and caring atmosphere in which everyone can speak up without being judged, regardless of their position in the company (Höge et al., 2020).

Participatory structures (Weber et al., 2009) and a servant leadership style (Verdorfer et al., 2015), which puts the employees and their personal development and needs in the foreground and the leader in the role of serving and supporting the employees and their needs (Greenleaf, 2002), are particularly favorable for a socio-moral climate at work. Furthermore, the applicability of character strengths represents an opportunity to promote a socio-moral climate, which Höge et al. (2020) found in their longitudinal study with physicians. The socio-moral climate is associated with a number of positive consequences such as prosociality at work (Weber et al., 2009), organizational commitment (Verdorfer et al., 2013), less organizational cynicism and deviance (Verdorfer et al., 2015), greater willingness to pass on knowledge (Verdorfer et al., 2013a), meaning in work (Schnell et al., 2013), and work engagement (Verdorfer et al., 2013a).

The socio-moral climate allows space for two very important resources in everyday work: social support and autonomy (Strecker et al., 2019; Zapf & Semmer, 2004, p. 1042). The integrative model of work and health by Glaser et al. (2015) showed that work-related resources such as social support or autonomy play an important buffering role between psychological stress and health impairments such as lack of relaxation, burnout and illness and are further enhancing individual factors of personality development such as motivation, well-being and performance. Precisely through its participatory and caring structures, the socio-moral climate is characterized by high social support (Verdorfer et al., 2013a; Weber et al., 2008, 2009). Due to open communication as well as the consideration of all employees and their needs regardless of their position, the socio-moral climate leads to autonomy which in return creates a certain amount of freedom to use one's personal strengths in fulfilling work tasks without being judged but being appreciated (Strecker et al., 2019). This climate sees individual differences not as something that should be condemned, but as something that should be respected, accepted, but above all valued. Individual differences are seen as a chance; each individual has his or her strengths, and these should be encouraged. Höge et al. (2020), thus, classify the socio-moral climate as a *weak situation*. The strength of a situation is defined as the implicit or explicit pressure exerted by a situation to

behave in a certain way. A *strong situation* is, in consequence, very restrictive and limits autonomous and individual behavior (Meyer et al., 2010). The socio-moral climate as a *weak situation* offers an open space that encourages employees to behave individualistically according to their personality with also applying one's character strengths and, therefore, allows each individual to develop in a liberal way (Cooper & Withey, 2009). The freedom to be yourself and to be able to contribute to work with your personal strengths as well as getting the appreciation for the person you are makes work easier and you feel more energized, which leaves more room for motivation and work engagement and increases well-being (Peterson & Seligman, 2004; Dubreuil et al., 2016; Kachel et al., 2020). In consequence, according with previous research, it is supposed that the perceived socio-moral climate in an organization is positively associated with the applicability of character strengths and is, mediated by that as well as directly, related to well-being and work engagement (Höge et al., 2020).

Work Engagement and Well-Being

Well-being and work engagement are very important health promoting mental and emotional states of nurses, as they are particularly affected by high burnout and depression rates. Approximately half of all nurses are affected by burnout (Shanafelt et al., 2015) and around a third by depression, which, in turn, holds a high risk of medical errors (Melnyk et al., 2018). Work engagement is seen as the counterpart to burnout (Schaufeli & Bakker, 2004) and, in turn, contributes to greater well-being in the context of medical work (Kanste, 2011).

Well-Being

Seligman and Csikszentmihalyi (2000) differentiate between two types of well-being: pleasure and enjoyment. Pleasure refers to the here and now and, thus, to fulfilling needs such as hunger, sex and bodily comfort. Enjoyment, on the other hand, refers to a longer period of time and means the happiness that results out of being challenged and, therefore, refers to personal growth (Seligman & Csikszentmihalyi, 2000).

Similarly, research on well-being is divided into two traditions: the Hedonistic and the Eudaimonic (Deci & Ryan, 2008; Ryan & Deci, 2001). The Hedonistic tradition is similar to the construct of

pleasure. It defines happiness as the presence of positive emotions and the absence of negative emotions as well as life satisfaction (Deci & Ryan, 2008). This form is also known as subjective well-being (SWB) (Diener, 1984). On the other side, in relation to enjoyment, the Eudaimonian tradition is more geared towards a longer period of time and aims for happiness by living a fulfilling and meaningful life (Deci & Ryan, 2008). It concentrates on characteristics for personal development such as autonomy, engagement, mastery, meaning, optimism and relationships and is also referred to as psychological well-being (PWB) (Ryff & Keyes, 1995; Su et al., 2014). Despite their interdependence, these two constructs of well-being were considered distinct aspects (Ring et al., 2007).

The connection between the 24 character strengths, especially their applicability, and well-being has already been proven in many studies (e.g. Huber et al., 2020; Wagner et al., 2020). Hausler et al. (2017b) found in their study a particularly strong connection to the so-called happiness strengths, namely curiosity, gratitude, hope, love and zest.

However, previous studies have shown that the use of character strengths is more strongly related to PWB than to SWB (Hausler et al., 2017b, 2017a). This is probably due to the fact that the use of character strengths is not directly related to positive feelings or reducing negative emotions, but rather to the challenge of accepting yourself, growing beyond yourself and finding meaning (Peterson & Seligman, 2004). In consequence, in accord with previous studies (Höge et al., 2020), we conclude that the use of character strength at work should be positively associated with well-being, while the association with PWB should be stronger than with SWB.

Work Engagement

Work engagement is a work-related, positive state of mind that can be described by three components, namely *vigor*, *dedication* and *absorption*. *Vigor* describes the motivation to invest in work accompanied by high levels of energy and resilience. *Dedication* means being strongly involved in work followed by high levels of enthusiasm. *Absorption* is a strong immersion in work, which is expressed by a high degree of concentration (Schaufeli et al., 2002). The third dimension can be described similar to the feeling of flow (Csikszentmihalyi, 2010): a state of being highly focused in an activity characterized by high enjoyment and a loss of the sense of time. Work

engagement is associated with a number of positive effects at work, such as physical and mental health (Bakker et al., 2011), task performance (Christian et al., 2011) as well as more motivation and work safety (Nahrgang et al., 2011), which is even related to lower mortality rates in hospitals (Bargagliotti, 2012). Therefore, work engagement is an important health promoting work-related mental state for nurses themselves as well as their patients.

Well-being and work engagement are highly intertwined constructs. As a result, within a broader and more general frame, engagement, as being similarly defined as work engagement with referring to a more universal context (Seligman, 2011), is often seen as part of well-being, as for example in Seligman's Authentic Happiness Theory (2002). In this theory, three elements play together to form the basis of happiness: positive emotions, engagement and meaning. Additionally, in his more recent PERMA-model, engagement plays an important role alongside positive emotions, positive relationships, meaning and accomplishment (Seligman, 2011). In consequence, referring back to the more specific frame of working context, work engagement can contribute to more work-related well-being (Kanste, 2011). The application of character strengths is associated with an engaged and fulfilling life and, therefore, nourishes well-being (Peterson & Seligman, 2004). Previous studies have linked the use of character strengths to both, work engagement (Harzer & Ruch, 2013; Lavy & Littman-Ovadia, 2017) and well-being (Hausler et al., 2017b; Huber et al., 2020; Wagner et al., 2020).

With regard to work engagement, numerous previous studies found a connection to using character strengths at work (e.g. Harzer & Ruch, 2013; Huber et al., 2020). Furthermore, according to Lavy and Littman-Ovadia (2017), this construct mediates the association between the application of character strengths and their positive work-related outcomes (i.e. productivity, organizational citizenship behavior and job satisfaction).

There are various conceivable mechanisms, why the application of character strengths leads to work engagement and well-being. Lavy and Littman-Ovadia (2017), for example, proposed the broaden and build theory of Fredrickson (2001) working as an upward spiral. This theory assumes that positive emotions broaden an individuals' mental and behavioral horizon and, therefore, form a basis for building up and using personal resources and strengths, which in turn can evoke

positive work-related outcomes via positive emotions and work engagement (Fredrickson, 2001; Lavy & Littman-Ovadia, 2017).

Furthermore, Höge et al. (2020) suggested three mechanisms of action. Firstly, with the help of the self-determination theory of Ryan and Deci (2000), they assumed that the application of character strengths in the working context is associated with well-being and work engagement due to satisfying the three basic needs, namely autonomy, competence and belonging (Linley et al., 2010). The application of character strengths fulfills the need for autonomy as well as the need for competence, since according to Peterson and Seligman (2004), the usage of character strengths is seen as a competence itself and leads to intrinsic motivation. Their application should also lead to more social interaction and support, which in turn fulfills the third need for belonging. Secondly, according to the self-concordance concept (Sheldon & Kasser, 1998), the application of character strengths positively influences well-being and work engagement, as using them feels very authentic and natural (Peterson & Seligman, 2004). Lastly, they mention the experience of meaning at work (Schnell et al., 2013). The application of one's character strengths at work creates a feeling of coherence between one's personality and work tasks, which, together with direction, significance and belonging, gives a feeling of meaningfulness at work (Schnell et al., 2013). In turn, this has a positive effect on well-being as well as, on the motivational component, work engagement (Höge & Schnell, 2012). However, these are certainly not all factors that can be taken into account. Another conceivable mechanism is self-efficacy (Bakker & van Wingerden, 2021; Bandura, 1977; van Woerkom et al., 2016). Self-efficacy is an important part of personal development, because it gives you a feeling of being able to actively create and affect your situation without being at the mercy of your circumstances (Bandura, 1977). Self-efficacy has been associated with work engagement and well-being in several studies (Avey et al., 2011; Seggelen - Damen & Dam, 2016; for a meta-analysis on work-related performance: Stajkovic & Luthans, 1998) and has also been related to character strengths (Bakker & van Wingerden, 2021; van Woerkom et al., 2016; van Woerkom & Meyers, 2019), as the use of character strengths can also convey a feeling of competence (Peterson & Seligman, 2004).

In consequence, according with previous studies (Höge et al., 2020), we conclude that the use of character strengths at work should be positively associated with work engagement and well-being, while the association with PWB should be stronger than to SWB.

Additionally, as Höge et al. (2020) confirmed in their study, the socio-moral climate with its participatory and appreciative structures and, therefore, a higher possibility of using character strengths, should directly and also indirectly, mediated by the applicability of character strengths, be associated with well-being and work engagement.

Patient Safety

Due to shift work, high levels of responsibility for patients and very close patient contact resulting in the compulsion to be friendly and always being available for the patients, the professional field of nurses is a very demanding one (Freimann & Merisalu, 2015; Korompeli et al., 2013). Furthermore, the number of older people is increasing (Meijer et al., 2000) and the growing requirement to document everything carefully (Blair & Smith, 2012), both leading to a greater amount of work. However, there is an immense shortage of nurses leading to involuntary overtime and an enormous workload (World Health Organization, 2020). In addition, the rates of fatigue, depression and burnout among caregivers are very high (Gander et al., 2019; Melnyk et al., 2018; Shanafelt et al., 2015). All of this can subsequently impair patient safety (Al Ma'mari et al., 2020; Melnyk et al., 2018). A higher workload of nurses is associated with unfinished clinical care and safety problems of patients (Cho et al., 2016; Sochalski, 2004; Weigl et al., 2015) as well as higher numbers of infections (Hugonnet et al., 2007), medical errors (Duffield et al., 2011) and patient mortality (West et al., 2014; review: Kane et al., 2007). Since nurses are closest to patients, they are often the contact person for all of their concerns. However, when they are too busy or overtired, there is often no time or resources left to listen to and care for the patient. As a result, mistakes can occur that can endanger both the nurses and patients.

According to Schaper (2014, p. 496), 80% of occupational accidents can be traced back to human factors such as misconduct. However, often the basis for accidents by human error are poor working conditions such as time pressure which lead to the perception of stress, fear, fatigue and loss of motivation making mistakes more likely due to reduced attention and concentration

(Schaper, 2014, p. 496). This is also underlined by Park and Kim (2013), who stated that reducing stress to reduce cognitive failure can be a very effective way of increasing patient safety. Applicability of character strengths were already introduced earlier as a personal resource according to the Job-Demands-Resources model by Bakker and Demerouti (2007) increasing the likelihood of a better way of coping with job demands and a high workload (van Woerkom et al., 2016). In consequence, resources reduce job strain whilst increasing motivation and commitment (Bakker & Demerouti, 2007) and, therefore, form a basis for more patient safety as there are more resources for paying attention carefully to follow safety instructions (Park & Kim, 2013). Furthermore, the applicability of character strengths is associated with an increased work efficiency (Dubreuil et al., 2014) which is further associated with an improved patient safety (Rainbow et al., 2020). A possible reason could be a feeling of authenticity because you are acting according to your personal strengths, which is associated with a lower perception of stress as well as less fatigue and having more energy (Peterson & Seligman, 2004), which is associated with increased quality of care and more patient safety (Montgomery, 2007). Consequently, as being a personal resource, applying one's character strengths can buffer demanding working conditions leaving more resources to work attentively and in a more conscious and safety-compliant manner, which should lead to higher patient safety. The study by Buljac-Samardzic and van Woerkom (2018) also gave initial indications that strengths use correlates with a higher quality of care and less perceived medication errors. Therefore, within this study it is supposed that the applicability of character strengths is positively related to patient safety.

An equally important resource in everyday professional life is social support (Strecker et al., 2019). The socio-moral climate as being characterized by high social support has already been identified as a preventive factor for greater patient safety (Kachel et al., 2020; Strecker et al., 2018). Through its participatory and non-judgmental structures, mistakes can be openly addressed and admitted without fear of being punished or convicted. Within the socio-moral climate, it is aimed to learn from mistakes and to solve the problem together as well as to support each other (Verdorfer et al., 2015; Weber et al., 2008). Due to its high level of transparency and openness, the socio-moral climate also shows similarities to the so-called safety climate, which is particularly highly correlated with patient safety (Reason, 2016). The safety culture is

characterized by four facets, namely a *reporting culture*, meaning that mistakes openly addressed, *just culture* referring to transparency about sanctions and trust, that no one will be sanctioned if one has acted without intent, *flexible culture* as responsibility can be passed on to experts on site in critical events and *learning culture* including a high level of willingness to practice self-reflection and learn from one's own mistakes and that of others (Reason, 2016, p. 195ff). With an open communication and resolution of conflicts but also trust-based allocation of responsibility, the socio-moral climate shows some parallels to the safety climate which makes it an important basis for more patient safety. Therefore, we assume that both the application of character strengths and the socio-moral climate are positively related to patient safety in caregivers.

Nahrgang et al. (2011) found in their meta-analysis that the connection between job resources such as social support and patient safety is mediated through work engagement. Similarly, Parr et al. (2020) found perceived organisation support mediated by engagement to be related to unit care quality. Both indicating that also the positive effect of a socio-moral climate on patient safety is mediated by work engagement. Additionally, Welp & Manser (2016) suggested in their review that the perception of teamwork, thus of a supportive working atmosphere like the socio-moral climate, increases well-being impacting the quality of care provided and therefore, also suggesting well-being as a mediator between socio-moral climate and patient safety. However, as patient safety is a highly controversial topic, the aim of this study is to address this issue as openly as possible, therefore, no hypotheses about mediations are made but just a positive connection from work engagement as well as well-being to patient safety as high levels of motivation and energy as well as feeling well at work indicates more resources for also being motivated to act in a more secure way (Park & Kim, 2013; Ree & Wiig, 2020; Welp & Manser, 2016).

In summary, within this study, it is assumed that patient safety is positively linked to applicability of character strengths, socio-moral climate as well as work engagement and well-being. Furthermore, in order to give this controversial and sensitive topic the necessary open space, it should be explored more exploratively.

The Present Study and Hypotheses

The medical context includes very difficult working conditions. On the one hand, it is emotionally very stressful as medical staff continuously deals with suffering and sometimes highly demanding patients (Freimann & Merisalo, 2015). On the other hand, it is mentally and physically exhausting because of a shortage of staff, an immense workload, which in combination with shift work and involuntary overtime can lead to a high level of stress and, in consequence, to other mental and physical illnesses (e.g. Brown et al., 2020; Watanabe & Yamauchi, 2018; Melynk et al., 2018). A long history of studies in this field (e.g. Engkvist et al., 2001; Mihdawi et al., 2020) and the still persisting problems show that working conditions in the medical field are difficult to change. Therefore, it seems important to increase personal resources of individuals, since, as earlier studies and work psychological models have shown, they can buffer negative consequences of difficult working conditions (Bakker & Demerouti, 2007; Glaser et al., 2015). Social support and autonomy, in particular, were identified as important resources in everyday professional life beneficial to increase well-being and motivation (Zapf & Semmer, 2004, p. 1042; Glaser et al., 2015). Therefore, this study would like to examine the connection between socio-moral climate, a climate with high levels of social support, the applicability of character strengths, the possibility of autonomously and individually contributing one's strengths, as well as well-being and work engagement. This has already been investigated in previous studies with a sample of medical students and physicians. This resulted in positive correlations between these variables and, using a longitudinal design, revealed that these effects persist over time and that applicability of character strengths acts as a mediator between socio-moral climate and well-being as well as work engagement (Höge et al., 2020). The present study aims to replicate these effects on a sample of nurses. This appears crucial as nurses are a particularly important profession in the medical context as they make up the majority of medical staff and work closest to the patient (World Health Organization, 2020). In addition to existing research, this study uses a more holistic approach applying a mixed-method design with an online survey and interviews and includes nurses, and, moreover, tries to include their work clientele and, therefore, also assesses patient safety. Thus, the study addresses both objective data and more subjective perceptions and includes nurses and their well-being as well as their assessment of patient safety.

In summary, on the basis of previous literature, this study wants to investigate the relationship between the applicability of character strengths, the socio-moral climate as well as work engagement and well-being among nurses and, further, wants to include patient safety into that relationship network.

In the following, the hypotheses used for the study are presented. The first four hypotheses (hypotheses 1-4) are based on the hypotheses of Höge et al. (2020) and are aiming to replicate their findings within a sample consisting of nurses. Hypotheses 5a-e expand their study by including patient safety. For a graphical illustration of the hypothetical relationships of the relevant study variables refer to figure 1.

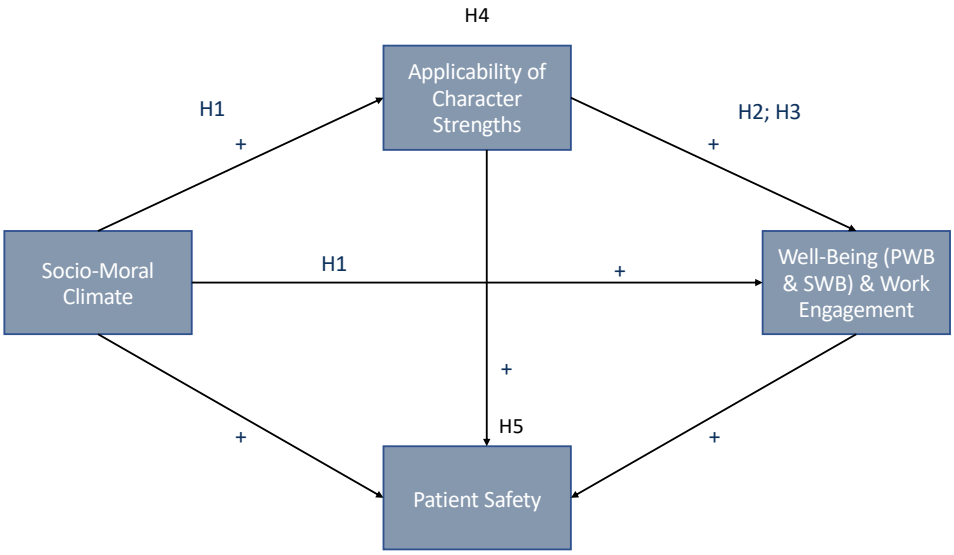

Figure 1 | Hypothetical model of the relationship between socio-moral-climate and well-being and work engagement mediated by the applicability of character strengths and their connection to patient safety.

First, the socio-moral climate is considered as a highly participative, open and appreciative environment supporting each individual with its personal needs. Therefore, it creates an open space to apply one's character strengths. Additionally, with feeling appreciated and supported, the socio-moral climate should be positively associated with well-being and work engagement (Verdorfer et al., 2013a; Weber et al., 2008; Höge et al., 2020).

1a. Perceived socio-moral climate will be positively associated with the applicability of character strengths of nurses at work.
1b. Perceived socio-moral climate will be positively associated with Eudaimonic psychological well-being of nurses.
1c. Perceived socio-moral climate will be positively associated with Hedonic subjective well-being of nurses.
1d. Perceived socio-moral climate will be positively associated with work engagement of nurses.

Second, the applicability of character strengths is associated with a flow-like feeling leading to feeling energized and motivated and should, therefore, be positively associated with work engagement (Peterson & Seligman, 2004; Lavy & Littmann-Ovadia, 2017).

2. Applicability of character strengths at work will be positively associated with work engagement of nurses.

Third, applying one's character strengths feels authentic and as the right thing to do, which should be positively related to well-being. However, as applying one's character strengths is related to personal development and thriving, it should show a higher correlation to Eudaimonic psychological well-being than to Hedonic subjective well-being (Peterson & Seligman, 2004; Hausler et al., 2017b).

3a. Applicability of character strengths at work will be positively associated with Eudaimonic psychological well-being of nurses.
3b. Applicability of character strengths at work will be positively associated with Hedonic subjective well-being of nurses.
3c. The positive association between applicability of character strengths at work and Eudaimonic psychological well-being of nurses will be stronger than the association with Hedonic subjective well-being.

Fourth, from the hypotheses 1-3 it can be concluded that, additionally to the assumed direct association of socio-moral climate with well-being and work engagement, the relation is mediated by the applicability of character strengths. As Höge et al. (2020) also proposed and verified within their study, an indirect effect of perceived socio-moral climate on work engagement and well-being via the applicability of character strengths is hypothesized (see figure 1).

4. The positive association between socio-moral climate and work engagement and well-being is mediated by the applicability of character strengths.

Last, to also consider the consequences for the patients, patient safety is included within this framework. Patient safety is negatively influenced by highly stressful working conditions (Al Ma'mari et al., 2020; Schaper, 2014; p. 496). Work-related resources such as a supportive environment, the possibility and free space to apply one's character strengths at work can buffer these detrimental effects and should higher patient safety (Bakker & Demerouti, 2007; Glaser et al., 2015; Kachel et al., 2020; Strecker et al., 2018). Therefore, socio-moral climate and applicability of character strengths should be positively associated with patient safety. Moreover, with higher well-being and work engagement, a nurse should have more motivation and resources to concentrate on patients and their well-being and safety (Park & Kim, 2013). In consequence, well-being and work engagement are assumed to be positively related to patient safety.

5a. The perceived socio-moral climate of nurses at work will be positively associated with patient safety.
5b. Applicability of character strengths of nurses at work will be positively associated with patient safety.
5c. Eudaimonic psychological well-being will be positively associated with patient safety.
5d. Hedonic subjective well-being will be positively associated with patient safety.
5e. Work engagement will be positively associated with patient safety.

Methods

In order to give such a vast and controversial topic the necessary space, an in-depth study design was chosen. Therefore, the study is open to the identification of connections between the variables by asking a large number of participants (quantitative part) and, additionally, these data can be supplemented by further problems and possible solutions through the opinion of nurses directly working in this field (qualitative part).

Quantitative Part

In the following, the methodical procedure for checking the hypotheses is described including sample and procedure as well as explanations of the instruments used.

Sample and Procedure

The optimal sample size was calculated in G*Power. Within the test family of *F-tests* the statistical test: "linear multiple regression: fixed model, R^2 deviation from zero" was used. A medium effect size was assumed (Höge et al., 2020) at a significance level of 0.05 and a power (1-ß) of 0.8 (Döring & Bortz, 2016). This resulted in an optimal sample size of 64 subjects.

A total of 182 people took part in the survey. All were German-speaking and worked as trained nurses in a hospital. The data from 116 people were excluded due to incomplete data.

The final sample consisted of 66 subjects, meaning 36.26% of all participants. This can be explained by the fact that the questionnaire was very long and the participants who completed the questionnaire without a break needed an average time of *M* = 31.55 minutes (three people took a break while doing the survey and, in consequence, needed a total time of 139.49, 152.37, and 411.10 minutes, respectively, and are not included in this average).

Of these 66 participants, 90.9% were female. This corresponds to the average gender distribution within the nursing profession in Europe (89% female, WHO, 2020). The subjects were on average 38.26 years old (range 19-60, *SD* = 10.91).

58 (88%) of the participants work in hospitals in Southern Germany and 8 (12%) come from hospitals in Austria.

Weekend and night shifts are taken over regularly by 77.3% of the subjects and only recently (approx. 4 weeks) by 1.5%. 21.2% reported that they do not work on weekends or in the night.
The average contractual working time was 33.47 hours (range: 3-40 hours, *SD* = 9.30). Most people (57.5%) work between 38.5-40 hours, which can be considered full-time (oesterreich.gv.at-Redaktion, 2021). Another 21.1% work between 30-38 hours, 13.6% work between 20-29.5 hours and 7.5% work less than 15 hours a week.
The actual working hours exceed the contractual working hours for 68.18% of the participants. These participants work an average of 9.58 hours per week of overtime (range: 1-35 hours, *SD* = 7.56). 27.27% exactly work within their normal working hours and 4.5% work less than their contractually regulated working hours.

This part of the study was based on a quantitative research approach. A questionnaire was used that collected self-reported data in a cross-sectional design. The questionnaire was available online via LimeSurvey (*www.limesurvey.org*) from mid-May to mid-June 2021. The participation was completely voluntary and anonymous.
The subjects were acquired by sending the link for the survey to personal contacts, who in turn were asked to share it with other nurses they know.
In order to increase the motivation to participate in the survey, the top five character strengths were shown within the survey.

In addition to demographic and control variables, character strengths and their applicability, socio-moral climate, work engagement, well-being and patient safety were measured. For a graphical illustration of the structural procedure of the quantitative online survey, refer to figure 2.

Figure 2 | Structure of the constructs examined within the quantitative part. The participants fill out an online questionnaire consisting of the constructs character strengths and their applicability, socio-moral climate, well-being, work engagement and patient safety.

Character Strengths and Their Applicability

To measure character strengths and their applicability, two questionnaires were combined: the VIA-120 and the ACS-RS (Harzer & Ruch, 2013). The VIA-120 (VIA Institute of Character, 2014) consists of 120 items measuring 24 character strengths. The items could be answered on a five-point Likert scale from 1 ("strongly disagree") to 5 ("strongly agree"). An example item for *kindness* is 'I really enjoy doing small favors to friends', and for *humor*: 'I try to approach everything I do with a bit of humor.' The results build a rank order of an individuals' character strengths. The first three to seven character strengths are called *signature character strengths* and are particularly characterizing the individual qualities and strengths of a person. Certainly, other criteria besides the highest position are important for the classification as a signature character strength (Peterson & Seligman, 2004), however, this is a measure often used in earlier literature (Harzer & Ruch, 2013; Höge et al., 2020; Linley et al., 2010). In this study, the first five character strengths were reported to the participants as *signature character strengths* as most studies did before (Ruch et al., 2020).

The VIA-120 is a short version of the VIA-IS which consists of 240 items, and has, according to Höfer et al. (2018), similar psychometric characteristics reaching from a Cronbach's alpha of 0.58 (*modesty*) to 0.87 (*spirituality*) in their first sample and 0.63 (*honesty*) and 0.90 (*spirituality*) in their second sample.

For the second step, the assessment of the applicability of their signature character strengths (in the following ASCS) in everyday working life, the *Applicability of Character Strengths Rating Scale* (ACS-RS) by Harzer and Ruch (2013) in the German version was applied. For each of their five signature character strengths, the participants answered four items to report their applicability at their work. The answer format was a five-point Likert scale reaching from 1 ("never") to 5 ("always"). An example item is 'This character strength is encouraged in my everyday work.'.

Socio-Moral Climate

For the survey of the perception of the socio-moral climate (SMC) the *Socio-moral Climate Questionnaire* (SMCQ) was applied. It uses 21 items to ascertain the five subscales of the socio-moral climate, namely open confrontation with conflicts, respect, open communication and

participative cooperation, allocation of responsibility and organizational concern. Using a confirmatory factor analysis, the five subscales could be based on a common second order factor, which proves the legitimization to calculate a total score of these five scales representing the entire socio-moral climate (Verdorfer et al., 2015). The response format was a five-point Likert scale ranging from 1 ("disagree") to 5 ("agree"). An example item is ‘Everyone is involved in important decisions that are made in our department.’.

Work Engagement

To determine work engagement, the German version of the short version of the *Utrecht Work Engagement Scale* (UWES; Schaufeli et al., 2006; Schaufeli & Bakker, 2004) was used. This measures the three dimensions of work engagement: vigor, dedication and absorption with nine items. Answers can be given on a seven-point Likert scale reaching from 0 ("never") to 6 ("always"). An example item is ‘I am enthusiastic about my work.’.

Well-Being

To measure well-being, the Comprehensive Inventory of Thriving (CIT) in the German version from Hausler et al. (2017) (original: Su et al., 2014) was implemented. With 54 items, the CIT assesses both, psychological and subjective well-being. In total, the CIT measures 18 sub-dimensions of these two factors. In a validation of the German version, these 18 sub-dimensions were verified as first order factors and SWB and PWB as second order factors. To measure SWB, three of these 18 sub-dimensions can be aggregated, namely positive emotions, negative emotions and life satisfaction. For the assessment of PWB, the remaining 15 scales can be subsumed under the following six categories: autonomy, engagement, meaning in life, mastery, optimism and relationships. Answers can be given on a five-point Likert scale from 1 (“strongly disagree”) to 5 (“strongly agree”) (Hausler et al., 2017). Example items are ‘I am on my way of fulfilling my dreams.’ (PWB, mastery) and ‘I mostly feel positive.’ (SWB, positive emotions).

Patient Safety

First, a filter question about regular contact with patients must be answered positively to be able to answer all other questions about patient safety. Due to the sensitive topic often being characterized by underreporting errors because of being ashamed of low patient safety at work (Davidoff, 2002), all questions on patient safety were voluntary. For the assessment of patient safety, the four-item scale of the *Patient Safety Culture Inventory* of Pfeiffer & Manser (2010) was used. The items could be answered in a five-point Likert scale ranging from 1 ("strongly disagree") to 5 ("strongly agree"). An example item is 'Patient safety is never neglected in order to get more work done.'.

Control Variables

Due to significant relationships with the relevant constructs in previous literature, additionally, five control variables were included, namely age (U-shaped curve of well-being regarding age: Blanchflower, 2021; positive association with work engagement: Goštautaitė & Bučiūnienė, 2015; negative association with patient safety: Holden et al., 2009; stronger connection from ASCS to well-being among younger people: Meyers et al., 2020), gender (women positively associated with work engagement: Adriaenssens et al., 2015; women are more likely to be more dissatisfied with patient safety at their hospital: Ban et al., 2017; women are negatively associated with well-being: Gómez-Baya et al., 2018), working hours (negatively associated with patient safety: Cho et al., 2016; with work engagement: Schaufeli, 2018; with well-being: Watanabe & Yamauchi, 2018) and shift work (negatively associated with well-being: Brown et al., 2020; Jamal & Baba, 1997; with work engagement: Sawatzky & Enns, 2012; with patient safety: Stimpfel et al., 2020). Character strengths can also be applied in everyday life also resulting in positive outcomes (Li et al., 2021). This possibly buffers negative effects of a detrimental work environment. In consequence, a scale for measuring the applicability of character strengths in everyday life was included. Therefore, the German version of the *Applicability of Character Strengths Rating Scale* (ACS-RS) by Harzer and Ruch (2013) was used. As for the work environment, for each of their five signature character strengths, the participants answered four items to report their applicability

in their everyday life. The answer format was a five-point Likert scale reaching from 1 (“never”) to 5 (“always”).

Qualitative Part

Survey Method

Since the focus of the interview is on both, the expertise and experience of the persons in their professional field and the perception of the individual within its social work environment including emotions, a combination of the expert interview and problem-centered interview was chosen (Helfferich, 2009).

The aim of these interviews is to collect further information and identify problems relating to the current state in the nursing profession, in addition to the collected quantitative data to be able to interpret the data in more depth, in order to achieve a deeper understanding of the complex topic.

Sample

Two people were interviewed. In order to cover the broadest range possible, a young person without a managerial function and an older person with a managerial function were selected, both working in a hospital in Southern Germany. Both took part in the online survey of the quantitative part and, therefore, had a certain overview of the relevant areas covered by the interview.

The first person (in the following text P1) is female and between 20 and 25 years old. She has been working in her momentary hospital for five years. Three years she was there as a trainee, afterwards she started working in the section of internal medicine and, six months before the interview, changed to the intensive care unit, where she is also doing a further training as an anesthetist and intensive care nurse. Since she works in the field without having a management position, she can convey a fairly comprehensive overall impression from the perspective of a currently working nurse.

The second person interviewed (in the following named P2) is already working in the field of nursing for 23 years and in the current hospital for five years. The person is female and between

40 and 50 years old. She is a trained nurse and is currently operating in nursing and in nursing management. This makes it possible to get a differentiated view of current difficulties as well as problems that have arisen over time. In addition, the management's somewhat distant perspective can create a larger picture and, therefore, a greater understanding of the situation. Both were known through personal contact and were therefore asked personally to take part in the interview.

Interview Implementation

Two types of expert interviews can be distinguished: the "systematizing expert interview", in which the expert provides relevant information and advices about the current situation, and a "theory-generating expert interview" collecting interpretative knowledge of the situation and possible ideas of solutions that can be reconstructed during the evaluation of the interview (Bogner & Menz, 2005, quoted from Helfferich, 2009, p. 162).

The developed interview guideline mainly contains theory-generating questions in order to obtain a broad extension to the quantitative data with leaving space for the introduction of new topics by the interviewed person.

In contrast to other interviews, in the expert interview, which aims for the examination of factual knowledge, a stronger structure is advised. It is possible to include thematic jumps and questions navigating to relevant information in a targeted manner. This intends to ensure the collection of information that is relevant for this study and supplement the quantitative data. Nevertheless, also in terms of a problem-centered interview, this structure is opened up to a certain extent in the course of the interview and, thus, enables the interviewed person to introduce their own perception about the situation including feelings and emotions as well as own topics to a desired amount. The aim is not to ask the experts purely for objective facts, but rather to seek an open, discursive and interactive interview situation (Helfferich, 2009).

The interview guideline was deductively derived from the questions of the quantitative survey and formulated into open questions. This makes it possible to stay close to the object of investigation and the quantitative data without leaving out the possibility of introducing further topics or ideas by the interviewed person. The interview guideline serves as a memory aid that

represents the golden thread throughout the conversation while still remaining variable and open according to the conversation (Witzel, 1985). The complete interview guideline in German language as it was used in both interviews can be found within the appendix (B).

The interviews were carried out on the 24th of July 2021 at 11 a.m. with a length of 51.12 minutes for P1 and on the 31st of July 2021 at 16 p.m. with a length of 88.33 minutes for P2, respectively. Both interviews were held in person and were recorded using a mobile phone and a laptop. For this purpose, a declaration of consent was obtained, which explains both the interview situation and the principles of data protection (see appendix B).

The interviews were transcribed manually using the audio recordings. According to Gläser and Laudel (2009, p. 193), there are no generally accepted and applicated transcription guidelines and, therefore, the transcription should depend on the subject of investigation. Since only the content is important for further analysis, only the pauses the interviewee made are transcribed in addition to the content, which are indicated in brackets with three dots, a hyphen and the number of seconds the break lasted (e.g.: (... - 2s)). As both interviews were held in German, both transcripts are written in German (both transcripts can be found within the appendix B). To make it easier to understand, the text passages used to substantiate the evaluation have been translated into English. In order to test the correctness of the translation, the respective passages were translated back again to German by an independent person and checked for the original meaning by both, the respective independent person and the interviewee.

Quality Criteria

In the following, the extent to which the interviews meet the quality criteria of objectivity, reliability and validity is illuminated.

Objectivity

The objectivity of an interview can be divided into three types (Schmidt & Kessler, 1976, quoted from Renner & Jacob, 2020, p. 86): The *recording objectivity*, the *interpersonal* and the

intrapersonal objectivity. The *recording objectivity* is only partially fulfilled in this work, since the interview was recorded, but its transcript was written manually and not by a computer software. A manual transcript always depends to a certain extent on its author. However, since the interviews were transcribed based on the content, only including the length of short breaks and not on interpreted emotions or facial expressions, a high traceability is given.

Intrapersonal objectivity refers to the extent to which the interviewer's behavior can be predicted in terms of implementation, recording, evaluation and interpretation. The *interpersonal objectivity* depends to a certain extent on this and refers to the intersubjective agreement in case of several interviewers. With *reflected subjectivity*, Helfferich (2009, p. 155) refers to these two types of objectivity in a similar way. The aim is not achieving objectivity but dealing appropriately with subjectivity by questioning and disclosing one's own position including previous experiences and assumptions (Helfferich, 2009, p. 157).

Both inter- and intrapersonal objectivity were met, as the interviews were structured using an interview guideline. Therefore, the subjective point of view of the interviewer only has a small influence on the interview and the focus is mainly on being open to the information provided by the interviewee. However, it should be noted that the interviewing person has the same background of experience because of working in the respective hospital as a nurse as well. Nevertheless, according to Helfferich (2009, p. 120-121), this can have a positive effect on the interview situation, since emotional closeness and the building of trust and, thus, access to the person is facilitated, as one can rather give the impression of being able to understand, what can increase the willingness to participate on the site of the interviewee. Furthermore, since conversations are difficult to predict due to their spontaneous and interactive nature, the freedom was taken to ask additional questions for reasons of understanding or to obtain further details. Therefore, it should not be neglected that interviews always depend to a certain extent on the interaction of both actors, which allows the desired subjectivity and openness.

Reliability

Reliability relates to the precision of a measuring instrument. It can be categorized in internal consistency and retest reliability (Jacob & Renner, 2020, p. 87).

The internal consistency measures the extent to which similar answers are given to homogeneous questions. According to Schmidt and Keßler (1976 quoted from Jacob & Renner, 2020, p. 87), this plays a subordinate role in interviews, as the interactive component always creates different conversations with different topics that rarely produce similar answers. Jacob and Renner (2020, p. 87) point out that it is certainly possible for interviews to check for partial questions whether different interviewees give similar answers. For some questions, the two interviewees answered in a similar way, which indicates that individual questions were asked in an understandable manner and can possibly achieve consistent answers. However, some answers to the same question highly differed in terms of content. Nevertheless, this was aimed for in order to get a broader and more differentiated picture of the respective situation.

Retest reliability refers to the stability of a certain feature of an individual over time. This could not be tested because the interview was just carried out once. A high level of stability would be expected with hard facts, such as place of residence or workplace. However, the interview that was conducted was primarily focusing on perceptions and attitudes changing quickly and thus indicating a lower level of stability over time (Renner & Jacob, 2020, p. 87). Since qualitative data are always context-dependent and the meaning a specific person ascribes to a certain situation is always fluid by depending on various factors such as current mood, memory or stress, the interview content will never be objective nor complete nor reproducible in the same way (Helfferich, 2009, p. 120). In addition, it is important to mention that interviews always stimulate self-reflection to a certain extent and can therefore also change the perspective of the individual (Renner & Jacob, 2020, p. 88).

Validity

Validity is used to determine whether what should be measured was actually measured. A distinction is made between different types of validity (Jacob & Renner, 2020, p. 88-90).

The *face validity* refers to the correspondence of the interviewee's attribution of meaning of a question with the actual construct behind it. Care was taken to ask questions as transparently as possible. This seems to have succeeded, as there were hardly any questions about understanding.

The *content validity* is given when a construct has been completely recorded in terms of content. This requires a high transparency of questions. When developing the interview guideline, attention was paid to examine the topic in its entirety. However, the topic is very complex and contains many facets, which is why the questions were asked as openly and transparently as possible in order to give the interviewee the opportunity to add details and further topics.

The *criterion validity* aims at the agreement of the interview statement with a criterion. To a certain extent, this can be compared with the quantitative data collected, which clearly showed agreement, but also some contradictions, which was exactly the intention of the interviews.

Incremental validity means that the interview can provide additional explanation of the variance of a criterion in addition to another instrument. This could not be measured since the interview was not quantified, but only served to supplement the quantitative data with information.

For interviews, *communicative validation* is recommended instead of *construct validity*. For this purpose, the interpretation of the interview was presented to the interviewees and their consent was obtained (Jacob & Renner, 2020, p. 88-90).

Results

Quantitative Results

In the following, the study's results are presented starting with preliminary and descriptive statistics and continuing with the examination of the hypotheses and additional analyses.

Preliminary Data Analysis

The data were analyzed using SPSS (version 26) and, for further in-depth analysis, Microsoft Excel (version 16.34). Alpha levels were set at $\alpha = 0.05$ and all reported *p*-values are two-tailed. Unless otherwise stated, results from all participants were subject to data analysis. For the mediation analysis of hypothesis 4, the PROCESS v4.0 macros from Andrew F. Hayes (2018) were used, with 5000 bootstraps using the HC3-method to control for any influence of heteroscedasticity on the standard error and including all control variables. Within the presentation of the results of the mediation calculations, the Sobel-test is not displayed since bootstrapping is a more powerful method and does not require a normal distribution of the indirect effect, which is very seldom

the case, especially in small samples (Hayes, 2009). Transforming all relevant variables into *z*-scores ($Z = \frac{x-\mu}{\sigma}$; Z = standard score, x = observed value, μ = mean of this variable, σ = standard deviation of this variable; *M* = 0, *SD* = 1) revealed no outliers ($z \geq \pm 3.29$).

The questionnaires on patient safety and well-being included questions asking for the level of risk of patients and dissatisfaction of the nurses, respectively, and were reversed in consequence. The reliability of each scale was assessed on the basis of internal consistency; all values were in an acceptable range (α > .70; Field, 2011). The Cronbach's Alphas were α = .89 for the applicability of character strengths at work (for everyday life: α = .93), α = .95 for socio-moral climate, α = .93 for work-engagement, α = .95 for well-being and α = .75 for patient safety. For well-being, the subscales PWB und SWB both showed excellent values of α = .93. The five subscales of the socio-moral climate also displayed acceptable Cronbach's Alphas, namely open confrontation α = .87, respect α = .79, open communication and participative cooperation α = .91, allocation of responsibility α = .75, organizational concern α = .89. For the VIA-120, Cronbach's Alpha ranged from α = .45 (*humility*) to α = .88 (*spirituality*). The low internal consistency of some character strengths indicates a low reliability of the respective character strengths within this sample. However, since the VIA-120 has already shown good reliability in several studies with larger sample sizes (Hausler et al., 2017b; Höfer et al., 2020), sufficient reliability is also assumed here.

To check for normal distribution, the Kolmogorov-Smirnov-test was used revealing non-significant results for applicability of character strengths in private life (*p* = .092), socio-moral climate (*p* = .200), well-being (*p* = .200; PWB: *p* = .200; SWB: *p* = .074), work engagement (*p* = .064) and patient safety (*p* = .200), indicating normal distribution. ASCS at work showed a significant result (*p* = .001) with a left-skewed distribution meaning that most of the participants reported a high degree of applicability of their signature character strengths at work. However, due to the sample size, a normal distribution can still be presumed in agreement with the central limit theorem (Backhaus et al., 2018).

A mediation model was calculated for hypothesis 4. Hayes (2018) names the following five prerequisites: linearity, normal distribution of the residuals, homoscedasticity, independence and temporal precedence. However, the mediation model uses bootstrapping, which is a very robust method, meaning minor violations of the prerequisites are not too important (Hayes,

2018). Linearity of the relationships between all relevant variables was visually checked using a scatter plot with a fitted line after LOESS-smoothing. After checking the histograms and P-P diagrams, normal distribution of the residuals can be confirmed for the mediation analyzes including PWB and work engagement as depended variables but not for SWB as dependent variable. However, according to Hayes (2018) this requirement is the one being least important, and, in consequence, the procedure is robust enough. Homoscedasticity of the residuals was checked using unstandardized predicted values, which were plotted against the studentized residuals, revealing constant residuals. Independence can be ensured through the anonymous and non-dyadic setting of the questionnaire. Temporal precedence can be assumed, since the mediation examined is a replication of the mediation model of Höge et al. (2020) who used a longitudinal design to explore the direction of the relationship between the variables.

In addition to bivariate correlation, for the hypotheses 1a-d, 2, 3a-c and 5a-e hierarchical multiple regression analyses were performed to exclude any influence of the control variables on the examined relationships. This procedure has very similar prerequisites as the mediation analysis. Further to linearity and homoscedasticity, independency of the residuals, no multicollinearity and no outliers are required. Similar to the analysis above, linearity and homoscedasticity of the residuals were checked using a scatter plot. For hypotheses 1a-d and 3a, additionally, the Breusch-Pagan test for heteroscedasticity was used, because there was a minimal deviation of the data points within the scatter plot. As the result for hypotheses 1b was significant (p = .05), homoscedasticity of the residuals can be assumed. Since for hypotheses 1a, 1b, 1d and 3a was not significant, homoscedasticity cannot be assumed. In consequence, additionally to the assumption that hierarchal regression analyses are very robust (Backhaus et al., 2018), the procedure for these hypotheses was calculated with 5000 bootstraps (Field, 2011, p. 163). For evaluating the independency of the residuals, the Durbin-Watson test was used. The values of this test range from 0 to 4, and, for independency of the residuals, should be distributed roughly around the value of 2. Values were d = 2.058 (H1a), d = 2.370 (H1b), d = 1.998 (H1c), d = 2.346 (H1d), d = 2.544 (H2), d = 1.912 (H3a), d = 2.037 (H3b), d = 1.887 (H5a), d = 2.145 (H5b), d = 2.115 (H5c), d = 2.036 (H5d) and d = 2.050 (H5e) and, therefore, being within the acceptable range (Backhaus et al., 2018, p. 98). Multicollinearity was examined with the help of tolerance (.606-

.973; critical values <.01) and VIF values (1.028-1.650; critical values >10), which were each in the acceptable range. Using box plots, no outliers were found within the relevant variables which are above the limit of three standard deviations.

To be able to examine the incremental explanation of variance of the relevant variables, the control variables were included in step one and the independent variables in step two of the calculated hierarchal regression analyses.

In order to exclude any influences from different scorings of the used questionnaires and to increase their comparability, all procedures were calculated using *z*-standardized values of all relevant variables.

Descriptive Analysis

In table 2, means, standard deviations, Pearson's correlation coefficient of all variables including control variables and internal consistency measured as Cronbach's Alpha of all relevant variables are presented.

Compared to available validation samples for the used questionnaires, the mean values of this sample are on average for SMC (Verdorfer et al., 2015), work engagement (Schaufeli & Bakker, 2004), SWB and PWB (Hausler et al., 2017). Applicability of character strengths at work has slightly higher values in our sample (M = 4.03 vs. M = 3.46; Harzer & Ruch, 2013) and patient safety slightly lower values than the validation sample of registered nurses by Pfeiffer and Manser (2010) (M = 3.17. vs. M = 3.96). Means of character strengths measured with the VIA-120 ranged from M = 1.59 (SD = .900; *spirituality*) to M = 3.32 (SD = .399; *honesty*).

There are no significant ($\alpha < 0.05$) relationships between age and gender with the relevant variables. Similarly, overtime and shift work mostly show no significant relationships. However, the relationship between overtime and patient safety (r = -.32; p = .012) is statistically relevant, meaning, the more overtime someone does, the lower the perceived patient safety is. Additionally, the relationship between shift work and SMC (r = -.26; p = .032) is statistically relevant, indicating, people who do shift work are more likely to perceive a less pronounced socio-moral climate at their work. ASCS in everyday life is connected to ASCS at work (r = .61; p < .001) as well as to SWB (r = .30; p = .014) and PWB (r = .37; p = .002).

Table 2 | Means, standard deviation & Pearson's coefficient inter-correlations between all relevant study variables

	N	*M*	*SD*	1	2	3	4	5	6	7	8	9	10	11
1. Age	66	38.26	10.91											
2. Gender[a]	66	.09	-	-.08										
3. Overtime[b]	66	5.87	9.20	.14	.01									
4. Shift Work[c]	66	.21	-	-.20	-.22[†]	-.13								
5. ASCS Private	66	4.24	.56	-.09	-.05	-.06	-.08	(.94)						
6. ASCS Work	66	4.03	.53	-.02	.04	-.04	-.06	.61**	(.89)					
7. SMC	66	3.20	.77	-.03	.09	.01	-.26*	.22[†]	.31*	(.95)				
8. SWB	66	3.99	.69	-.05	.02	-.19	.01	.30*	.28*	.41**	(.93)			
9. PWB	66	4.00	.43	-.15	-.01	-.13	-.14	.37**	.49*	.41**	.74**	(.93)		
10. Work Engagement	66	3.49	1.21	-.06	.07	-.09	-.14	.17	.42*	.61**	.51**	.45**	(.93)	
11. Patient Safety	61	3.17	2.81	-.11	.09	-.32*	-.19	.12	.12	.56**	.43**	.36**	.29*	(.75)

Notes. *N* = sample size, *M* = Mean, *SD* = standard deviation, Cronbach's Alpha (reliability of scale) is located in brackets in the matrix diagonal, ASCS = Applicability of signature character strengths, SMC = socio-moral climate, SWB = subjective well-being, PWB = psychological well-being.

[a] 0 = female, 1 = male. [b] number in hours. [c] 0 = no shift work, 1 = shift work. All scales reaching from 1 ("never" or "disagree") to 5 ("always" or "agree"), despite work engagement reaching from 0 ("never") to 5 ("always").

[†] $p < .10$, * $p < .05$, ** $p < .01$

Regarding the relevant variables, out of 15 intercorrelations, just one was non-significant (ASCS at work with patient safety: $r = .12$, $p = .414$). The other 14 intercorrelations ranged between $r = .28$ ($p = .021$; ASCS at work and SWB) and $r = .74$ ($p < .001$; PWB and SWB). Strong correlations ($r \geq .50$) were, found for work engagement and SMC ($r = .61$; $p < .001$), SMC and patient safety ($r = .56$; $p < .001$), as well as work engagement and SWB ($r = .51$; $p < .001$). The remaining values range between $r = .28$ to $r = .49$ and result in a mean of $r = .39$, corresponding to a medium effect size (Cohen, 1988).

In descending order, work engagement ($r = .60$; $p < .001$), PWB ($r = .41$; $p = .001$), SWB ($r = .41$; $p = .001$) and applicability of character strengths at work ($r = .31$; $p = .010$) are positively associated with the perceived socio-moral climate, providing preliminary support for hypotheses 1a-d.

With applicability of character strengths at work being positively associated with work engagement ($r = .42$; $p < .001$), PWB ($r = .49$; $p < .001$) and SWB ($r = .28$; $p = .021$), additionally hypotheses 2 and 3a-c can be preliminary supported.

Regarding patient safety, the bivariate correlations provide preliminary support for hypotheses 5a, c, d and e with positive associations with SMC ($r = .56$; $p < .001$), SWB ($r = .43$; $p = .001$), PWB ($r = .36$; $p = .004$) and work engagement ($r = .29$; $p = .025$). However, there is no significant association between the applicability of character strengths at work and patient safety, preliminary opposing hypotheses 5b.

The character strengths being evaluated most often as signature strengths were *honesty* ($N = 43$), *kindness* ($N = 35$), *fairness* ($N = 35$), *love* ($N = 27$) and *humor* ($N = 20$); least mentioned were *modesty* ($N = 1$), *self-regulation* ($N = 2$), *spirituality* ($N = 3$), *zest* ($N = 5$) and *gratitude* ($N = 5$). These results are very similar to the ones found in Höge et al. (2020) with *honesty*, *kindness*, *love*, *judgment*, and *fairness* as the most often named signature strengths and *self-regulation*, *perspective*, *spirituality*, *prudence*, and *leadership* being mentioned least often. Character strengths could be applied more often in everyday life compared to work ($M = 4.24$ vs. $M = 4.03$), which was also found in Harzer and Ruch (2013). Regarding the perceived applicability of character strengths in the working context, *self-regulation* ($M = 4.73$), *prudence* ($M = 4.52$), *hope* ($M = 4.25$), *leadership* ($M = 4.22$) and *humor* ($M = 4.18$) received the highest ratings, all indicating to be applied often (score = 4.00) to (almost) always (score = 5.00). Looking at the most often occurring

signature strengths, *humor* received the highest perceived applicability (*M* = 4.18), followed by *honesty* (*M* = 4.11), *fairness* (*M* = 4.10), *kindness* (*M* = 4.04), and *love* (*M* = 4.00) meaning they could be applied often (score = 4.00). *Appreciation of beauty and excellence* (*M* = 3.41), *zest* (*M* = 3.62), *modesty* (*M* = 3.70), *social intelligence* (*M* = 3.73) and *creativity* (*M* = 3.80) showed the lowest perceived applicability at work, indicating to be applied sometimes (score = 3.00) to often (score = 4.00). In comparison to the results of Harzer and Ruch (2013), within their sample, *love of learning* and *honesty* could be applied most often and *spirituality*, *bravery* and *love* least often in the working context.

Evaluation of Hypotheses

The following section presents the results of the hypotheses testing. First, the relationships between SMC and ASCS at work, SWB, PWB and work engagement (hypotheses 1a-d) were examined. Second, the association between ASCS at work and work engagement (hypotheses 2) and well-being (hypotheses 3a-c) is demonstrated. Third, the relationships between patient safety with SMC, ASCS at work, SWB, PWB and work engagement (hypotheses 5a-e) is presented and, last, the mediation analysis of hypothesis 4.

Association of Socio-Moral Climate with Applicability of Character Strengths, Well-Being and Work Engagement

Since only the dependent variable differs between hypothesis 1a-d, the results of hypothesis 1a and 1b (table 3) as well as 1c and 1d (table 4) are summarized in one table (for further details on the first step of the analysis and facets of the included variables, please refer to the appendix A). With regard to hypothesis 1a, the model consisting of SMC and the control variables could explain 41.6% (corrected R^2 = .356) of the variance of ASCS at work (F (6,59) = 6.993; p <.001). However, only 3.7% were incrementally attributable to SMC. On closer inspection of the regressors, SMC only showed a marginally significant relationship to ASCS at work including the control variables (β = .203, p = .084).

Table 3 | Hierarchical regression analyses for hypotheses 1a-b

		H1a: ASCS Work				H1b: PWB			
Step	Predictor	*B*	*SE*	β	*p*	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-	-	-	-	-
	R^2	.379				.185			
	p	< .001[d]				.028			
2	*Control Variables*								
	Age	.006	.009	.065	.522[d]	-.011	.011	-.117	.312
	Gender[a]	.239	.457	.069	.575[d]	-.194	.395	-.056	.624
	Overtime[b]	-.001	.011	-.010	.920[d]	-.013	.012	-.115	.308
	Shift Work[c]	.176	.292	.073	.526[d]	-.194	.294	-.080	.512
	ASCS Private	.581	.131	.581	< .001[d]	.271	.114	.271	.020
	Independent Var.								
	SMC	.203	.112	.203	.084[d]	.338	.117	.338	.005
	ΔR^2	.037				.102			
	R^2	.416				.286			
	p	< .001[d]				.002			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. PWB = Psychological well-being. SMC = Socio-moral climate. Var. = Variable.

Only the control variable ASCS Private had a significant association with ASCS at work (β = .581, *p* <.001). Although a positive relationship between SMC and ASCS at work could be determined using bivariate correlations (*r* = .31, *p* = .010), this did not hold up when control variables were included. This leads to the rejection of hypothesis H1a.

Regarding hypothesis 1b, the model including SMC and the control variables could explain 28.6% (corrected $R^2 = .213$) of the variance of PWB (F (6,59) = 3.941; *p* = .002). SMC incrementally explained 10.2% of this variance and had a positive correlation to PWB (β = .338, *p* = .005). In addition to SMC, the sole contribution from ASCS Private to PWB was also statistically significant,

Table 4 | Hierarchical regression analyses for hypotheses 1c-d

		H1c: SWB				H1d: Work Engagement			
Step	Predictor	*B*	*SE*	β	*p*	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-	-	-	-	-
	R^2	.124				.060			
	p	.150[d]				.582			
2	*Control Variables*								
	Age	.003	.010	.033	.769[d]	-.002	.010	-.017	.886[d]
	Gender[a]	.084	.327	.024	.792[d]	.059	.373	.017	.870[d]
	Overtime[b]	-.019	.013	-.176	.105[d]	-.010	.010	-.092	.280[d]
	Shift Work[c]	.285	.331	.117	.388[d]	.015	.282	.006	.955[d]
	ASCS Private	.220	.148	.220	.132[d]	.033	.129	.033	.806[d]
	Independent Var.								
	SMC	.397	.131	.397	.006[d]	.601	.097	.601	< .001[d]
	ΔR^2	.140				.320			
	R^2	.264				.380			
	p	.005[d]				< .001			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. SWB = Subjective well-being. SMC = Socio-moral climate. Var. = Variable.

pointing into a positive direction (β = .271, *p* = .020). With a closer look at the five subscales of SMC, *allocation of responsibility* showed a positive relationship to PWB (β = .447; *p* = .028). This leads to the confirmation of the 1b.

Referring to H1c, the model including SMC and the control variables was able to explain 26.4% (corrected $R^2 = .189$) of the variance of SWB (F (6,59) = 3.519; *p* = .005). Incrementally, SMC explained 14% and showed a positive association with SWB (β = .397; *p* = .006). With a closer look at the subscales of SMC, *respect* displayed a marginally significant positive relationship with SWB (β = .388; *p* = .069). Therefore, hypothesis 1c can be confirmed.

Concerning hypothesis 1d, the regression model with SMC and the control variables explained 38% (corrected $R^2 = .317$) of the variance of work engagement (F (6,59) = 6.027; $p < .001$). SMC incrementally contributes 32% and showed a positive relationship to work engagement (β = .601; $p < .001$) and, thus, showed the largest contribution of SMC to the respective dependent variables. Regarding the subscales of SMC, *open confrontation with conflicts* indicated a positive association with work engagement (β = .400; $p = .029$). This confirms H1d.

Association of Applicability of Character Strengths with Work Engagement and Well-Being

For further details, refer to table 5 (hypothesis 2) and table 6 (hypothesis 3a-c). For further details on the first step of the analysis, please refer to the appendix (A).

Table 5 | Hierarchical regression analyses for hypothesis 2

		H2: Work Engagement			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	R^2	.060			
	p	.582			
2	*Control Variables*				
	Age	-.007	.011	-.081	.503
	Gender[a]	.000	.414	.000	.999
	Overtime[b]	-.009	.013	-.087	.458
	Shift Work[c]	-.380	.298	-.156	.208
	ASCS Private	-.166	.148	-.166	.266
	Independent Var.				
	ASCS Work	.506	.146	.506	.001
	ΔR^2	.159			
	R^2	.219			
	p	.020			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. ASCS = Applicability of character strengths. Var. = Variable.

Looking at H2, ASCS at work including the control variables was able to explain 21.9% (corrected R^2 = .139) of the variance of work engagement (F (6,59) = 2.752; p = .020). In addition to the control variables, ASCS at work incrementally explained 15.9% and showed a positive association with work engagement (β = .506; p = .001), therefore confirming H2.

Table 6 | Hierarchical regression analyses for hypotheses 3a-c

		H3a: PWB				H3b: SWB			
Step	Predictor	*B*	*SE*	β	*p*	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-	-	-	-	-
	R^2	.185				.124			
	p	.028				.150[d]			
2	*Control Variables*								
	Age	-.015	.010	-.161	.161	.000	.011	.000	.997[d]
	Gender[a]	-.267	.392	-.077	.498	.092	.448	.027	.830[d]
	Overtime[b]	-.012	.012	-.111	.321	-.019	.015	-.174	.166[d]
	Shift Work[c]	-.424	.282	-.175	.138	.033	.346	.014	.924[d]
	ASCS Private	.067	.140	.067	.633	.200	.171	.200	.227[d]
	Independent Var.								
	ASCS Work	.434	.138	.434	.003	.155	.159	.155	.324[d]
	ΔR^2	.117				.015			
	R^2	.302				.139			
	p	.001				.168[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. PWB = Psychological well-being. SWB = Subjective well-being. Var. = Variable.

With regard to H3a-c, the first model including ASCS at work with all control variables explained 30.2% (corrected R^2 = *.231*) of the variance of PWB (F (6,59) = 4.247; p = .001). Incrementally,

11.7% referred to ASCS at work with a positive relationship to PWB (β = .434; p = .003), confirming H3a.

The second model included ASCS at work and all control variables and was able to explain 13.9% (corrected $R^2 = .051$) of the variance of SWB but was not significant (F (6,59) = 1.583; p = .168). In this connection, ASCS at work incrementally explained 1.5% and showed no significant correlation with SWB (β = .155; p = .324). This leads to the rejection of H3b.

Looking at hypotheses 3c, the bivariate correlation between ASCS at work with PWB was r = .49 (p < .001) and with SWB r = .28 (p = .021), respectively. For calculating the difference of these two correlations an online version of Fisher's r-to-z transformation in combination with Steiger's (1980) third and 10th equation (Lee & Preacher, 2013) was used, revealing a significant difference (z = -2.575; p = .01). Additionally, since, within the hierarchal regression analysis, PWB showed a positive association with ASCS at work (β = .434; p = .003), while SWB showed no significant relationship with ASCS at work (β = .160; p = .323) within a non-significant model, H3c can be confirmed as well. Interestingly, this is only the case for ASCS at work, but not for the applicability of character strengths in everyday life. ASCS in private also showed a higher association to PWB than to SWB (r = .37 vs. r = .30) albeit there is not a significant difference between these two correlations.

Association of Patient Safety with Socio-Moral Climate, Applicability of Character Strengths, Well-Being and Work Engagement

As the questions on patient safety were not mandatory, only n = 61 out of n = 66 completed all questions, meaning five participants were excluded from this analysis due to non-complete answers within the variable of patient safety. Even though previous power analysis revealed a required n = 64, all prerequisites are met and, therefore, 5000 bootstraps were used to control for any possible errors. Since for the hypotheses 5a-e only the independent variable is changing, the results of H5a and H5b (table 7) as well as H5c and H5d (table 8) are presented in a combined table and the findings of H5e can be found in table 9. For further details to step one of the analysis and facets of the relevant variables refer to the appendix (A).

Table 7 | Hierarchical regression analyses for hypotheses 5a-b

		H5a+b: Patient Safety						
Step	Predictor	*B*	*SE*	β	*p*	ΔR^2	R^2	*p*
1	*Control Variables*	-	-	-	-	-	.165	.070
2a	*Control Variables*							
	Age	-.004	.002	-.043	.725[d]			
	Gender[a]	.075	.586	.021	.894[d]			
	Overtime[b]	-.033	.011	-.309	.002[d]			
	Shift Work[c]	-.229	.276	-.085	.391[d]			
	ASCS Private	-.041	.119	-.041	.714[d]			
	Independent Var.							
	SMC	.546	.122	.540	< .001[d]	.257	.422	< .001[d]
2b	*Control Variables*							
	Age	-.009	.013	-.102	.472[d]			
	Gender[a]	.095	.727	.026	.890[d]			
	Overtime[b]	-.034	.017	-.318	.034[d]			
	Shift Work[c]	-.577	.395	-.215	.148[d]			
	ASCS Private	.055	.159	.055	.708[d]			
	Independent Var.							
	ASCS Work	.016	.181	.016	.931[d]	.000	.165	.121[d]

Notes. N = 61. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. SMC = socio-moral climate. Var. = Variable.

Regarding H5a, the model including SMC as well as all control variables explained 42.2% (corrected $R^2 = .357$) of the variance of patient safety (F (6,54) = 6.562; p = <.001). SMC incrementally explained 25.7% with a positive association with patient safety (β = .546; p < .001). With a closer look at the facets of SMC, *open communication and participative cooperation* showed a

marginally significant association with patient safety (β = .335; *p* = .063). This leads to the confirmation of H5a.

Table 8 | Hierarchical regression analyses for hypotheses 5c-d

		H5c+d: Patient Safety						
Step	Predictor	*B*	*SE*	β	*p*	ΔR^2	R^2	*p*
1	*Control Variables*	-	-	-	-	-	.165	.070[d]
2c	*Control Variables*							
	Age	-.005	.011	-.055	.676[d]			
	Gender[a]	.111	.688	.031	.873[d]			
	Overtime[b]	-.030	.016	-.282	.041[d]			
	Shift Work[c]	-.480	.411	-.179	.240[d]			
	ASCS Private	-.039	.139	-.039	.773[d]			
	Independent Var.							
	PWB	.292	.127	.300	.026[d]	.073	.237	.019[d]
2d	*Control Variables*							
	Age	-.009	.011	-.099	.440[d]			
	Gender[a]	.088	.633	.024	.889[d]			
	Overtime[b]	-.026	.015	-.241	.052[d]			
	Shift Work[c]	-.606	.370	-.226	.104[d]			
	ASCS Private	-.054	.129	-.054	.653[d]			
	Independent Var.							
	SWB	.372	.122	.383	.004[d]	.126	.291	.004[d]

Notes. N = 61. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. PWB = Psychological well-being. SWB = Subjective well-being. Var. = Variable.

For H5b a model was calculated including ASCS at work and all control variables. The model explained 16.5% (corrected $R^2 = .072$) of the variance of patient safety. However, this model was not significant (F (6,54) = 1.780; p = .121). Additionally, ASCS at work displayed no significant association with patient safety as it was expected (β = .016; p = .931). The only significant relationship with patient safety within this model was overtime (β = -.318, p = .034). This leads to the rejection of H5b.

Table 9 | Hierarchical regression analyses for hypothesis 5e

		H5e: Patient Safety						
Step	Predictor	*B*	*SE*	β	*p*	ΔR^2	R^2	*p*
1	*Control Variables*	-	-	-	-	-	.165	.070
2e	*Control Variables*							
	Age	-.008	.012	-.089	.507[d]			
	Gender[a]	.105	.715	.029	.880[d]			
	Overtime[b]	-.031	.016	-.289	.031[d]			
	Shift Work[c]	-.510	.392	-.190	.198[d]			
	ASCS Private	.034	.133	.034	.785[d]			
	Independent Var.							
	Work Engagement	.205	.135	.208	.139[d]	.040	.205	.045[d]

Notes. N = 61. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. Var. = Variable.

Referring to H5c, the model consisting out of PWB and all control variables explained 23.7% (corrected $R^2 = .153$) of the variance of patient safety (F (6,54) = 2.803; p = .019). PWB incrementally explained 7.3%, while showing a positive association with patient safety (β = .300; p = .026).

Additionally, also overtime displayed a statistically significant connection to patient safety (β = -.282; *p* = .041). This leads to the confirmation of H5c.

Looking at H5d, the calculated model including SWB and all control variables was able to explain 29.1% (corrected $R^2 = .212$) of the variance of patient safety (*F* (6,54) = 3.688; *p* = .004). Incrementally, SWB explained 12.6% and resulted in a positive association with patient safety (β = .383; *p* = .004). In addition, overtime showed a positive relationship with patient safety (β = -.241; *p* = .052). This leads to the confirmation of H5d.

Regarding H5e, the model including work engagement and all control variables explained 20.5% (corrected $R^2 = .117$) of the variance of patient safety (*F* (6,54) = 2.326; *p* = .045). However, the incremental contribution of work engagement was 4.0% with no significant relationship between these two variables (β = .208; *p* = .139). Even though the bivariate correlation of work engagement with patient safety showed a positive association, this could not persist including all control variables. Only overtime showed a significant relationship with patient safety within this model (β = -.289; *p* = .031). This leads to the rejection of H5e.

Mediation Analyses of Socio-Moral Climate via Applicability of Character Strengths at Work on Work Engagement and Well-Being

In hypothesis 4 it is assumed that the effect of SMC on work engagement and well-being is mediated by the applicability of character strengths at work. For this hypothesis, three mediation models were calculated. Including all control variables, SMC as independent variable, ASCS at work as the mediator and as outcome variable SWB, PWB or work engagement, respectively. However, to guarantee a more direct replication of the mediation model calculated in Höge et al. (2020), all three mediation models were calculated a second time without including the control variables, as these were not integrated in their study. Even if not all paths were significant, all mediation analyses were carried out fully as Zhao et al. (2010) argue that a significant indirect effect a*b is the only precondition necessary to presume a mediation. The results of these analyses are documented in tables 10.1 to 12.2.

Table 10.1 | Mediation analysis for hypothesis 4 regarding SWB including control variables

			Outcome: SWB			
Step	Variables	Path	β	*SE*	*p*	95% CI
1 (X → Y)	SMC → SWB	c	.40	.14	.01	[.12;.68]
2 (X → M)	SMC → ASCS_W	a	.20	.12	.09	[-.03;.44]
3 (X + M → Y)	ASCS_W → SWB	b	.04	.18	.81	[-.31;.40]
	SMC → SWB	c'	.39	.16	.02	[.07;.71]
Indirect Effect (X → M → Y)	SMC → ASCS_W → SWB	a*b	.01	.04		[-.08;.09]

Notes. N = 66. SMC = Socio-moral climate. SWB = Subjective well-being. ASCS_W = applicability of character strengths at work. c = total effect. a,b = indirect effect. c' = direct effect. β = standardized regression coefficient. p = probability level (two-tailed). 95% CI bootstrapping confidence interval.

Table 10.2 | Mediation analysis for hypothesis 4 regarding SWB excluding control variables

			Outcome: SWB			
Step	Variables	Path	β	*SE*	*p*	95% CI
1 (X → Y)	SMC → SWB	c	.41	.14	< .001	[.14;.69]
2 (X → M)	SMC → ASCS_W	a	.31	.11	.01	[.09;.54]
3 (X + M → Y)	ASCS_W → SWB	b	.17	.14	.22	[-.11;.45]
	SMC → SWB	c'	.36	.15	.02	[.06;.64]
Indirect Effect (X → M → Y)	SMC → ASCS_W → SWB	a*b	.05	.05		[-.03;.16]

Notes. N = 66. SMC = Socio-moral climate. SWB = Subjective well-being. ASCS_W = applicability of character strengths at work. c = total effect. a,b = indirect effect. c' = direct effect. β = standardized regression coefficient. p = probability level (two-tailed). 95% CI bootstrapping confidence interval.

First, looking at the mediation model including SWB as outcome variable, the total effect displayed was significant (β = .40; *p* = .01). Including both variables, SMC and ASCS at work, the direct effect is still significant and about the same effect size (β = .39; *p* = .02), while the effect of

SMC on ASCS at work was marginally significant (β = .20; *p* = .09) and the effect of ASCS at work on SWB was not significant (β = .04; *p* = .81), neither was the effect of SMC on SWB mediated by ASCS at work (β = .01; 95% CI[-.08;.09]). Therefore, hypothesis 4 has to be rejected.
Excluding all control variables, the total effect of SMC on SWB was significant (β = .41; p < .001). The direct effect when including both variables was smaller but still significant (β = .36; p = .02) and the indirect effect of SMC on SWB mediated by ASCS at work was not significant (β = .05; 95% CI[-.03;.16]).

Table 11.1 | Mediation analysis for hypothesis 4 regarding PWB including control variables

			Outcome: PWB			
Step	Variables	Path	β	*SE*	*p*	95% CI
1 (X → Y)	SMC → PWB	c	.34	.13	.01	[.08;.59]
2 (X → M)	SMC → ASCS_W	a	.20	.12	.09	[-.03;.44]
3 (X + M → Y)	ASCS_W → PWB	b	.36	.17	.05	[.01;.71]
	SMC → PWB	c'	.27	.13	.04	[.01;.53]
Indirect Effect (X → M → Y)	SMC → ASCS_W → PWB	a*b	.07	.05		[-.01;.17]

Notes. N = 66. SMC = Socio-moral climate. PWB = Psychological well-being. ASCS_W = applicability of character strengths at work. c = total effect. a,b = indirect effect. c' = direct effect. β = standardized regression coefficient. p = probability level (two-tailed). 95% CI bootstrapping confidence interval.

Second, regarding the mediation model with PWB as outcome variable, the total effect of SMC on PWB was significant (β = .34; *p* = .01) as well as the direct effect when including both variables (β = .27; *p* = .04). However, the indirect effect of SMC on PWB mediated by ASCS at work was not significant (β = .07; 95% CI[-.01;.17]), leading to the conclusion of rejecting H4.
Excluding all control variables, the model resulted in a significant total effect of SMC on PWB (β = .42, *p* < .001). When including both variables, the direct effect of SMC on PWB was smaller than the total effect and still significant (β = .29; *p* = .02). The indirect effect of SMC on PWB mediated by ASCS at work was significant (β = .12; 95% CI[.03;.24]).

Table 11.2 | Mediation analysis for hypothesis 4 regarding PWB excluding control variables

			Outcome: PWB			
Step	Variables	Path	β	*SE*	*p*	95% CI
1 (X → Y)	SMC → PWB	c	.42	.14	< .001	[.14;.69]
2 (X → M)	SMC → ASCS_W	a	.31	.11	.01	[.09;.54]
3 (X + M → Y)	ASCS_W → PWB	b	.40	.10	< .001	[.19;.61]
	SMC → PWB	c'	.29	.12	.02	[.04;.54]
Indirect Effect (X → M → Y)	SMC → ASCS_W → PWB	a*b	.12	.05		[.03;.24]

Notes. N = 66. SMC = Socio-moral climate. PWB = Psychological well-being. ASCS_W = applicability of character strengths at work. c = total effect. a,b = indirect effect. c' = direct effect. β = standardized regression coefficient. p = probability level (two-tailed). 95% CI bootstrapping confidence interval.

Last, a mediation model was calculated with work engagement as outcome variable. This model presented a significant total effect of SMC on work engagement (β = .60; $p < .001$). The direct effect including both variables was smaller and significant (β = .53; $p < .001$). The indirect effect of SMC on work engagement mediated by ASCS at work was not significant (β = .07; 95% CI[-.00;.21]). This leads to the rejection of H4, meaning that there is a direct effect of SMC on work engagement but not mediated by ASCS at work when all control variables are included.

Excluding all control variables, the total effect of SMC on work engagement was significant (β = .61; $p < .001$). The direct effect of SMC on work engagement when including both variables was smaller and also significant (β = .53; $p <$. .001). The indirect effect mediated by ASCS at work was significant indicating that the relationship of SMC and work engagement is mediated by ASCS at work (β = .08; 95% CI[.01;.18]).

As the mediation model including PWB and work engagement, respectively, as outcome variable showed a significant mediation via ASCS at work, the control variables were analysed in more detail for these two models. For both mediation model in the first step, measuring the association of SMC with ASCS at work, additionally to SMC, ASCS in private had a significant relationship to

Table 12.1 | Mediation analysis for H4 regarding work engagement including control variables

			Outcome: Work Engagement			
Step	Variables	Path	β	*SE*	*p*	95% CI
1 (X → Y)	SMC → Work Engagement	c	.60	.10	< .001	[.39;.81]
2 (X → M)	SMC → ASCS_W	a	.20	.12	.09	[-.03;.44]
3 (X + M → Y)	ASCS_W → Work Engagement	b	.35	.15	.02	[.05;.65]
	SMC → Work Engagement	c'	.53	.12	< .001	[.29;.77]
Indirect Effect (X → M → Y)	SMC → ASCS_W → Work Engagement	a*b	.07	.06		[-.00;.21]

Notes. N = 66. H = hypothesis. SMC = Socio-moral climate. ASCS_W = applicability of character strengths at work. c = total effect. a,b = indirect effect. c' = direct effect. β = standardized regression coefficient. p = probability level (two-tailed). 95% CI bootstrapping confidence interval.

Table 12.2 | Mediation analysis for H4 regarding work engagement excluding control variables

			Outcome: Work Engagement*			
Step	Variables	Path	β	*SE*	*p*	95% CI
1 (X → Y)	SMC → Work Engagement	c	.61	.10	< .001	[.41;.80]
2 (X → M)	SMC → ASCS_W	a	.31	.11	.01	[.09;.54]
3 (X + M → Y)	ASCS_W → Work Engagement	b	.25	.10	.02	[.05;.46]
	SMC → Work Engagement	c'	.53	.10	< .001	[.33;.73]
Indirect Effect (X → M → Y)	SMC → ASCS_W → Work Engagement	a*b	.08	.04		[.01;.18]

Notes. N = 66. H = hypothesis. SMC = Socio-moral climate. ASCS_W = applicability of character strengths at work. c = total effect. a,b = indirect effect. c' = direct effect. β = standardized regression coefficient. p = probability level (two-tailed). 95% CI bootstrapping confidence interval.

ASCS at work (in both models: β = .58; $p < .001$) as it was also displayed within the intercorrelation matrix (r = .61; p < .001). However, neither in the model including PWB (β = .06; $p = .75$) nor in the one including work engagement (β = -.17; $p = .35$) as outcome variable was a significant

connection of ASCS in private to the specific dependent variable. Meaning that this control variable is mainly influencing the first indirect path (a) to ASCS at work.

Qualitative Part

For evaluating the qualitative data, the qualitative content analysis according to Mayring (2008) was applied, which was supplemented by the axial coding of the grounded theory (Boehm, 1994). The two transcripts of the interviews carried out were used as material for the evaluation (see appendix B). The analysis is aiming at generating direct experience reports and opinions on the relevant variables from the work environment of a nurse in order to better and more deeply understand the influencing factors related to the hypotheses but to also explore problems and potential chances of the work situation of a nurse.

Qualitative Content Analysis According to Mayring

The qualitative content analysis according to Mayring is a sociological method aiming to analyze fixed, mostly written down, communication. Since the procedure is systematic, rule-guided and theory-guided, the intersubjective comprehensibility can be considered as quite high (Mayring, 2008, p. 12). For the present analysis, the general content-analytical process model (see Mayring, 2008, p. 54) was followed, whereby it should be noted that a different order of the individual steps was used for better clarity.

There are three basis forms of qualitative content analysis according to Mayring: *summary*, *explication* and *structuring*. First, *summary* serves to reduce and abstract the material in order to create an overview. Second, *explication* wants to provide more understanding for unclear text passages through additional material and, last, *structuring* aims to find order and a structure within the material. These three basic forms are by no means to be seen as independent separate steps but as intertwined constructs complementing each other. For the analysis of the present interviews, mainly summarizing and structuring techniques were used (Mayring, 2008, p. 58).

Initially, analysing units were defined, namely coding unit, context unit and evaluation unit. Coding unit is the smallest component that can fall under a category. The coding unit is defined as a word. Context unit describes the largest component that can fall under a category, and is defined

here as the totality of paragraphs that can be assigned to one question of the interviewer. Evaluation unit relates to the order in which the transcripts are evaluated. This is mainly done sequentially within the transcript with the option of jumps within the text when it is thematically necessary, as, for example, the interviewee later adds something to an earlier question (Mayring, 2008, p. 53).

The next step was to create a system of categories. The first step corresponds to the method of summarizing qualitative content analysis and is a rather inductive procedure having the text material as starting point and forming categories on this basis. All relevant passages were highlighted, while all embellishments, digressions or repetitions were excluded from further analysis. No paraphrasing and generalization were made here, as clarity remains due to the small number of interviews. In a first reduction, passages of the same meaning and with no essential additional content are removed and in a second reduction, similar passages and statements are bundled. This creates a preliminary system of categories (Mayring, 2008, p. 59-62; Mayring, 2008, p. 74-76). The second step is a more deductive procedure and can be considered to structuring qualitative content analysis. Using the variables utilized within the quantitative part (e.g. work engagement, SMC or well-being), categories were developed and applied to the material and compared with the inductively created categories. This was done in a circular manner, in which inductive categories were formed, which in turn were deductively compared with the theory-based categories, being further adapted and again compared with the material. This was carried out until all relevant text passages were assigned to a category (Mayring, 2008, p. 74-76; Mayring, 2008, p. 82-83). In order to be able to clearly assign each text passage, each sub-category was provided with an anchor example as well as with a definition and associated coding rules as recommended by Haußer et al. (1985, quoted by Mayring, 2008, p. 83); a complete list can be found within the appendix (B). Refer to table 13 for an overview of all categories built.

Axial Coding

In the interest of exploring the connections as well as possible causes and effects between the different categories, the procedure of axial coding of the grounded theory was chosen for further evaluation. The grounded theory is a method of forming area-specific or subject-specific theories

Categories	**Subcategories**
1. Stressors	Shortage of staff
	Inefficient staff
	Overtime
	Shift work
	Perception of lack of time
	High workload and problematic way of working
	Emotional burden
2. Consequences of stress and mis-matching demands	Conflict between expectations and reality
	Lack of sleep
	Mood and well-being of a nurse
	Work engagement and motivation
	Thoroughness of work
	Emotional encounter of patients
3. (Work-related) Resources	Socio-moral Climate
	Political and social appreciation and support
4. Well-Being	Mood and well-being of nurses
	Well-being of patients
	Recovery of patients
5. Work Engagement	High work engagement and motivation
	Little work engagement and motivation
6. Socio-moral Climate	Open confrontation with conflicts
	Respect
	Open communication and participative cooperation
	Allocation of responsibility
7. Character Strengths	Love
	Kindness
	Self-Regulation
	Honesty

	Social Intelligence
	Teamwork
	Humor
	Prudence
8. Factors influencing ASCS	Socio-moral Climate
	Leader
	Personality
	Perception of lack of time
9. Patient safety and quality of care	Patient safety
	Safety of a nurse
	Well-being of a patient
	Recovery of a patient
10. Factors influencing patient safety	Perception of lack of time
	Shortage of staff
	High workload and problematic way of working
	Lack of sleep
	Mood and well-being of a nurse
	Work engagement and motivation
	Socio-moral climate
	Equipment and monetary resources
	Emotional encounter of the patient
	Thoroughness of working
	Non-compliant patient behavior
11. Possible Solutions	Technical improvement of the equipment
	Artificial intelligence
	Supervisor support

Table 13 | All categories with their respective subcategories resulting from the qualitative content analysis according to Mayring (2008).

by relating different concepts with the aim of describing and explaining social phenomena (Glaser & Strauss, 2005, p. 12-16).

Axial coding in particular is a systematic analysis of the data material with the aim of finding relationships between previously built categories. These relationships can be formal in nature or based on the content and can, therefore, among other things, refer to motivations, causes and effects or means and purpose relationships. The associations found are continuously checked on the basis of the data and adjusted if necessary. Within this framework, new hypotheses and theories can arise, which in turn are checked using the data. This results in a circular procedure, which is quite common in qualitative research (Boehm, 1994, p. 130-131).

Specifically, further analyses will focus on Strauss (1987, p. 64) coding paradigm. This paradigm assumes that different causes lead to the occurrence of a specific phenomenon further leading to different consequences. The specific phenomenon is always located within certain context conditions and there are several strategies and tactics to deal with it, which can be both social and individual in nature. According to the previously established hypotheses, mainly potential causal factors and consequences of a phenomenon are evaluated and explored with mentioning potential influencing context factors when being mentioned by the interviewees (Strauss, 1987, p. 64).

Besides the previously defined hypotheses, the inductive manner of the process of building categories revealed additionally exploratory subjects, namely stressors of a nurse, character strengths important for the well-being of a nurse, factors influencing the applicability of character strengths or patient safety and possible solutions to create more positive working conditions for nurses. In the following, the evaluation of these exploratory subjects is presented together with the results of the evaluation of the hypotheses.

Evaluation of Hypotheses

In the following, the proposed hypotheses for the quantitative part are additionally evaluated using the transcripts of the interviews. Since no separation into psychological and subjective well-being could be made based on the interviews only the term of well-being is used. For the qualitative analysis of the hypotheses, the following categories were formed: *socio-moral climate*,

well-being, *work engagement and motivation* and *patient safety and quality of care*. Since the applicability of character strengths was only mentioned explicitly in the questions of the interviewer, the hypotheses could be checked, but not a separate category could be created. The present constructs, such as the socio-moral climate or the different character strengths, were not presented to the interviewed persons in order to guarantee an open and free conversation atmosphere with the possibility to introduce new aspects.

Socio-moral climate, referring to the extent of a socio-moral climate in the workplace, was further divided into four subcategories, which also describe four out of five facets of the socio-moral climate used by Verdorfer et al. (2015): *open confrontation with conflicts*: "And here you clarify everything immediately, you can also address something, if something didn't go well or you made a mistake." (P1, 98-99, translated into English), *respect,* meaning an appreciative and supportive interaction among colleagues (P2, 554-556; P1, 95-96), *open communication and participative cooperation,* meaning to be able to take part in decision-making processes and criticize general regulations or norms at work: "And that you can get involved within the team and be integrated by the time. Simply that everyone can participate, everyone can address everything, and everyone supports each other." (P1, 378-380, translated into English), and *allocation of responsibility,* referring to the assignment of tasks according to the competencies of an employee:

> *And the physicians really trust in us that we can do a lot of things, for example taking blood samples for CRP, dealing with medication at one's own discretion, preparing patients for the operations independently (… -3s). Yes, I just have the feeling that they trust in me and my competencies." (P1, 78-82, translated into English)*

The fifth category of organizational concern was not introduced by the interviewees.

For *well-being,* which refers to the general mood within the team and of the interviewee in regard of work as well as the mental and physical well-being of patients, the following subcategories were formed: *mood and well-being of nurses*:

> *Yes, the whole atmosphere is much better there, too. So, all in all, I think you notice it. You can really notice it in general, and I also recognize it by myself. I am really happy to work there now. It is really good for me and I have a lot more fun at work again […] (P1, 108-111, translated into English)*

well-being of patients, regarding the emotional condition and mood of a patient (P1, 51-55), and *recovery of patients,* looking at the speed of recovery and health status of a patient (P1, 16-18). Since the analysis of the hypotheses refers to the working context of a nurse, the focus will be on the subcategory of *mood and well-being of nurses*.

Within the category of *work engagement and motivation,* there are two subcategories, namely *high work engagement and motivation*, meaning being highly motivated and engaged at work with also doing some extra work voluntarily (P1, 107-108) and *little work engagement and motivation*, meaning being little motivated and engaged at work, thinking about leaving the workplace and just doing what is necessary (P1, 400-403).

Patient safety and quality of care refers to the likelihood of errors within the nursing context and to the extent of the safety of patients as well as nurses. This includes *patient safety* referring specifically to the likelihood of errors reducing the safety of a patient's health (P2, 505-507), *well-being of a patient*, meaning the emotional condition and mood of a patient (P1, 51-55), and speed of *recovery of a patient* (P1, 16-18). However, also the safety of a nurse is mentioned as a subcategory and refers to the likelihood of ways of working and behavior reducing the safety of the health of a nurse (P1, 303-307). As the following analysis refers to the proposed hypotheses, the focus within this category is on *patient safety*. A more detailed analysis of the other factors within this category as well as factors influencing *patient safety and quality of care* are explained in more detail below.

Looking at the first block of hypotheses (1a-d), all hypotheses can be confirmed on the basis of the interview material, since the socio-moral climate was positively associated with the applicability of character strengths at work (P2, 343-361; P1, 209-212) as well as with *well-being of a nurse*:

> *[…] but the team there and the cooperation with the doctors is so appreciative! Even the students are allowed to have a say and participate in decisions. During the doctor's visit, the chief doctor comes in and, first of all, the nurses are asked for their opinion on the patient, nothing is simply presumed by the doctors, but you always know that the nurses are closest and therefore (... - 1s) yes know best how things are going with the patient. And the physicians really trust in us that we can do a lot of things, for example taking blood samples for CRP, dealing with medication at one's own discretion, preparing patients for the operations*

> *independently (… - 3s). Yes, I just have the feeling that they trust in me and my competencies and I have the feeling that the doctors listen to you, know that you have a clue and appreciate that. And there, I also have the feeling that the nurses feel comfortable, come to work in a good mood. (P1, 72-83, translated into English)*

and work engagement of a nurse (P1, 86-107). This is in line with the results of the quantitative data for well-being and work engagement, but not for the results for ASCS indicating no relation to SMC when including all control variables. With a closer look, especially the subcategory of *respect* and *open communication and participative cooperation* was mentioned most often in regard of ASCS (e.g. RE: P1, 210-212; CC: P2, 343-361) and work engagement (e.g. RE: P2, 551-558; CC: P2, 95-105), meaning especially the factors of a supportive and appreciative team as well as being able to participate in daily decision-making are connected to a higher applicability of character strengths as well as higher work engagement according to both interviewees. For well-being, *respect* was the subcategory emphasized the most by both interviewees (e.g. P2, 88-90), meaning especially the support, appreciation and help provided within the team seems to be most important for well-being according to both interviewees.

Regarding hypotheses 2 and 3a-c, a positive connection between the applicability of character strengths at work and work engagement and well-being, can also be confirmed, in line with the previous quantitative results:

> So, I think those who can apply all of them well, they feel more comfortable and are also happier and certainly more motivated for work. I mean, that's clear, you remain, as I said earlier, true to yourself and do what you are good at and because you are able to do it well, it is also fun and you are motivated to do more of it. I think these *[people] have more fun at work* and that's why they're more motivated *[…] (P1, 185-190, translated into English)*

Interestingly, in addition to well-being in the sense of emotions and feelings, P2 also mentioned as consequence of applying one's character strengths that there would be "less stomach-ache, fewer sick reports, *[…] [and]* fewer gaps in the roster" (P2, 454-455, translated into English), meaning that there are not only positive connections to mental well-being, but also possibly to physical health and well-being. However, it should be noted that this statement was not only related to the applicability of character strengths, but also to hypothetical pauses between the

prevailing and persistent lack of time (P2, 455-463). This suggests that applying character strengths can have a positive effect on mental and physical well-being, but that there are always other factors that come into play.

Regarding hypothesis 4 of ASCS as a potential mediator between SMC and well-being and work engagement, no statements could be made due to a lack of material. The interviewees themselves never mentioned ASCS, but always only referred to the questions of the interviewer asking for possible prerequisites and consequences of ASCS meaning the interviewees addressed the connections separately, as shown in hypothesis 1-3, but never in an interdependent manner, therefore, not providing enough material to confirm the mediation.

Looking at hypothesis 5, there was a positive connection found to SMC. The subcategory named most often in this regard was *respect*: “If you help each other and you support each other, fewer mistakes happen, you help each other, teamwork.” (P2, 551-552, translated into English) meaning within a team highly supporting each other and caring for each other errors are less likely. Therefore, hypotheses 5a can also be confirmed within the qualitative data. ASCS was neither mentioned by P1 nor P2 in terms of patient safety and, therefore, hypothesis 5b is rejected which is in line with the results of the quantitative data. However, patient safety was positively related to well-being and work engagement: “When you are in a better mood, you treat the patient very differently. And then you are much more motivated and pay much more attention to safety (... -2s) for yourself and the patient.” (P2, 556-559). In consequence, hypotheses 5c-e can be confirmed, partly in agreement with the results of the evaluation of the quantitative data. Only hypothesis 5e connecting patient safety with work engagement, could be confirmed within the qualitative data but not within the quantitative data.

In summary, the analysis of the qualitative data resulted in similar findings as the quantitative analysis with almost all hypotheses being answered in the same direction; only the mediation hypothesized in hypothesis 4 could not be answered with the present interviews.

Exploratory Analysis

The following analyses are exploratory in nature based on the material from the present interviews and are no longer based on hypotheses. Starting with various stressors in the working

context of a nurse as well as their interrelationships. In addition, consequences of stress and mismatching demands are illustrated as well as (work-related) resources. Furthermore, factors named by the interviewees relevant for the applicability of character strengths are presented as well as character strengths considered as important for the well-being of a nurse. In addition, factors influencing patient safety and the quality of care and their connections between each other are displayed. Finally, possible solutions for the stressors as well as the precarious working situation mentioned by the two interviewees are outlined.

The first three categories, namely stressors, consequences of stress and mismatching demands as well as (work-related) resources, strongly influence each other. According to the interviewees, stressors have various detrimental consequences on mental and physical health such as lack of sleep or poor well-being. Resources, however, can have a buffering function on these negative effects and are also directly positively influencing these factors. The interrelationships are described in more detail within the respective categories. For a graphical illustration of these relations refer to figure 3.

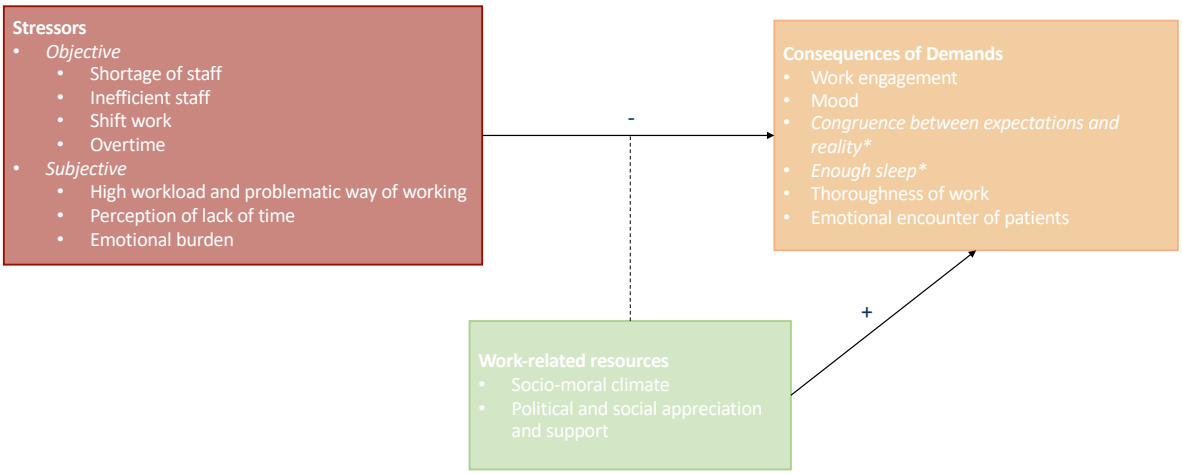

Figure 3 | Interconnections between stressors, consequences of demands and work-related resources. + = positive association. - = negative association. * = variable name is reversed for better understanding and refers to *conflict between expectations and reality* and *lack of sleep,* respectively.

Stressors

Regarding stressors in the working context of a nurse, seven subcategories were formed. This category was most frequently addressed by both interviewees with covering almost a fifth of the speaking time (20% for P1 and 21% for P2, respectively). First, *shortage of staff* (P2, 466-471), meaning there is not enough staff to fully occupy all shifts and therefore the same amount of work is done with fewer staff. In addition, few younger people want to do the nursing training as the job is rather unattractive due to lots of shift work and very little social and financial recognition leading to fewer staff in the future as well (P2, 59-73). Second, P2 stated *inefficient staff* (P2, 48-51) as another stressor, meaning there is staff which is, on the one hand, not suitable for the nursing profession, because they cannot stand to see so much suffering meaning they tend to quit work early and are not able to join all working tasks (P2, 261-266) or do not have sufficient qualification because they only barely passed their training (P2, 48-52), or, on the other hand, are not able to speak German sufficiently meaning they are not able to understand and communicate everything (P2, 33-45). Third, *overtime* (P2, 367-368) and, fourth, *shift work* (60-63) were mentioned. Moreover, *perception of lack of time* (P2, 464-465*)* was mentioned and *high workload and problematic way of working* (P2, 537-544) meaning, as a nurse, there is a lot of work to do with a lot of interruptions often leading into multitasking. In addition, *emotional burden* (P2, 166-170) was named as being confronted with suffering and severe illness on a daily basis:

> *And then there is this emotional, unpleasant work with patients, all the misery: someone dies, a leg is broken and has to be amputated. There are so many bad fates you should listen to, show compassion, understanding, but you must not get involved, otherwise you will perish. (P2, 166-170, translated into English)*

These mentioned stressors can be further categorized in objective and subjective stressors. Objective means being objectively measurable e.g. in hours and subjective refers to the individual perception of an aspect as more or less stressful (see Lazarus & Folkman, 1984). This additional classification helps to understand the interplay between objectively precarious working conditions and the subjective perception of some aspects as stressful by an individual with further getting a deeper knowledge about the effects of different stressors and the influence of resources. Therefore, the first four stressors, namely *shortage of staff*, *inefficient staff*, *overtime*

and *shift work* can be categorized as objective stressors, while the last three stressors, namely *perception of lack of time*, *high workload and problematic way of working* and *emotional burden* can be classified as subjective stressors.

Furthermore, these factors are not independent but highly intertwined and influencing each other. As, for example, within the nursing context, there is a very high workload that requires a lot of multitasking and has a lot of interruptions, however, there is not enough staff, which together leads to the perception of not having enough time:

> *[…] we had 38 beds and there were quite a lot who need a lot of care […] and that takes time (... – 1s) and, mostly, there were two of us during the day (... – 2s) and maybe we had some help from a student, (… - 2s) but actually there were two of us. (P1, 5-8, translated into English)*

In addition, due to the lack of staff, new staff is recruited quickly without paying attention to their qualifications (P2, 52-53). This leads to more interruptions and increasing lack of time because you have to help them:

> *[…] but imagine you have staff not being able to speak German language. That means when I read through the findings I know what's going on. She reads it three times while I just need to do so once and that takes time and then she comes anyway and asks what's written in there. So, again, you take your time because you want her to learn something and explain it. I'll do that in two minutes, and with her I'll need ten minutes. So that, again, takes time. (P2, 474-479, translated into English)*

In summary, four objective and three subjective stressors were mentioned which are all influencing each other and, therefore being different but highly interdependent constructs.

Consequences of Stress and Mismatching Demands

In addition to stressors at work, the interviewees addressed six consequences resulting from these stressors and mismatching demands, namely *conflict between expectations and reality, lack of sleep, mood and well-being of a nurse, work engagement and motivation, thoroughness of work,* and *emotional encounter of patients.* Especially for the subcategories of *conflict between expectations and reality* and *lack of sleep,* it is important to mention that these constructs are consequences of the before mentioned stressors but can also cause stress itself by creating an inner conflict and physical exhaustion possibly leading to a downward spiral.

First, an increasing *conflict between expectations and reality* (P1, 38-41) was pointed out, meaning with being a nurse you have certain expectations how you want to do your work, for example, properly care for a patient by taking time to wash them or take them out for a short walk. However, due to lack of time and staff, there is no possibility but to hurry up everything and do not have the time to do your work as you would expect it from yourself:

> *And as a nurse […], I know that I should show interest and really, really, take care [of the patients] […]. I know that, but I just can't. And that's a problem. I find that so stressful, too. That I am just not able to do my job properly. I'm supposed to look after people, nurse them back to health, and I don't think that's what we do here anymore. We only do the bare minimum, so that the process is running and that the patients (... - 3s), phew, yes, that sounds hard now, but sometimes just survive. (P1, 56-62, translated into English)*

Second, *lack of sleep* was pointed out, as with overtime and shift work often there is not enough time to get enough sleep (P1, 355-358) and, additionally, with all mentioned job strain and emotional burden on a daily basis, some find it hard to fall asleep:

> *And then you sit there and still have to document things over time, even though you only have eight and a half hours between the shifts. When should you sleep? You also need a little time to relax at home. And then you're really exhausted in the next shift. (P1, 328-331, translated into English)*

Third, the *mood and well-being of a nurse* as well as *work engagement and motivation* suffer from too much workload and stress:

> […] we had 38 beds and there are quite a few who need a lot of care […] (... - 2s) and that takes time (... - 1s) and […] there were two of us. And that has affected the mood (… - 1s), most nurses did not like coming to work, more than half talked about the fact that they no longer want anymore and would like to work something else. (P1, 5-10, translated into English)

In consequence of being in a rush all the time, the *thoroughness of work* is lowered because it is more important to do everything very fast than in a correct and conscious way (P1, 45-48). Additionally, the *emotional encounter of patients* is not in a friendly and caring manner anymore but in a highly stressed and tensed way (P1, 48-50). Therefore, also the performance of work is suffering in the end. In summary, stressors can have several negative consequences referring to mental and physical health as well as performance at work.

(Work-Related) Resources

In addition to this combination of stressors and consequences of stress and mismatching demands, the interviewees mentioned two resources which are positively influencing the consequences of stress and, further, have a buffering effect for the negative effects of stress on mental and physical health according to both interviewees. Both named resources refer to social support. First, the interviewees addressed a *socio-moral climate* at work as a resource mainly because of being appreciated and heard (P1, 81-84; P2, 652-662) and, therefore, refers to social support at work within the working team. Second, in addition to social support at work, *political and social appreciation and support* (P1, 344-350) was named. This refers to monetary and governmental support as well as social status of the profession, meaning it is partly related to work, e.g. financial recognition, but can also be found outside of work, e.g. social status of a nurse. Unfortunately, too little financial recognition is given (P2, 63-65) and, additionally, the nursing profession is neither socially very highly regarded (P2, 65-67) nor supported by the government (P2, 67-69).

To put it in a nutshell, the interviewees mentioned several stressors within the working context of a nurse. These stressors were connected to different negative consequences such as reduced well-being or lack of sleep. Resources such as a socio-moral climate or political and social appreciation and support can buffer these negative consequences. However, these resources are often lacking within the nursing context making the stressful working conditions even more frustrating (P1, 344-350).

Factors Influencing the Applicability of Character Strengths

Four factors were addressed by the interviewees that influence the applicability of character strengths of nurses in their work environment in their opinion. First, both named factors that can be assigned to *socio-moral climate* with *open communication and participative cooperation* (P2, 343-345) and *respect* (P1, 209-212) being particularly emphasized. Second, P2 highlighted the importance of the *supervisor*, referring to the leadership style applied as well as to how a leader reacts to employees, in this context:

> *The supervisor plays a major role. To what extent he introduces you to your work and to what extent he recognizes what your strengths are, he breaks through your reserve. Where he gives you the possibility to show your abilities and to what extent he directs you in a certain direction. (P2, 226-229, translated into English)*

In addition, it was mentioned that "[…] the leader has to briefly analyze each individual […], how do I deal with them, so that is also very individual. [He should] pick up everyone where he is and everyone is somewhere else." (P2, 106-108, translated into English), which indicates the importance of a leadership style that includes responding to individual needs of every employee.

Third, P1 addressed *personality* as a factor:

> *I, uh, think some people are able to apply their strengths more easily, just in terms of their personality (… - 3s), how do you say that? (… - 1s) Yes, doers. These are doers. They are just very active people and they always make the best out of their situation and, I think, they are also the ones who somehow manage to apply their strengths more easily. (P1, 220-225, translated into English)*

For increasing the applicability of character strengths, P1 emphasized an active personality with shaping one's lives according to one's wishes and goals and, therefore, always remaining able to (re)act. This is not just evident within the working context but also in private life (P1, 248-253).

Last, as a factor decreasing the applicability of character strengths at work the *perception of lack of time* was pointed out:

> *But I also think that you often are not able to apply your strengths at all because you are under such time pressure due to the lack of staff and the large number of patients. I think you are often so stressed that you are in such a tunnel vision, you are no longer able to be empathetic or really care or be humorous, you are just stressed and just try to finish your work somehow and nothing more. (P1, 213-218, translated into English)*

Character Strengths Important for Well-Being

Another inductively found category represents character strengths (see Peterson & Seligman, 2004) that are important for the well-being of a nurse within the nursing working context. These were evaluated using frequency analyses on the basis of the previously defined coding units and

context units. For this purpose, it was counted how often a respective character strength was mentioned. A visualization of this analysis can be found in table 14.

Character Strengths	*P1*	*P2*
Self-Regulation	5	4
Empathy	2	6
Prudence	1	5
Honesty	3	1
Kindness	2	1
Social Intelligence	1	2
Teamwork	-	2
Humor	1	-

Table 14 | Frequency analysis of number of mentioned character strengths (see Peterson & Seligman, 2004) important for well-being within the nursing context.

In descending order of summarized frequency, *self-regulation* (P1, 151-154; P2, 151-153), *love* (P1, 117-122; P2, 127), *prudence* (P1, 143-145; P2, 402-404), *honesty* (P1, 125-126; P2, 191-193), *kindness* (P1, 133-135; P2, 136) and *social intelligence* (P1, 150-151; P2, 128-129) were addressed by both interviewees. *Teamwork* was only mentioned by P2 (P2, 420-423) and *humor* only by P1 (P1, 157-161), respectively. P1 mentioned *self-regulation* most often, followed by *honesty*, while P2 emphasized *love* most often, followed by *prudence* and *self-regulation*. Interestingly, the character strengths *self-regulation, honesty* and *love* in particular were related to one another in the sense of that it is important to be able to regulate your own emotions and also communicate emotions and borders in a genuine way to be able to get involved in a caring relationship:

> *So, you should be able to be there for someone else, empathize with their situation and should be able to build a certain bond, but still be able to only stay in an "as if" perspective and also being able to draw boundaries so that you don't get too involved. You have to be able to set yourself apart, that's also important. So, I think you just have to know yourself well and (... - 2s), yes, I think that's important, being able to be honest with yourself, know yourself, be able to stand up for yourself, yes, somehow, also remain loyal to yourself, also in the sense of 'taking care of yourself'. (... - 4s) So, you understand, I think, as a nurse, you are always with other people and always take care of others, of patients. I think you just have to be able to*

take care of yourself. And being able to regulate (... - 2s) your emotions. (P1, 119-130, translated into English)

Factors Influencing Patient Safety

In the following, the categories of *patient safety and quality of care* and *factors influencing patient safety and quality of care,* are described.

Since the construct of patient safety is a very complex one, the approach was to address the topic as openly and holistically as possible. Therefore, the category of *patient safety and quality of care* encompasses both sides: *patient safety*, *well-being of patients* and *recovery of patients* as well as *safety of the nurse*. *Patient safety*, on the one hand, relates to the likelihood of occurring errors that could endanger the safety and health of the patient: "Or when moving the patient from bed to the wheelchair, she was careless and did not use the brakes and he slips away" (P2, 505-507, translated into English). In addition, both *well-being of patients*, meaning how a patient feels during hospital stay (P1, 51-55), and *recovery of patients*, which relates to how quickly a patient recovers while being in the hospital (P1, 16-18), were mentioned. On the other hand, *safety of the nurse*, refers to the health of a nurse by involving the likelihood of ways of working and behavior that reduces the safety and health of a nurse:

Usually, these are just things that are more likely to harm you than the patient, for example, not heightening the bed to move the patient or not using a pad to turn him around. Well, that is just my back which breaks, but nothing happens to the patient. (P1, 303-307, translated into English)

The last subcategory of *safety of the nurse* overlaps with consequences of stress and mismatching demands as it also includes impacts of work-related aspects reducing health and well-being of a nurse. However, it is still important to mention it as a distinct subcategory as it specifically addresses safety-related aspects and behavior of working and was named by both interviewees in addition to patient safety and therefore highlighting its importance. These four sub-categories are mentioned as indicators of *patient safety and quality of care* at a hospital and, in the following, several factors mentioned to influence *patient safety and quality of care* are described.

Starting with three subcategories previously mentioned within the category of stressors. First, *perception of lack of time*: "But I also think that you were under more time pressure. As I said (…

- 1s), we had 38 beds and there were two of us. How can you do everything well and always do everything right?" (P1, 268-270, translated into English).

Furthermore, *shortage of staff* was mentioned, meaning that many tasks required to do in a team can only be done alone, as there is not enough staff, leading to errors (P1, 315-320).

Furthermore, *high workload with many interruptions* was named, which means that nursing is associated with a high workload and a lot of multitasking including many interruptions, for example due to a phone call, which is why something can be forgotten quickly leading to errors (P2, 501-505).

Another factor mentioned was *lack of sleep*, which was connected to stressor before as being a consequence of too much stress as it is hard to fall asleep due to not being able to relax after work or not having enough time to sleep due to shift work *(P1, 328-331)*. If you do not sleep enough, you can be overtired and not work as concentrated as you would normally do, which means mistakes can happen more quickly (P1, 370-372). P2 mentioned the *mood and well-being of the nurse* as a further factor, "because you approach the patient in a completely different way. When you are in a better mood, you treat the patient very differently" (P2, 556-557, translated into English). Additionally, *work engagement and motivation* within the working context was named meaning when "you are […] more motivated […] [you] pay much more attention to safety (... - 2s) for yourself and the patient." (P2, 557-559, translated into English).

Both interviewees addressed indicators of a *socio-moral climate* as factors influencing patient safety and quality of care:

> *Well, I think that the support of the team can be very valuable, so that you are always supported and cared for and can also address things openly, for example, address any errors that may have happened and ask for help and that you can get involved within the team and be integrated by the team. So, simply that everyone can participate, everyone can address everything, and everyone supports each other. I already have the feeling that this makes it better, that less [errors] happen there. (P1, 374-380, translated into English)*

Moreover, *equipment and monetary resources* was referred. With more financial possibilities, better or more technical advanced equipment can be bought, which can possibly counteract errors (P2, 496-500). Furthermore, *non-compliant patient behavior* was stated. Patients acting independently even though they are not in the right health condition for doing so are putting their

own safety at risk: “So, I try to get up on my own, even though my health condition no longer allows it. And what happens then? Then I fall.” (P2, 529-530, translated into English).

Additionally, P1 mentioned *emotional encounter of the patient*, referring to the way a nurse acts with the patient. This can be in a more friendly and caring way or in an annoyed and stressed way, for example (P1, 48-50), which indirectly influences patient safety by enhancing the likelihood of a patient acting alone, even when not able to, because the patient does not want to ask the nurse anymore when the nurse was too stressed or annoyed before *(P2, 567-571)*. *Thoroughness of working* was cited as a last influencing factor, which relates to a conscientious and correct execution of work activities and can therefore have a very direct influence on nursing errors.

Similar to the graphical illustration of the relationships between *stressors, consequences of stress and mismatching demands* and *(work-related) resources,* and also in orientation with the integrative work model of Glaser et al. (2015), the stated factors influencing patient safety are interdependent and can be classified within a similar pattern. For a graphical illustration of the relationships found within these subcategories refer to figure 4.

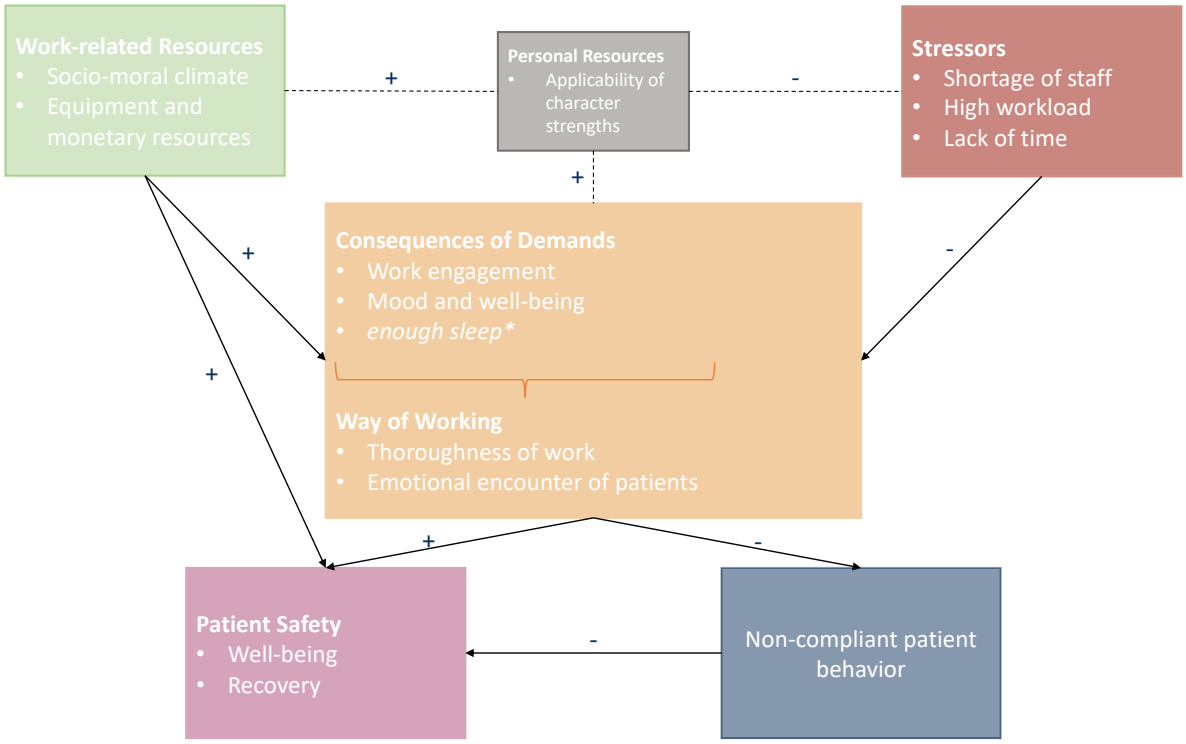

Figure 4 | Interrelations of subcategories mentioned for patient safety. + = positive association. - = negative association. * = variable name is reversed for better understanding and refers to *lack of sleep*.

Three factors were named also falling under the category of *stressors*: *perception of lack of time, lack of staff and high workload and problematic way of working*. In the quantitative part of this work, the control variable of *overtime* refers to a construct with a similar direction as perception of lack of time and was also negatively related to patient safety. As a possible reason for lack of time, the analysis of both transcripts indicates a combination of a *lack of staff* in addition to a *high workload and problematic way of working* with a lot of multitasking and interruptions. In consequence, there is too much work to be done with not enough staff leading to a constant *perception of lack of time* (P1, 381-382; P1, 268-270).

These stressors were negatively connected to several consequences, namely *lack of sleep (P1, 328-331)* as well as the *mood of a nurse* (P1, 4-9; P1, 408-411; P1, 416-417) and *work engagement and motivation* of a nurse (P1, 398-402). As already mentioned above within the category of *consequences of stress and mismatching demands*, as possible reasons for this connection, objective reasons such as overtime can lead to a lack of sleep as well as constant tension and stress can reduce well-being and motivation while also causing a hard time to relax and fall asleep (P1, 328-330; P1, 4-15).

Further, this results in a reduction of the *thoroughness of work,* since under time pressure, there is less motivation to do work tasks in a correct and safe way. Therefore, things are often done more quickly and, in consequence, incompletely or less conscientious with safety instructions such as hygiene regulations often being neglected: “And then I often find myself working uncleanly, sometimes not moving down a bed when I should, to protect my back or forget to disinfect my hands as soon as I leave or enter a room.” (P1, 45-48, translated into English). This affects both, the safety of patients and nurses (P2, 442; P2, 501-508; P1, 303-307). The *thoroughness of work* of a nurse is, additionally, reduced by *lack of sleep* (P2, 511-516). P1 mentioned that with *lack of sleep*, there is a tendency to work less concentrated making mistakes more likely which, in consequence, can endanger the safety of the nurse or the patient (P1, 371-372).

In addition, the *work engagement and motivation* as well as the *mood of a nurse* is related to the way in which a nurse emotionally encounters a patient, for example, to what extent she treats the patient calmly and in a friendly manner and is motivated to meet all patient’s needs or is stressed and irritated (P1, 393-398). The *mood of a nurse* itself “reflects on the patient” (P2, 586-

587, translated into English) but also how a nurse emotionally encounters a patient is positively related to the *well-being of a patient*, according to P2 (559-569), which in turn was positively associated with the *recovery of a patient* referring to both interviewees (P1, 16-18; P2, 590-593). Interestingly, how a nurse emotionally encounters a patient was associated with the extent to which a patient acts autonomous, meaning carrying out activities alone even though a nurse would actually be required, often leading to injuries, and, therefore reducing the patient safety. This was explained by a reduced well-being of the patient, on the one hand, because of feeling neglected even though being in need and, therefore, trying to do things autonomous to try to fulfill this needs, and, on the other hand, to 'help' the nurse in saving time while also protecting oneself of a tensed interaction:

> *So what do I do? I get dissatisfied as a patient because I've been ringing the bell for I don't know how many times, and I have a stomach ache and the nurse doesn't come or was in such a bad mood before that I don't even dare [to ring again] and then I try to get up myself and then my circulation system fails. (P2, 567-571, translated into English)*

> *How does a patient perceive that? I have a need, but she has no time for me, but I need her. Do you understand? So, the next time he won't ring the bell because he won't even dare. And then mistakes happen again because he tries himself. (P2, 583-586, translated into English)*

Within this framework of stressors leading to several negative mental and physical health consequences which are further connected to reduced patient safety, the interviewees named two work-related resources being positively connected to patient safety as well as buffering the negative impact of stressors on health.

First, *equipment and monetary resources* is connected to an increasing safety of the patient as well as the safety of nursing staff. Height-adjustable beds can be used that can protect the nurse's back while reducing the risk of injury of a patient falling out of bed if you reduce the height of the bed to floor-level (P1, 45-48; P2, 496-499). Second, a socio-moral climate at work is related to *patient safety* and *safety of a nurse (P1, 72-86)*. Particularly emphasized, within the category of *socio-moral climate*, was *open confrontation with conflicts (P2, 552-554)* and *respect (P2, 551-552)*. Referring to *open confrontation with conflicts*, P1 stated that "you clarify everything immediately, you can also address something, if something didn't go well or you made a mistake." (P1,

98-99, translated into English), meaning, when a socio-moral climate is present to a high extent, mistakes are not concealed but openly addressed which leaves open the possibility to solve the problem (P2, 553-554). *Respect*, on the one hand, is seen in a positive relation to *patient safety* as, within a team with a high socio-moral climate, nurses try to support and help each other and, therefore, avoid errors in the first place (P1, 374-376; P2, 551-552). On the other hand, the respect, support and appreciation given within a team was stated to positively affect the *mood of nurses* (P1, 72-84) as well as the *work engagement and motivation* of nurses (P2, 551-558), again leading to encountering the patient more friendly and, therefore, this reflects on the patient's well-being as well (P2, 551-559). In consequence, this was also mentioned in connection to the *well-being of a patient*: "*[…]* and how happy she is about it. And I have the feeling that this appreciation that you show the patients (... - 2s) is important. That they feel seen and heard. That they are really being looked after." (P1, 31-34, translated into English). This means that a socio-moral climate at work is related to more patient safety while also buffering the negative consequences of stressors by increasing well-being and work engagement.

In addition to the influencing aspects mentioned in direct relation to patient safety, an attempt should be made to combine the model described with the hypotheses proposed in the quantitative part of this study. The model partly is in line with the hypotheses as positive associations of socio-moral climate with well-being, work engagement and patient safety are displayed. However, the applicability of character strengths is not mentioned as an impacting factor directly. Nonetheless, by confirming the hypotheses, a positive connection of applicability of character strengths to well-being and work engagement with socio-moral climate as a conducive aspect of the working environment for being able to apply one's character strengths at work. Therefore, even though not mentioned explicitly by the interviewees in this context, the applicability of character strengths is integrated into the model as a possible personal resource (see *individual resources* in Glaser et al., 2015), which can be influenced negatively by detrimental working conditions and positively by a supportive climate at work and, further, can have a positive impact on well-being and work engagement.

Possible Solutions

Within the interviews, there were also spontaneous suggestions for solutions that could possibly improve the working situation. First, P2 mentioned *technical improvement of the equipment* especially to enhance patient safety. She mentioned that there could be "sensors somehow, that there would be an alarm when someone is too close to the borders of the bed, like parking sensors on a car" (P2, 520-521, translated into English). Second, P1 referred to *artificial intelligence* as an additional helping hand for nurses without aiming to replace them but to safe time for example with documenting:

> *[…] everybody is always talking about nursing robots. I do not find that sensible at all, but you could use them for documentation. That they just always come with you and write down what you do or that you can at least dictate them everything or something, Siri does exist, too. That has to work. So, less that care is being replaced by robots, I mean, I think that's totally stupid, you want to be cared for by a person as a patient (… - 2s), well, but I mean that robots could support care, just like documenting what always costs so much time and what is unnecessarily wasting time. (P1, 290-299, translated into English)*

Last, P2 addressed *supervisor support* as a possible solution meaning the possibility that a leader helps and supports the employees by taking over some of their work. As an example, she mentioned that, as a manager, she enabled the nurses to take a break for having breakfast together by doing their work for half an hour which resulted in increased well-being and motivation (P2, 458-464).

Discussion

In the following, the results of the quantitative and qualitative part of this work will first be summarized and then further discussed with reference to the current state of research. In addition, limitations and implications as well as future directions of research are presented with a final conclusion.

Summary of Results

The aim of the work was to attain a deeper understanding of the precarious working conditions of a nurse and to explore possible positive or stress-buffering effects of work-related resources such as a socio-moral climate or the applicability of character strengths. Therefore, a questionnaire was used to determine the relationships between the applicability of character strengths, socio-moral climate, well-being, work engagement and patient safety within a sample of nurses. Höge et al. (2020) examined these relations within a sample consisting of physicians, meaning the present study also wants to replicate the findings of this paper within the nursing context. Furthermore, with the help of two qualitative interviews, an attempt was made to confirm the hypotheses qualitatively as well as to explore further backgrounds and possibilities of the nursing field of work.

Socio-moral climate showed positive correlations with applicability of character strengths, well-being and work engagement (hypotheses 1a-d). Including all control variables, the effect on applicability of character strengths was no longer significant and applicability of character strengths in everyday life being the best predictor. The facet *allocation of responsibility* of the socio-moral climate was particularly relevant for PWB, whereby *respect* had the highest impact on SWB and *open communication and participative cooperation* was most important for work engagement.

The applicability of character strengths at work could be positively associated with work engagement (hypotheses 2) and PWB (hypotheses 3a). A positive connection to SWB could be recorded within the correlations, but this could not be maintained when the control variables were included (hypotheses 3b). In addition, the correlative relationship to PWB was significantly higher than to SWB (hypotheses 3c).

When all control variables were included, no mediation from SMC via ASCS at work to well-being nor work engagement could be found. In-depth analysis showed that the control variable of applicability of character strengths in everyday life had a greater predicting impact than SMC on ASCS at work. With excluding all control variables, ASCS could be confirmed as mediator between SMC and PWB as well as work engagement, but not with SWB.

Last, positive connections between patient safety and socio-moral climate, well-being and work engagement were found. The effect of work engagement on patient safety could no longer be

confirmed when the control variables were included, while the control variable of overtime remained as the only significant predictor. Furthermore, no connection could be examined between patient safety and the applicability of the character strengths. With regard to socio-moral climate, the facet of *open communication and participative cooperation* was particularly relevant for predicting patient safety. Furthermore, in addition to the significant effects of socio-moral climate, PWB and SWB on patient safety, the control variable of overtime was revealed as a significant predictor. In the context of ASCS and work engagement, overtime was the only significant predictor.

Within the qualitative part of this study, the hypotheses could be confirmed in a similar pattern. Socio-moral climate was positively associated with applicability of character strengths, well-being and work engagement. The facets of *respect* as well as *open communication and participative cooperation* were emphasized within the context of ASCS and work engagement, while, regarding well-being just the facet of *respect* was mentioned. Applicability of character strengths was positively related to work engagement and well-being. Interestingly, ASCS was not just mentioned in connection to mental well-being but also physical well-being. Patient safety had a positive association with socio-moral climate, with emphasizing the facet of *respect*, well-being and work engagement, but not with ASCS. However, no statements were made about a possible mediation between socio-moral climate via ASCS on well-being or work engagement.

Further Interpretation of the Results

In the following, the present results will be discussed in the context of the current state of research, beginning with the established hypotheses of the connections between socio-moral climate, applicability of character strengths, well-being, work engagement and patient safety. The first four hypotheses related to hypotheses that were also used and confirmed by Höge et al. (2020) within a sample of physicians. Therefore, the discussion should also refer to the replication of these results within the nursing context. Subsequently, further exploratory findings from the qualitative part are discussed.

Association of Socio-Moral Climate, Applicability of Character Strengths at Work, Well-Being and Work Engagement

The socio-moral climate showed positive associations with ASCS at work, PWB, SWB and work engagement. This could also be examined within the qualitative data of this study giving strong support for the socio-moral climate as an environment that fosters individual development by appreciating and giving space to unfold for every personality with their specific strengths. Furthermore, these findings underline that a socio-moral climate strengthens well-being at work mainly by creating an appreciative and respectful environment as it was also shown in Kachel et al (2020) while also highlighting the importance of allocation of responsibility for PWB as this aspect probably promotes autonomy and mastery by getting the opportunity to learn new skills and abilities (Verdorfer et al., 2015; Weber et al., 2008). Additionally, as also shown in previous studies (e.g. Höge et al., 2020), a socio-moral climate gives space to develop at work and, therefore, motivates to get involved and put dedication and effort in work tasks. Moreover, ASCS was found to be mediating the relationship between socio-moral climate and PWB as well as work engagement but not the relationship from socio-moral climate with SWB supporting previous findings showing socio-moral climate as a preceding factor of ASCS and ASCS itself as a mechanism how socio-moral climate impacts PWB and work engagement (Höge et al., 2020). However, the relationship between socio-moral climate and the applicability of character strengths as well as the mediation analyses could no longer hold up when all control variables were included. In particular, the control variable of applicability of character strengths in everyday life was the only predictor with a significant positive predicting value within the analysis regarding socio-moral climate and ASCS. Similar, regarding the mediation analysis, applicability of character strengths in everyday life had the largest influence on ASCS at work but was not further connected to PWB nor work engagement meaning it mainly influenced the first path of the mediation analysis, the association of socio-moral climate with ASCS at work. On the one hand, this may be the case because the sample size with regard to the inclusion of such a large number of control variables was too small to be able to differentiate the explanation of variance in a statistically meaningful way (Döring & Bortz, 2016) making a replication with a larger sample essential. Especially the positive correlation of these two variables as well as the qualitative data suggest a tendency

towards a confirmation of the hypothesis. However, not all of the control variables analyzed here have been taken into account in previous studies on this topic. In specific, the applicability of character strengths in everyday life, which had the greatest explanative value, has not yet been identified as a control variable regarding a large literature research. This illustrates the importance of replicating study results and the inclusion of control variables to get a more in-depth and generalizable picture of the phenomena studied. Above all, this highlights the relevance of a holistic view of an individual. It is important to not only view an individual within its working context, but to include its everyday life as well as its personality. The present results show in no way that a socio-moral climate is not a predictor for the applicability of character strengths at work. It rather illustrates that a socio-moral climate is positively connected to a higher applicability of character strengths at work but that the applicability of character strengths in everyday life could also be an important predictor that should be considered in future research. As a possible explanation, personality can be considered. Within the qualitative data, one of the interviewees mentioned a proactive personality that is more likely to engage in strengths use. The importance for proactivity for applying strengths at work was also underlined by Botha and Mostert (2014). Additionally, van Woerkom et al. (2016) even included applying character strengths in the definitions of proactivity with characterizing proactivity as an initiatively starting behavior for using one's strengths.

However, before being proactive, it is essential to get to know one's strengths in the first place. People who know themselves very well and know about their strengths are more likely to have more positively reinforcing experiences while applying their character strengths and are presumably more motivated to apply them in the future (Peterson & Seligman, 2004). Van Woerkom et al. (in press) identified *strengths awareness* among *credibility* (confidence in using and relying on strengths) and *coordination* of work tasks according to strengths as an important antecedent of strengths use. Within further research, it can be examined, on the one hand, whether people were already familiar with their strengths. Similar to the construct of *credibility* as introduced by van Woerkom et al. (in press), the construct of *self-efficacy* could be an important factor for applying strengths. With the perception of oneself as an active being with being confident in one's competencies and being able to make a difference with one's behavior, people with high self-

efficacy may tend to be more motivated to use their character strengths and are more likely to proactively look for environments, both at work and in private life, in which their strengths are more applicable (within the working context, see *job crafting* as introduced by Tims et al. in 2010). Bakker and van Wingerden (2021) found initial evidence for self-efficacy among assertiveness and resilience to be a factor leading to more strengths use at work. However, within their study, they used an intervention based on increasing personal resources (self-efficacy, assertiveness and resilience) and strengths use meaning it is not clear whether the increase in resources, additionally to strengths use training, enhanced applying one's strengths implicating further research in this topic to be necessary.

In summary, it should be underlined how important it is to view an individual in a more holistic way considering, among other things, the work context, with promoting a more supportive and appreciative climate as well as the personality of the employees by helping them to get to know their strengths (*strengths awareness*) and to find confidence as well as motivation in using them (*self-efficacy*, *credibility* and *proactivity*). In consequence, future research should concentrate on developing interventions for employees to identify their strengths and discover ways to apply them in different areas, including everyday and professional life with also relying on increasing personal resources such as self-efficacy. Additionally, trainings should be established for supervisors to learn to recognize the strengths of employees and to instruct them to use them widely.

Consequences of Applying One's Character Strengths

A positive connection between the applicability of character strengths at work with work engagement as well as PWB and SWB was examined. However, the connection to SWB was not significant anymore, when including all control variables. Even just partly replicating the effects of Höge et al. (2020), this reflects a similar pattern as their results. Within their study, PWB displayed a stronger connection to ASCS at work than SWB, which is also confirmed within the present study looking at the correlation analysis. It is possible that the effect of ASCS on SWB is rather small and, therefore, cannot hold up when including other predicting factors. This is underlined by previous research, also resulting in a stronger association between ASCS and PWB than ASCS and SWB (e.g. Hausler et al., 2017b; Huber et al., 2020). The applicability of character strengths is, in

consequence, related to recognizing the true self by identifying one's strengths and growing beyond oneself by engaging in strengths use and, therefore, contributing to the world as the person one truly is (Peterson & Seligman, 2004). This, in turn, contributes to finding meaning in life (Harzer & Ruch, 2013). In summary, the applicability of character strengths can be rather seen as a process of personal growth by continuously challenging yourself resulting in longer lasting enjoyment instead of a fast but not sustainable way of fulfilling personal needs just for momentary pleasure (Peterson & Seligman, 2004; Csikszentmihalyi, 2000). Additionally, within the qualitative data, applicability of character strengths was also mentioned to be connected to physical health opposing the findings of Hausler et al. (2017a) and, therefore, highlighting the importance of replicating this study to further investigate the impact of applicability of character strengths within the context of physical health.

The positive association found of applicability of character strengths at work with work engagement is in line with previous research and also replicating the effects of Höge et al. (2020). This highlights the relevance of creating an environment at work of being able to apply one's character strengths as work engagement is further related to physical and mental health (Bakker et al., 2011) and is seen as counterpart to burnout (Schaufeli & Bakker, 2004), which seems highly important considering the high burnout rates among nurses (Shanafelt et al., 2015).

Influences on Patient Safety

Patient safety was positively associated with socio-moral climate, PWB and SWB and work engagement and was not connected to ASCS considering both, quantitative and qualitative data. Including all control variables, the relationship with work engagement was no longer significant. However, as mentioned above the small sample size considering this large amount of control variables was probably not enough to show lower but theoretically meaningful values in a statistically significant manner (Döring & Bortz, 2016). The qualitative data as well as the correlation analysis suggest a tendency towards confirming the hypotheses as they show a relation from patient safety to work engagement as it was also found within previous research (e.g. Ree & Wiig, 2020), underlining the importance for replicating this findings to better understand the connection of the respective variables.

A positive association of the applicability of character strengths at work with patient safety could not be found within this study. With socio-moral climate as strong influencing factor, this suggests that mainly supporting and helping each other within a team and being able to participate and communicate openly is impacting patient safety which is in line with previous findings linking a socio-moral climate to patient safety (Kachel et al., 2020). In addition, the control variable of *overtime*, referring to similar constructs of the qualitative part such as lack of time and high workload, was significantly influencing all calculated models suggesting a strong impact of time pressure on patient safety. This supports previous studies, showing that job stressors, especially in combination with low job control and little social support, highly influence patient safety in a negative way (Berland et al., 2008). In consequence, for patient safety, it is less important to be able to apply one's own strengths and being able to develop personally but it is more important to focus together on helping and supporting each other to be able to manage the lack of time and properly care for a patient.

The connection of patient safety with PWB and SWB is in line with previous studies (review: Welp & Manser, 2016). Feeling well with oneself at the moment could mean that there are more resources for caring for another person leading to more patient safety. However, it could also be the other way around that helping another person and ensuring a high level of quality of care could lead to higher well-being because helping another person can create a feeling of connectedness fulfilling the need of relatedness (Aknin & Whillans, 2020). Using a longitudinal design, it can further be examined whether feeling well at work positively affects patient safety or whether it is the other way around that caring safely for a patient creates well-being, as respective findings are not clear (Welp & Manser, 2016).

Oriented towards the integrative work model of Glaser et al. (2015), within the qualitative part, a graphical illustration of the connection of influences on patient safety was created (see figure 5 for a graphical comparison). While stressors such as shortage of staff or high workload can negatively affect work engagement and well-being, sleep and working behavior, work-related resources such as a socio-moral climate can buffer these detrimental effects and, further, can positively influence these consequences which further influences patient safety. The applicability of character strengths was integrated as personal resource that can also affect consequences of

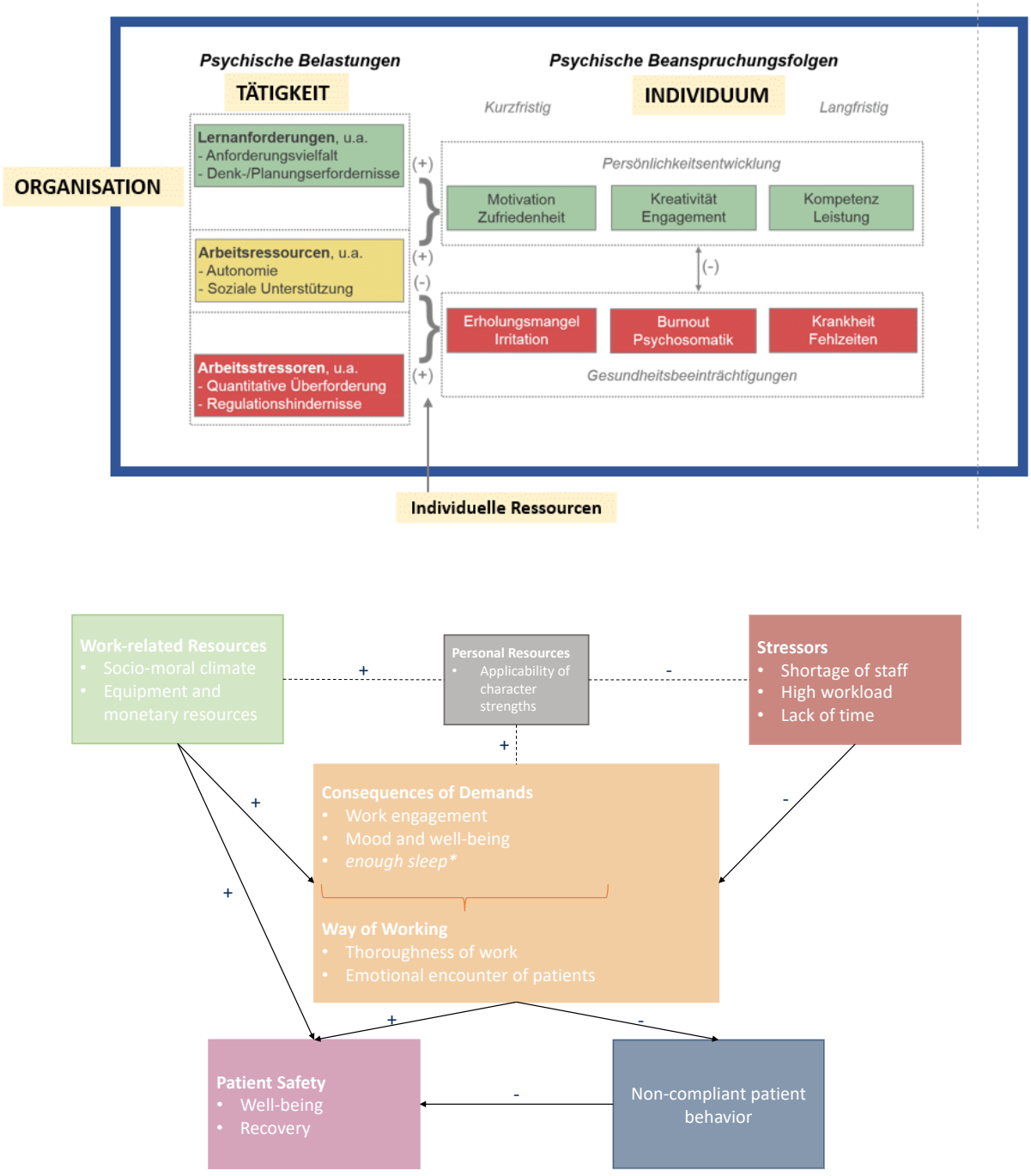

Figure 5 | Comparison of the integrative work model introduced by Glaser et al. (2015; at the top) and the graphical illustration of the interrelations of the subcategories influencing patient safety (at the bottom).

stressors and is influenced by working conditions itself. This connection was not directly mentioned by the interviewees. Due to a small number of interviews, it is possible that it was simply forgotten to address because of being of smaller importance than the other factors mentioned.

However, as a connection of applicability of character strengths to socio-moral climate and consequences of demands such as well-being and work engagement were named, similar to the integrative model by Glaser et al. (2015) this construct was included as personal resource. This also supports the hypotheses of the quantitative part, with showing positive connections of socio-moral climate to work engagement, ASCS, well-being and patient safety, positive associations of ASCS to work engagement and well-being and positive relations from work engagement, well-being and socio-moral climate to patient safety. Moreover, this graphical illustration further suggest a possible explanation of ASCS not being statistically connected to patient safety, as it is not directly influencing patient safety but is rather connected to higher well-being and work engagement and is positively influenced by a socio-moral climate indicating an rather indirect influence functioning more as an positive add-on than being a crucial factor. This means that supportive working conditions can enhance personal resources that can have an additional positive influence, further to the impact of favourable working conditions, such as enhancing well-being and work engagement. Similar to the construct of *motivators* introduced by Herzberg and colleagues in their dual-factor theory (1959), the applicability of character strengths could work as a factor fulfilling the need for personal growth and, therefore, leading to more well-being and engagement at work without resulting in negative consequences when this factor is missing. The associations found within the qualitative part of this study support the proposed hypotheses of this study as well as the integrative work model proposed by Glaser et al. (2015) with adding patient safety as a further construct important for the nursing context. However, the associations in this graphical illustration are exploratory in nature and it is important to examine these relationships within a quantitative design to be able to get a more generalizable picture.

Including the Negative Side in a Positive Framework

The category of stressors was the one most often addressed by the interviewees. This underlines that this issue is of great importance to nurses and that stress at work is likely to be a great burden for them. The relevance of stressors can also be seen in the fact that the stressor *overtime* had a significant influence on each calculated model for patient safety, which probably means that stress resulting of time pressure leading into working overtime especially has a negative

effect on patients and their health and safety. This supports prior research linking job stressors to lower patient safety especially in combination with low job control. Meaning besides trying to work on less stressful working conditions, it is also important to give nurses more space for autonomous decisions and actions (see Strecker et al., 2019) highlighting the relevance of a socio-moral climate as a possible buffering factor for job stressors in relation to patient safety. With its appreciative and participative structures, a socio-moral climate allows for having a voice in decision-making processes, being heard and able to question established rules and norms or ways to do tasks enhancing the feeling of control by being able to participate and change things at work (Verdorfer et al., 2015; Weber et al., 2008).

Stressors could be classified as objective and subjective. Objective stressors can be stated objectively on the basis of hours or the number of staff. Subjective stressors, on the other hand, relate to the individual perception of work-related aspects as stressful. This is particularly interesting against the background of Lazarus' appraisal theory (Lazarus & Folkman, 1984). In this theory, stress arises when a situation is perceived and appraised as threatening and one's resources as not enough for coping properly with the situation. Accordingly, Kerr et al. (2020) showed a higher subjective psychological but not objective biological stress response to psychosocial stress and interruptions at work including threat appraisal as mediator, underlining the importance of the appraisal of a situation and one's resources for subjectively perceived stress. In connection with patient safety, mainly subjective factors, namely perception of lack of time and high workload, were mentioned. As appraisal is an individual and highly subjective process depending on the perception of a situation as well as one's resources (Lazarus & Folkman, 1984), it is possible that subjective stressors are more likely to be influenced by the perception of having variable resources as objective stressors are. The influence of the perception of a situation as threatening as well as the appraisal of resources on the perception of stress resulting from objective as well as subjective stressors would be an interesting topic for future research.

Nonetheless, stressors seem to be of tremendous importance to nurses as well as patient care. Furthermore, the influence of stressors on patient safety can probably not be eliminated by a positive climate or well-being of nurses. This makes clear that while it is important to improve the working atmosphere and ensure well-being of nurses, it should not be neglected that a

nurse's working conditions are disastrous at the moment. For the well-being of the nursing staff as well as their patients, it is vital to ensure that there is enough staff to regulate and reduce the workload. It also seems important to make the job more attractive again for younger people, which could e.g. be achieved through a higher salary (Abdul Wahed, 2021). As much as this should be one of the highest priorities of a hospital, the government and society, it is not possible to change the whole situation for a nurse alone who is currently in this situation and who may be suffering from it. Therefore, it is still important to be able to give these nurses opportunities and help them finding resources to make the best of their situation at the moment. In consequence, it is highly relevant to develop interventions to help nurses to create a positive and supportive climate and to make greater use of their strengths, in order to increase their well-being and motivation as well as the safety of their patients. For a single nurse right now, this is very important. Nevertheless, it should never lose importance for society and politics to improve the general working conditions of a nurse.

The Importance of Self-Care

Within the qualitative part of this study, the interviewees highlighted the relevance of the character strengths *self-regulation* for well-being. Furthermore, it was argued that it is important to know oneself and be able to recognize and regulate emotions as well as being able to distance oneself from suffering of patients. They even went one step further and mentioned that it is essential to take care of yourself first to be able to really connect with a patient in an other-oriented manner without identifying with suffering but with listening, showing concern and taking care. This is in line with previous research, showing that emotion regulation is as an important prerequisite for social functioning (English et al., 2013; Van Kleef, 2009) as well as a predictor for positive relationships with others (Lopes et al., 2003). Goetz et al. (2010) argued within their appraisal model that a lack of resources prevents compassion (a form of empathy) and instead leads to distress, anxiety or fear because of not feeling like being able to help. They further underlined the importance of self-other distinction in this context. Meaning being able to see the patient as a related but distinct being with completely different life experiences and emotions which one cannot comprehend by trying to imagine oneself in the situation of the patient but

with trying to really understand by putting oneself in the shoes and perspective of the other. Without distinction of oneself and the other, distress instead of empathy arises, in consequence of feeling involved or identifying with the emotions of the patient (Goetz et al., 2010). This indicates that being capable of taking care of oneself and regulating one's emotions could be important for having the resources to shift the focus from oneself and one's emotions to the patient. Meaning self-regulation is important for not getting involved and being able to empathize in a target-centered way in order to care in a supportive manner (Longmire & Harrison, 2018).

This supports results from Lampert and Glaser (2018) regarding the construct of *detached concern*. Detached concern is defined as empathizing with the patient while still knowing about the separateness of one's feelings and the patient's feelings. Meaning it is more about feeling *with* the patient instead of feeling *as* the patient (Lief & Fox, 1963). Lampert and Glaser (2018) separated the construct in two dimensions, namely *concern* as empathizing with patients in an other-oriented way, and d*etachment* as self-oriented emotion regulation and could show that high concern was just emotional exhausting when detachment was high, meaning low emotion regulation. In line with the findings of this study, this emphasizes the relevance of emotion regulation and taking care of oneself and one's needs in furtherance of having the resources to fully concentrate on another being without getting involved.

In order to being able to support the people being in charge for patients, it is further important to train supervisors in being empathic. A supervisor, as it was mentioned by the interviewees, should be a person who can detect one's strengths and tries to create conditions that encourage and include using one's character strengths. In consequence, it is important to develop and explore interventions for supervisors to encourage them to empathize with and care for the human beings and their needs within their company instead of managing and controlling their performance. A supervisor should be a person, who tries to serve the employees so that they have the best conditions for working, referring back to the concept of *servant leadership* and its importance for creating a supportive and appreciative environment encouraging strengths-use (Greenleaf, 2002; Verdorfer et al., 2015).

Limitations and Future Directions

First of all, it should be noted that an in-depth design can give a broader and deeper understanding of a specific situation than a purely quantitative survey, however, only using a cross-sectional design does not allow for retrieving causal inferences from the findings. Therefore, the present study should be replicated within a longitudinal design conducive to take a closer look at causal relationships, the direction of the respective effects as well as long-term consequences. Therefore, a similar design as Höge et al. (2020) used within their study could be applied within a sample of nurses. Furthermore, the online questionnaire used in this study was quite long, which can be seen by the long average processing times and the low rate of completely answered questionnaires. Therefore, it is possible that especially towards the end of the questionnaire the answers were given in a more unconcentrated and less conscious way (Herzog & Bachman, 1981). This underlines the importance of a replication of this study and, in order to possibly solve this problem, control variables could be included (e.g. “Tick 1 ‘Strongly disagree’ here”).

In addition, only two interviews were carried out, which limits the generalizability. The aim of the qualitative part of this study was to include subjectivity and openness to create a deeper understanding of the whole topic, nevertheless, it is important to note that communication is never complete, as it is only a selection of all possible expressions (Helfferich, 2009, p. 120), meaning it is possible that interviewees forgot to address something or did not mention something because it did not seem important enough to them. The interviewees were not presented with the character strengths or our different concepts for the reason of creating the opportunity to answer spontaneously and openly without targeting already known constructs. It is to be presumed that with more interviews carried out this effect cancels out because with several different people it is more likely that someone mentions something another one forgot to address.

Furthermore, it would have been interesting to include the perspective of the patients especially within the interviews but also the questionnaire. In particular, the construct of patient safety was only included as the nurses' subjective perception. However, since this directly affects the patient, an assessment of the patient, in addition to the perception of the nurse, to create a more valid overall perception of patient safety is important. A field observation for objectively

assessing risks and accidents in the caring working context would also be conceivable in future studies.

Conclusion

The job field of nursing is characterized by detrimental working conditions such as shortage of staff, high workload and working overtime leading to high numbers of sleeping problems, depression or burnout (e.g. Brown et al., 2020; Melynk et al., 2018). On the one hand, this decreases well-being and motivation of nurses and, on the other hand, quality of care provided to the patients (Brown et al., 2020). As these precarious working conditions seem to persist, it is even more important to help nurses finding resources at work to maintain healthy (Glaser et al., 2015). Therefore, this study aimed for getting a deeper understanding of the working conditions of a nurse and examining the relationship of a socio-moral climate, the applicability of character strengths, well-being and work engagement within the nursing context as also Höge et al. (2020) did within their study and adding patient safety in this framework.

Results underlined the favourable effects of a socio-moral climate as well as high applicability of character strengths at work for well-being and work engagement. However, the detrimental working conditions are still having a great impact especially on patient safety. Therefore, it is important to focus on strengthen well-being and work engagement by creating supportive environments and encouraging strengths use for improving the resources of nurses to buffer negative consequences of stressful working conditions (Glaser et al., 2015). However, the negative work environment which is hard but necessary to change is essential to be considered as well. As it is relevant to include individuals as whole beings with their strengths and not just managing their weaknesses, it is necessary to include the whole work environment and work conditions instead of just managing the people working there. In hospitals, there is so much pain and so much suffering. It should be the job of nurses to relieve suffering of patients and not adding to it by being mean or in a rush because of too much stress. Patient is determined as a (human) being, who is suffering (lat.: patiens), so to some extent we are all patients at some point. And it should matter to all of us to give nurses the possibility, the resources and the time to care for patients, for us, to fulfill our needs and take away as much suffering as possible.

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Appendix

Appendix A: Additional quantitative tables

A.1: Additional analyses to table 3

		H1a: ASCS Work				H1b: PWB			
Step	Predictor	*B*	*SE*	β	*p*	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-	-	-	-	-
	Age	.005	.009	.052	.623[d]	-.013	.011	-.139	.259
	Gender[a]	.264	.462	.076	.476[d]	-.153	.418	-.044	.716
	Overtime[b]	-.001	.010	-.010	.923[d]	-.013	.013	-.115	.335
	Shift Work[c]	.052	.274	.021	.845[d]	-.402	.302	-.165	.189
	ASCS Private	.620	.120	.620	< .001[d]	.336	.118	.336	.006
	R^2	.379				.185			
	p	< .001[d]				.028			
2	*Control Variables*								
	Age	.006	.009	.065	.522[d]	-.011	.011	-.117	.312
	Gender[a]	.239	.457	.069	.575[d]	-.194	.395	-.056	.624
	Overtime[b]	-.001	.011	-.010	.920[d]	-.013	.012	-.115	.308
	Shift Work[c]	.176	.292	.073	.526[d]	-.194	.294	-.080	.512
	ASCS Private	.581	.131	.581	< .001[d]	.271	.114	.271	.020
	Independent Var.								
	SMC	.203	.112	.203	.084[d]	.338	.117	.338	.005
	ΔR^2	.037				.102			
	R^2	.416				.286			
	p	< .001[d]				.002			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. PWB = Psychological well-being. SMC = Socio-moral climate. Var. = Variable.

A.2: Additional analyses to table 4

		H1c: SWB				H1d: Work Engagement			
Step	Predictor	*B*	*SE*	β	*p*	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-	-	-	-	-
	Age	.001	.011	.008	.950[d]	-.005	.012	-.055	.669[d]
	Gender[a]	.133	.409	.038	.745[d]	.133	.384	.039	.714[d]
	Overtime[b]	-.019	.015	-.176	.155[d]	-.010	.014	-.092	.408[d]
	Shift Work[c]	.041	.337	.017	.910[d]	-.354	.318	-.146	.264[d]
	ASCS Private	.296	.138	.296	.031[d]	.148	.142	.148	.287[d]
	R^2	.124				.060			
	p	.150[d]				.582[d]			
2	*Control Variables*								
	Age	.003	.010	.033	.769[d]	-.002	.010	-.017	.886[d]
	Gender[a]	.084	.327	.024	.792[d]	.059	.373	.017	.870[d]
	Overtime[b]	-.019	.013	-.176	.105[d]	-.010	.010	-.092	.280[d]
	Shift Work[c]	.285	.331	.117	.388[d]	.015	.282	.006	.955[d]
	ASCS Private	.220	.148	.220	.132[d]	.033	.129	.033	.806[d]
	Independent Var.								
	SMC	.397	.131	.397	.006[d]	.601	.097	.601	< .001[d]
	ΔR^2	.140				.320			
	R^2	.264				.380			
	p	.005[d]				< .001[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. SWB = Subjective well-being. SMC = Socio-moral climate. Var. = Variable.

A.3: Detailed analyses of facets of SMC for work engagement

		H1d: Work Engagement			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.005	.012	-.055	.678[d]
	Gender[a]	.133	.449	.039	.768[d]
	Overtime[b]	-.010	.014	-.092	.470[d]
	Shift Work[c]	-.354	.325	-.146	.280[d]
	ASCS Private	.148	.127	.148	.249[d]
	R^2	.060			
	p	.582			
2	*Control Variables*				
	Age	.001	.010	.009	.940[d]
	Gender[a]	.084	.375	.024	.823[d]
	Overtime[b]	-.010	.011	-.088	.406[d]
	Shift Work[c]	.001	.284	.000	.998[d]
	ASCS Private	.031	.119	.031	.792[d]
	Independent Var.				
	SMC: OC	.116	.052	.400	.029[d]
	SMC: RE	.012	.051	.039	.809[d]
	SMC: CC	.048	.036	.238	.180[d]
	SMC: RSPY	.004	.060	.014	.941[d]
	SMC: CONC	.000	.049	.001	.998[d]
	ΔR^2	.354			
	R^2	.414			
	p	.001[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. SMC = Socio-moral climate. OC = Open confrontation with conflict. RE = Respect. CC = Open communication and participative cooperation. RSPY = allocation of responsibility. CONC = organizational concern. Var. = Variable.

A.4: Detailed analyses of facets of SMC for SWB

		H1c: SWB			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	.001	.011	.008	.958[d]
	Gender[a]	.133	.414	.038	.737[d]
	Overtime[b]	-.019	.015	-.176	.162[d]
	Shift Work[c]	.041	.347	.017	.906[d]
	ASCS Private	.296	.139	.296	.033[d]
	R^2	.051			
	p	.150[d]			
2	*Control Variables*				
	Age	-.002	.011	-.017	.891[d]
	Gender[a]	.015	.320	.004	.964[d]
	Overtime[b]	-.019	.014	-.179	.135[d]
	Shift Work[c]	.222	.334	.091	.493[d]
	ASCS Private	.223	.152	.223	.148[d]
	Independent Var.				
	SMC: OC	-.064	.059	-.179	.280[d]
	SMC: RE	.122	.067	.388	.069[d]
	SMC: CC	.034	.035	.170	.332[d]
	SMC: RSPY	.003	.074	.011	.967[d]
	SMC: CONC	.033	.061	.130	.588[d]
	ΔR^2	.193			
	R^2	.317			
	p	.013[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. SMC = Socio-moral climate. OC = Open confrontation with conflict. RE = Respect. CC = Open communication and participative cooperation. RSPY = allocation of responsibility. CONC = organizational concern. SWB = Subjective well-being. Var. = Variable.

A.5: Detailed analyses of facets of SMC for PWB

		H1b: PWB			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.013	.011	-.139	.259
	Gender[a]	-.153	.418	-.044	.716
	Overtime[b]	-.013	.013	-.115	.335
	Shift Work[c]	-.402	.302	-.165	.189
	ASCS Private	.336	.118	.336	.006
	R^2	.185			
	p	.028			
2	*Control Variables*				
	Age	-.008	.011	-.090	.458
	Gender[a]	-.279	.395	-.081	.483
	Overtime[b]	-.014	.012	-.132	.240
	Shift Work[c]	-.204	.299	-.084	.497
	ASCS Private	.375	.125	.375	.004
	Independent Var.				
	SMC: OC	-.055	.054	-.190	.315
	SMC: RE	.054	.054	.172	.316
	SMC: CC	.018	.037	.091	.624
	SMC: RSPY	.142	.063	.447	.028
	SMC: CONC	-.036	.051	-.142	.486
	ΔR^2	.168			
	R^2	.352			
	p	.004			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. SMC = Socio-moral climate. OC = Open confrontation with conflict. RE = Respect. CC = Open communication and participative cooperation. RSPY = allocation of responsibility. CONC = organizational concern. PWB = Psychological well-being. Var. = Variable.

A.6: Additional analyses to table 5

		H2: Work Engagement			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.005	.012	-.055	.678
	Gender[a]	.133	.449	.039	.768
	Overtime[b]	-.010	.014	-.092	.470
	Shift Work[c]	-.354	.325	-.146	.280
	ASCS Private	.148	.127	.148	.249
	R^2	.060			
	p	.582			
2	*Control Variables*				
	Age	-.007	.011	-.081	.503
	Gender[a]	.000	.414	.000	.999
	Overtime[b]	-.009	.013	-.087	.458
	Shift Work[c]	-.380	.298	-.156	.208
	ASCS Private	-.166	.148	-.166	.266
	Independent Var.				
	ASCS Work	.506	.146	.506	.001
	ΔR^2	.159			
	R^2	.219			
	p	.020			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. ASCS = Applicability of character strengths. Var. = Variable.

A.7: Additional analyses to table 6

		H3a: PWB				H3b: SWB			
Step	Predictor	*B*	*SE*	β	*p*	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-	-	-	-	-
	Age	-.013	.011	-.139	.259	.001	.011	.008	.952[d]
	Gender[a]	-.153	.418	-.044	.716	.133	.416	.038	.739[d]
	Overtime[b]	-.013	.013	-.115	.335	-.019	.015	-.176	.171[d]
	Shift Work[c]	-.402	.302	-.165	.189	.041	.340	.017	.900[d]
	ASCS Private	.336	.118	.336	.006	.296	.138	.296	.035[d]
	R^2	.185				.124			
	p	.028				.150[d]			
2	*Control Variables*								
	Age	-.015	.010	-.161	.161	.000	.011	.000	.997[d]
	Gender[a]	-.267	.392	-.077	.498	.092	.448	.027	.830[d]
	Overtime[b]	-.012	.012	-.111	.321	-.019	.015	-.174	.166[d]
	Shift Work[c]	-.424	.282	-.175	.138	.033	.346	.014	.924[d]
	ASCS Private	.067	.140	.067	.633	.200	.171	.200	.227[d]
	Independent Var.								
	ASCS Work	.434	.138	.434	.003	.155	.159	.155	.324[d]
	ΔR^2	.117				.015			
	R^2	.302				.139			
	p	.001				.168[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. PWB = Psychological well-being. SWB = Subjective well-being. Var. = Variable.

A.8: Additional analyses to table 7

		H5a: Patient Safety			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.009	.012	-.102	.449[d]
	Gender[a]	.102	.701	.028	.875[d]
	Overtime[b]	-.034	.017	-.319	.030[d]
	Shift Work[c]	-.578	.387	-.216	.131[d]
	ASCS Private	.064	.132	.064	.600[d]
	R^2	.165			
	p	.070[d]			
2	*Control Variables*				
	Age	-.004	.002	-.043	.725[d]
	Gender[a]	.075	.586	.021	.894[d]
	Overtime[b]	-.033	.011	-.309	.002[d]
	Shift Work[c]	-.229	.276	-.085	.391[d]
	ASCS Private	-.041	.119	-.041	.714[d]
	Independent Var.				
	SMC	.546	.122	.540	< .001[d]
	ΔR^2	.257			
	R^2	.422			
	p	< .001[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. SMC = Socio-moral climate. Var. = Variable.

A.9: Additional analyses to table 7

		H5b: Patient Safety			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.009	.012	-.102	.449[d]
	Gender[a]	.102	.701	.028	.875[d]
	Overtime[b]	-.034	.017	-.319	.030[d]
	Shift Work[c]	-.578	.387	-.216	.131[d]
	ASCS Private	.064	.132	.064	.600[d]
	R^2	.165			
	p	.070[d]			
2	*Control Variables*				
	Age	-.009	.013	-.102	.472[d]
	Gender[a]	.095	.727	.026	.890[d]
	Overtime[b]	-.034	.017	-.318	.034[d]
	Shift Work[c]	-.577	.395	-.215	.148[d]
	ASCS Private	.055	.159	.055	.708[d]
	Independent Var.				
	ASCS Work	.016	.181	.016	.931[d]
	ΔR^2	.000			
	R^2	.165			
	p	.121[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. Var. = Variable.

A.10: Additional analyses to table 8

		H5c: Patient Safety			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.009	.012	-.102	.449[d]
	Gender[a]	.102	.701	.028	.875[d]
	Overtime[b]	-.034	.017	-.319	.030[d]
	Shift Work[c]	-.578	.387	-.216	.131[d]
	ASCS Private	.064	.132	.064	.600[d]
	R^2	.165			
	p	.070[d]			
2	*Control Variables*				
	Age	-.005	.011	-.055	.676[d]
	Gender[a]	.111	.688	.031	.873[d]
	Overtime[b]	-.030	.016	-.282	.041[d]
	Shift Work[c]	-.480	.411	-.179	.240[d]
	ASCS Private	-.039	.139	-.039	.773[d]
	Independent Var.				
	PWB	.292	.127	.300	.026[d]
	ΔR^2	.073			
	R^2	.237			
	p	.019[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. PWB = Psychological well-being. Var. = Variable.

A.11: Additional analyses to table 8

		H5d: Patient Safety			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.009	.012	-.102	.449[d]
	Gender[a]	.102	.701	.028	.875[d]
	Overtime[b]	-.034	.017	-.319	.030[d]
	Shift Work[c]	-.578	.387	-.216	.131[d]
	ASCS Private	.064	.132	.064	.600[d]
	R^2	.165			
	p	.070[d]			
2	*Control Variables*				
	Age	-.009	.011	-.099	.440[d]
	Gender[a]	.088	.633	.024	.889[d]
	Overtime[b]	-.026	.015	-.241	.052[d]
	Shift Work[c]	-.606	.370	-.226	.104[d]
	ASCS Private	-.054	.129	-.054	.653[d]
	Independent Var.				
	SWB	.372	.122	.383	.004[d]
	ΔR^2	.126			
	R^2	.291			
	p	.004[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. SWB = Subjective well-being. Var. = Variable.

A.12: Additional analyses to table 9

		H5e: Patient Safety			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.009	.012	-.102	.449[d]
	Gender[a]	.102	.701	.028	.875[d]
	Overtime[b]	-.034	.017	-.319	.030[d]
	Shift Work[c]	-.578	.387	-.216	.131[d]
	ASCS Private	.064	.132	.064	.600[d]
	R^2	.165			
	p	.070[d]			
2	*Control Variables*				
	Age	-.008	.012	-.089	.507[d]
	Gender[a]	.105	.715	.029	.880[d]
	Overtime[b]	-.031	.016	-.289	.031[d]
	Shift Work[c]	-.510	.392	-.190	.198[d]
	ASCS Private	.034	.133	.034	.785[d]
	Independent Var.				
	Work Engagement	.205	.135	.208	.139[d]
	ΔR^2	.040			
	R^2	.205			
	p	.045[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = Applicability of character strengths. Var. = Variable.

A.13: Detailed analyses of facets of SMC for patient safety

		H5a: Patient Safety			
Step	Predictor	*B*	*SE*	β	*p*
1	*Control Variables*	-	-	-	-
	Age	-.009	.012	-.102	.449[d]
	Gender[a]	.102	.701	.028	.875[d]
	Overtime[b]	-.034	.017	-.319	.030[d]
	Shift Work[c]	-.578	.387	-.216	.131[d]
	ASCS Private	.064	.132	.064	.600[d]
	R^2	.165			
	p	.070[d]			
2	*Control Variables*				
	Age	-.007	.012	-.081	.539[d]
	Gender[a]	.085	.620	.024	.891[d]
	Overtime[b]	-.033	.011	-.308	.002[d]
	Shift Work[c]	-.208	.292	-.078	.469[d]
	ASCS Private	-.087	.123	-.087	.480[d]
	Independent Var.				
	SMC: OC	-.048	.053	-.167	.372[d]
	SMC: RE	.081	.059	.260	.174[d]
	SMC: CC	.075	.038	.355	.063[d]
	SMC: RSPY	-.046	.057	-.144	.426[d]
	SMC: CONC	.089	.055	.353	.103[d]
	ΔR^2	.316			
	R^2	.481			
	p	< .001[d]			

Notes. N = 66. All p-values are two-tailed. [a] 0 = female, 1 = male. [b] Number in hours. [c] 0 = no shift work, 1 = shift work. [d] Application of 5000 bootstraps. ASCS = applicability of character strengths. SMC = Socio-moral climate. OC = Open confrontation with conflict. RE = Respect. CC = Open communication and participative cooperation. RSPY = allocation of responsibility. CONC = organizational concern. Var. = Variable.

Appendix B: Documents for the interviews

B.1 Interview Guideline

Einstieg	Danke für Teilnahme Kurze Erklärung des Projekts Interview wird aufgenommen – Einverständnis? Noch Fragen? *Aufnahme starten*	

Wie würden Sie Ihre momentane Arbeitssituation beschreiben?	Arbeitsklima, Wohlbefinden, Arbeitsengagement	„Wie würden Sie das Arbeitsklima beschreiben?“ „Wie ist die Stimmung in Ihrer Abteilung?“ „Was sind Faktoren, die die Stimmung in Ihrer Abteilung beeinflussen?“ „Wie würden Sie das Arbeitsengagement beschreiben?“

		„Welche Faktoren beeinflussen das Arbeitsengagement?“
Was macht eine Person besonders geeignet für den Beruf der Krankenpflege?	Charakterstärken	„Was charakterisiert eine typische Pflegekraft?“ „Welche Eigenschaften empfinden Sie als ideal für eine Pflegekraft?“ „Welche persönlichen Stärken helfen im pflegerischen Berufsalltag?“ „Was beeinflusst, ob eine Person sich mit ihren persönlichen Stärken einbringen kann?“ „Was sind Ihrer Meinung die Folgen, wenn man sich mit seinen Stärken mehr einbringen kann?

Wie würden Sie in Ihrem Krankenhaus die Patientensicherheit einschätzen?	Patientensicherheit, Zusammenhang mit Charakterstärken	„Was beeinflusst die Patientensicherheit Ihrer Meinung nach?“
Abschluss	Fragen, Ergänzungen, Dankeschön	„Haben wir etwas vergessen, was Sie gerne noch ansprechen würden?“ „Haben Sie ansonsten noch offene Fragen?“ „Vielen Dank und einen schönen Tag noch!“

B.2 Declaration of Consent

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Einwilligungserklärung

Im Rahmen meiner Masterarbeit zum Thema soziomoralisches Klima, die Anwendbarkeit von Charakterstärken, Wohlbefinden, Work Engagement und Patientensicherheit unter der Betreuung von Cornelia Strecker, PhD, im Masterstudiengang Psychologie an der Universität Innsbruck möchte ich ein Interview mit Ihnen führen um genauere Hintergründe zum pflegerischen Arbeitskontext zu erhalten.

Um die Interviewdaten wissenschaftlich nutzen zu können, werden die Inhalte des Gesprächs schriftlich protokolliert und Ihnen zur Kontrolle übermittelt. Sollte das Gespräch mit Ihrer mündlichen Zustimmung aufgezeichnet werden, wird die Aufzeichnung direkt nach der Verschriftlichung endgültig gelöscht.

Alle personenbezogenen und auch alle das Umfeld identifizierenden Daten werden in anonymisierter Form gespeichert bzw. verschriftlicht, d.h. es werden keine persönlichen Angaben im Protokoll angeführt, die Rückschlüsse auf Ihre Person ermöglichen. Um Ihren Persönlichkeitsschutz zu wahren, wird Ihre Einwilligungserklärung an einem sicheren Ort getrennt vom Transkript aufbewahrt.

Sie haben jederzeit das Recht zur Einsichtnahme in die von Ihnen gespeicherten Daten und können deren Löschung verlangen.

Die Teilnahme an diesem Interview erfolgt freiwillig. Sie haben das Recht Ihre Einwilligung jederzeit ohne Konsequenzen zu widerrufen.

Ich stimme der Nutzung der anonymisierten erhobenen Daten im Rahmen der Masterarbeit von Felizitas Löffler zu:

☑ Ja ☐ Nein

Name der interviewten Person: [redacted]

Oberammergau, den 31.07.2021

Datum Unterschrift

Name der Interviewerin / des Interviewers: Felizitas Löffler

Oberammergau, den 31.07.2021

Datum Unterschrift

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Einwilligungserklärung

Im Rahmen meiner Masterarbeit zum Thema soziomoralisches Klima, die Anwendbarkeit von Charakterstärken, Wohlbefinden, Work Engagement und Patientensicherheit unter der Betreuung von Cornelia Strecker, PhD, im Masterstudiengang Psychologie an der Universität Innsbruck möchte ich ein Interview mit Ihnen führen um genauere Hintergründe zum pflegerischen Arbeitskontext zu erhalten.

Um die Interviewdaten wissenschaftlich nutzen zu können, werden die Inhalte des Gesprächs schriftlich protokolliert und Ihnen zur Kontrolle übermittelt. Sollte das Gespräch mit Ihrer mündlichen Zustimmung aufgezeichnet werden, wird die Aufzeichnung direkt nach der Verschriftlichung endgültig gelöscht.

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Die Teilnahme an diesem Interview erfolgt freiwillig. Sie haben das Recht Ihre Einwilligung jederzeit ohne Konsequenzen zu widerrufen.

Ich stimme der Nutzung der anonymisierten erhobenen Daten im Rahmen der Masterarbeit von Felizitas Löffler zu:

☑ Ja ☐ Nein

Name der interviewten Person: [redacted]

Oberammergau, den 24.06.2021 .....

Datum Unterschrift

Name der Interviewerin / des Interviewers: Felizitas Löffler

Oberammergau, den 24.06.2021 .....

Datum Unterschrift

B.3 Transcripts of the interview with P1

Interviewerin (I):	Felizitas Löffler
Interviewpartnerin (P1):	Examinierte Pflegekraft, 25-30 Jahre alt, weiblich, 3 Jahre Ausbildung und nun seit 5 Jahren in der Klinik, hat vor etwa sechs Monaten von der Inneren auf die Intensivstation gewechselt und macht dort nun die Weiterbildung zur Anästhesie- und Intensivpflegekraft
Interviewsituation:	am 24.07.2021 um 11 Uhr (Länge 51:12min) als persönliches Gespräch (vorherige Bekanntschaft, da wir in derselben Station gearbeitet haben) im Rahmen meiner Masterarbeit zum Thema Anwendbarkeit von Charakterstärken und deren Auswirkung auf das Arbeitsklima, das Wohlbefinden, das Arbeitsengagement und die Patientensicherheit unter Pflegekräften. Allgemein sehr entspannte Atmosphäre, haben sehr offen geredet und viel gelacht.

I1: Wie würden Sie Ihre momentane Arbeitssituation beschreiben?

P1.1: (… - 1s) Ui, ja (… - 1s) also ich würd sagen (… - 2s), da hat sich in letzter Zeit einiges getan. Hm, ich hab ja gewechselt. Also ich war davor auf der Inneren tätig und jetzt bin ich mittlerweile auf der Intensivstation. Und ja (… - 3s), da hat sich nun einiges verändert. Davor war alles viel stressiger, also wir waren 38 Betten und da sind ja durchaus viele dabei, die ganz viel Pflege brauchen auf der Inneren (… - 2s) und das kostet halt Zeit (… - 1s) und da waren wir am Tag meistens zu zweit (… - 2s) und vielleicht hatten wir noch Hilfe durch eine Schülerin mal, (… - 2s) aber eigentlich waren wir zu zweit. Und das hat schon an der Stimmung gezogen (… - 1s), die meisten kamen ungern in die Arbeit, mehr als die Hälfte redete darüber, dass sie nicht mehr wollen und gern was anderes arbeiten würden. Hm, ja (… - 1s) und zwei Schwestern haben jetzt auch schon die Station verlassen, um woanders zu arbeiten, die eine arbeitet jetzt in so einer Tagesbetreuung im Klinikum für die Krebskranken und eine andere macht jetzt ganz was anderes. Aber die haben das nicht mehr gepackt (… - 1s) also den Stress nicht. Und ich verstehe das sehr gut. Ich fand das immer so schade (… - 3s), naja also als Schülerin war ich ja damals auch auf der Station. Und damals hatte ich mir noch richtig viel Zeit nehmen können. Und ich hatte wirklich das Gefühl, die Patienten sind dann schneller gesund geworden. Denen ging es einfach besser (… - 3s) also, naja, also einfach weil sich jemand die Zeit genommen hat. Weißt du, ich hab ein Beispiel. Wir hatten da eine Frau, die hat immer nur geklingelt, immer und zu jeder Zeit. Jeder war super genervt von ihr und wollte schon gar nicht mehr auf die Klingel gehen. Und genau die Frau hab ich dann natürlich als Schülerin als Patientin bekommen. Und anfangs hab ich mich schon echt n bisschen gefürchtet, weil die verlangt ja dann viel, oder? (… - 1s) Aber ich muss sagen, ich bin dann zu ihr rein und dann dacht ich mir, nachdem es nach dem Wochenende war, wir gehen duschen. Dann hab ich sie geduscht – ich

war dann gleich mitgeduscht – und dann hab ich ihr einen schönen Zopf geflochten, weil sie meinen gesehen hat und meinte, der wäre so schön. Dann hab ich mit ihr zusammen Klamotten ausgesucht. Also nicht ich für sie, sondern wir für sie gemeinsam, damit sie das mitentscheiden kann. Ja und dann hab ich sie wieder ins Bett gepackt und frühstücken lassen. Und weißt du was? Sie hat den ganzen Tag nicht mehr geklingelt und stattdessen lag die Frau grinsend im Bett und hat jedem erzählt der reinkam, was für eine tolle Frisur sie doch heute hat und wie glücklich sie darüber ist. Und ich hab das Gefühl, dass diese Wertschätzung, die man den Patientinnen und Patienten da entgegenbringt (… - 2s), das ist wichtig. Dass die sich gesehen und gehört fühlen. Dass man sie eben noch wirklich pflegt. Das war ja früher echt anders. Also das hör ich immer von den älteren Schwestern. Dass sie früher wirklich Zeit sich haben nehmen können, oder? (… - 2s) Also sich wirklich Zeit für den Patienten und dessen Bedürfnisse (… - 3s) und sie meinten auch, dass damals noch der Beruf das war, was sie gerne machen wollten, ja und das jetzt sei nicht mehr das, was sie sich vorgestellt haben. Sie würden gerne pflegen, sich gern Zeit nehmen und können aber gar nicht. Und ja (… - 2s), ich find halt auch, man lebt da immer in so einem Konflikt, dass man weiß, der Patient bräuchte eigentlich mehr, um gesund zu werden und nicht nur das nötigste, aber man kann halt nicht, weil da halt auch noch andere warten. Hm, aber naja, als ich dann dort normal anfing und wir eben nur noch zu zweit waren und ich ganz normal arbeiten musste, nicht so wie davor als Schülerin, ab dann wurde es stressig. Ich hatte keine Zeit mehr. Ich renne nur noch von Zimmer zu Zimmer und kann mir gar nicht die Zeit nehmen und dann ertappe ich mich häufig, dass ich unsauber arbeite, mal ein Bett nicht runterfahre, wenn ich es doch tun sollte, um den Rücken zu schonen oder halt mal vergesse, die Hände zu desinfizieren, sobald ich das Zimmer verlasse oder betrete. Und vor allem aber fällt mir auf, dass ich oft genervt bin von den Patienten und gar nicht wohlwollend und lieb sein kann zu ihnen, sondern immer nur so schnell schnell (… - 5s), das ist so schade. Ja, weil, ich mein, das muss man sich mal vorstellen. Da ist man jetzt eh schon im Krankenhaus und es geht einem da ja nicht gut, man ist viel allein, vielleicht tut was weh oder man hat Angst, weil man gar nicht weiß, was jetzt als nächstes passiert. Also es geht einem dort ja einfach nicht gut. Und dann sind die Schwestern auch nur so ein Gehetze, niemand hat Zeit. Und niemand dort ist wirklich nett oder wirkt so, als wäre er wirklich interessiert. Das ist doch schrecklich. Und als Schwester (… - 3s), man weiß das ja, ich weiß ja, dass ich Interesse zeigen sollte und wirklich, also wirklich, Pflegen sollte und nicht so dieses schnell schnell. Ich weiß das ja und kann aber halt nicht. Und das ist ein Problem. Das find ich auch so belastend. Dass es mir einfach nicht ermöglicht wird, mein Job richtig auszuführen. Ich soll ja Menschen pflegen, gesund pflegen, und ich find das machen wir hier nicht mehr. Wir machen nur noch das nötigste, dass halt der Ablauf passt und die Patienten halt (… - 3s), puh, ja, das klingt jetzt hart, aber halt teilweise halt einfach nur überleben. Naja und ich finde, das merkte man im ganzen Team. Alle

waren irgendwie so genervt. Alle waren so ausgelaugt und hatten keine Lust. Und was halt da jetzt auch noch dazukommt war, dass die Zusammenarbeit mit den Ärzten dort gar nicht gut war, also die haben einem einfach nichts zugetraut und nichts mit uns abgesprochen, dabei kennen wir Schwestern die Patienten ja am besten, wir sind ja am nächsten dran. Und da fühlt man sich find ich dann schon auch selbst einfach nicht wertgeschätzt oder naja (… - 2s) als kompetent wahrgenommen. Und alles läuft dann halt irgendwie so nebeneinander her. Aber dass ist jetzt anders. Auf der neuen Station, also jetzt arbeite ich seit zwei Monaten etwa auf der Intensivstation (… - 1s) und dort ist das echt anders. Dort ist es zwar zeitlich immer noch sehr getaktet, keine Frage, aber das Team dort und auch die Zusammenarbeit mit den Ärzten ist so… wertschätzend! Sogar die Schüler dürfen dort mitreden und mitentscheiden. Bei der Visite kommt der Chefarzt herein und als allererstes werden die Schwestern nach der Meinung zum Patienten gefragt, da wird nichts einfach angenommen von den Ärzten, sondern man weiß immer, dass die Schwestern am nächsten dran sind und daher (… - 1s) ja auch am besten wissen, wie es gerade um den Patienten steht. Und es wird einem auch was zugetraut von den Ärzten, wir dürfen da richtig viel machen zum Beispiel Blutabnahme für das CRP, viel mehr nach eigenem Ermessen mit den Medikamenten umgehen, Patienten eigenständig auf die OPs vorbereiten (… - 3s). Ja, also ich hab einfach das Gefühl, einem wird dort richtig was zugetraut und ich hab das Gefühl, die Ärzte hören einem zu, wissen, dass man Ahnung hat und schätzen das wert. Und dort hab ich auch viel mehr das Gefühl, die Schwestern fühlen sich wohl… kommen gut gelaunt zur Arbeit, übernehmen gerne mal einen Dienst, falls jemand ausfällt, jeder hilft jedem. Ich hab auch das Gefühl, dass man dadurch gründlicher arbeitet und man weniger Fehler macht, weil man zusammen hilft und auch den anderen helfen kann, Fehler aufzudecken oder zu verhindern. Also zum Beispiel ist mir mal passiert, dass ich einen Monitor kaputt gemacht hatte, als ich den runtergeworfen hatte und aus meinem Dienst haben dann alle zusammen dafür unterschrieben, also dass das nicht ich war, sondern eben wir alle gemeinsam. Das fand ich total schön oder ich hab auch mal an dem Tag vergessen die Drainage eines Patienten zu reinigen, einfach weil ich einen Notfall hatte und da hat dann einfach meine Kollegin das gemacht, weil sie dann kurz nach meinem Patienten geschaut hat. Und so hilft man sich einfach gegenseitig, also das einfach alles funktioniert und zusammenhilft halt. (… - 3s). Ich find halt, man arbeitet dort viel mehr zusammen und hat viel mehr Wertschätzung allen gegenüber. Man spricht auch Sachen find ich viel eher an. In der anderen Station wurde in jedem Dienst über den vorhergehenden gelästert und jeder war schlecht auf den anderen zu sprechen und hier klärt man alles sofort auf, kann auch ansprechen, wenn mal was nicht gut lief oder man mal einen Fehler gemacht hat (… - 2s). Hier kann man auch Fehler sich eingestehen, weil man weiß, dass man hier immer noch angenommen wird und alle zusammenhalten, dass es wieder alles glatt läuft und alles gut geht. Hier ist irgendwie auch da alles offener. Da wird

viel mehr kommuniziert, eben viel offener, auch über Sachen, die schlecht laufen. Aber dadurch klärt sich halt alles schnell auf. (… - 5s). Ja, und auf der neuen Station, da redet man auch viel eher mal über Privates, also auch mal nicht über die Arbeit. Ich hab zu den Schwestern dort auch viel die engere Verbindung gleich aufgebaut, weil man halt viel mehr redet, eben auch über privates. Das kann man dort viel mehr erzählen. Und ich hab das Gefühl, dort kommen die Schwestern viel lieber zur Arbeit und haben auch viel mehr Energie (… - 1s) oder Motivation. Ja, die ganze Stimmung dort ist auch viel besser. Also ganz insgesamt find ich merkt man das. Das merkt man richtig und ich merk das auch bei mir. Ich bin richtig froh, dort jetzt zu arbeiten. Das tut mir schon sehr gut und ich hab wieder viel mehr Spaß bei der Arbeit (… - 4s), genau.

I2: Das freut mich richtig zu hören, dass du da jetzt einen so guten Platz für dich gefunden hast. Richtig schön. Was macht denn, deiner Meinung nach, eine Person besonders geeignet für den Beruf der Krankenpflege?

P1.2: Hm (… - 7s). Wow, das (… - 4s). Ja, das (… - 2s). Doch, also ich find Empathie ganz wichtig. Einfach, dass man sich in jemand anderen einfühlen kann (… - 1s), sich um jemand anderen kümmern kann. Ich mein, nicht umsonst heißt es ja Pflege. Also man soll ja für jemand anderen da sein können, sich in dessen Lage einfühlen können, also da auch eine gewisse Bindung aufbauen können, aber dennoch in der Lage sein können, nur in dieser „als-ob"-Perspektive zu bleiben und auch seine Grenzen ziehen zu können, damit man eben selbst nicht so involviert wird. Man muss sich da schon abgrenzen können, das ist auch wichtig. Also ich find da muss man auch einfach sich selbst gut kennen und (… - 2s) ja, das find ich auch wichtig, ehrlich zu sich sein können, sich selbst kennen, für sich selbst einstehen können, ja irgendwie halt auch sich selbst da treu bleiben können, auch im Sinne von „für sich selbst sorgen". (… - 4s) Also, verstehst du, ich find du bist ja immer mit anderen Menschen zusammen in der Pflege und sorgst immer für die anderen, die Patienten. Ich find, das muss man einfach für sich selbst sorgen können müssen. Und halt auch seine Emotionen da selbst (… - 2s), ja regulieren können. Das kann man ja schlecht am Patienten rauslassen, ich mein, das passiert viel zu oft, aber man sollte das eigentlich nicht. Eigentlich sollte man schon da einfach für sich selbst sorgen können und damit umgehen lernen (… - 3s). Genau. Aber ich glaub was ja wirklich alle Pflegekräfte irgendwie haben ist so dieses helfen wollen. Vielleicht haben wir alle so ein bisschen ein Helfersyndrom, wir sind alle viel zu gut. (… - 3s) Aber ich mag das auch, ich helf sehr gerne und mir gibt das auch viel zurück, das muss man auch sagen. Aber das muss man schon können, helfen wollen und natürlich auch können. Weil ich find, manchmal kann man sich nicht so gut auf andere konzentrieren, manchmal hat man zu viel Stress bei einem selbst, da find ich kann man gar nicht mehr so gut für jemand anderen sorgen, da ist man zu sehr beschäftigt mit sich

und seiner Situation. Also ich glaub auch für das helfen wollen ist es schon auch wichtig, dass man auch erst für sich selbst gesorgt hat, dass es einem selbst einigermaßen gut geht, damit man wirklich offen für die Probleme und den Stress einer anderen Person ist. (… - 4s). Ja gut und dann gibt es eben einfach noch so ein paar Basics, also zum Beispiel selbstständiges Arbeiten, also auch, so selbst einschätzen können, wann man was wie macht, also irgendwo auch Zeitmanagement sollte man beherrschen. Aber das ist ja grundlegend. Das ist sicherlich auch in anderen Berufen wichtig. Ich denk in der Pflege ist vor allem Empathie wichtig, helfen wollen, ja eben ehrlich zu sich sein können, also authentisch, man selbst sein können und halt auch für sich sorgen und mit seinen Emotionen gut umgehen können, damit man auch für andere adäquat da sein kann und ja dann halt auch soziale Kompetenz, also wie begegne ich Menschen, wie kann ich mit ihnen umgehen. Und aber eben zu der Abgrenzung passt das auch gut, also auch ein bisschen, dass ich eben auch mit meinen Emotionen gut klarkommen kann und diese regulieren kann, diese auch nicht an anderen rauslasse. Also ich glaub das find ich schon sehr wichtig. Aber ich find fast, dass das dazu gehört zu dem, sich selbst kennen und einschätzen können und auch ehrlich kommunizieren können, so eine gewisse Authentizität eben. Das find ich im Umgang mit anderen Menschen immer wichtig, also im Pflegeberuf ganz besonders. (… - 4s). Und naja, was mir immer hilft ist halt auch einfach Humor. Also einfach lachen können über alles, was so schiefläuft. Das haben bei uns ganz viele und ich muss echt sagen, dass das ganz erheblich den Alltag erleichtert. Es passieren so oft so viele blöde oder eklige Dinge und mit den Kollegen da einfach drüber zu lachen (… - 2s), ja, das hilft einfach. Ja, ich glaub das würd ich so grob sagen.

I3: Würdest du sagen, dass sich diese Eigenschaften von einer typischen Pflegekraft unterscheiden?

P1.3: Ähm, hm (… - 4s), hm, nee. Ich glaub nicht, nein. (… - 3s). Naja gut, also nicht alle Pflegekräfte sind so humorvoll, also vielleicht ist das so ein bisschen weniger bei manchen. Aber ich hab auch das Gefühl, dass die dann eher resignieren und schneller keine Lust mehr haben (… - 2s) und müde und abgeschlagen sind. Also ich glaub schon, dass eben die meisten das sind, was oben beschrieben wurde und ich glaub auch, dass es wichtig ist, diese Eigenschaften zu haben, damit man eben auch gut klar kommt in diesem Beruf, sich halt auch wohl fühlt. Und natürlich entscheiden sich Menschen, die gern helfen oder empathisch sind auch mal eher für so einen Beruf, das ist klar. (… - 3s) Also ich glaub das passt schon.

I4: Jetzt hast du ja gerade schon angesprochen, dass es auch wichtig sein kann, diese Stärken einzusetzen. Was meinst du denn, hat es für Auswirkungen, wenn man seine Stärken gut einsetzen kann im beruflichen Alltag?

P1.4: Hm ja, also eigentlich das, was ich oben meinte, also dass naja, Menschen fühlen sich wohler (… - 3s), also ich hab manchmal das Gefühl, dass die anderen, also die, die ihre Stärken nicht so einbringen können, weil sie halt zum Beispiel auch einfach nicht so zum Berufsbild passen, vielleicht, also weil die halt vielleicht was machen, das nicht so zu ihnen passt. Dass die eher mal resignieren und gehen wollen, total demotiviert sind und eher rummeckern. Also die sind eher unzufriedener. Also ich denke, die, die das alles gut einsetzen können, die fühlen sich wohler und sind auch glücklicher und sicherlich auch motivierter für die Arbeit. Ich mein, das ist ja klar, also da ist man dann ja eh wie ich vorhin meinte, sich selbst treu und macht das, was einem gut liegt und weil man das gut kann, macht es ja auch Spaß und motiviert, mehr davon zu machen. Ich glaub denen macht die Arbeit dann einfach mehr Spaß und daher sind sie auch motivierter und das wirkt sich natürlich auch auf alle anderen aus. Also ich arbeite schon lieber mit jemandem zusammen, der Spaß und Motivation an der Arbeit hat, das färbt ja auch ein bisschen ab, wenn man selbst mal einen schlechten Tag hat oder keine gute Laune hat. Also ich denk halt, dass man einfach da mehr das macht, was einem eh liegt und eh Spaß macht und dann ist Arbeit auch nicht mehr so sehr Arbeit, das hilft schon sehr denke ich (… - 2s), ja.

I5: Denkst du denn, dass man in der Pflege seine Charakterstärken generell gut einsetzen kann?

P1.5: Oh, hm, naja, ich glaub das kommt ein bisschen darauf an, was die eigenen Stärken sind. Also ich glaube sowas wie Empathie und dieses helfen wollen kann man glaub ich gut einsetzen und (… - 2s) ich glaub auch, dieses (… - 3s) sich abgrenzen natürlich auch. Aber manche gehen natürlich nicht so gut, ich mein, wenn man zum Beispiel eine Führungspersönlichkeit ist, aber einfach keine Führungsposition übernimmt, dann wird das schon schwierig. (… - 2s) Obwohl ich sagen muss, man kann natürlich dadurch, dass wir im Team arbeiten eh auch immer ein bisschen Führung übernehmen, das ist jetzt vielleicht ein schlechtes Beispiel. (… - 2s) Also ich denke schon, dass man bei uns viele Stärken gut einsetzen kann. Ich glaub, das hängt vielleicht weniger von den Stärken selbst ab, irgendwie findet man da schon einen Weg, diese einzusetzen (… - 2s). Ich find aber auch, dass ist auch immer ein bisschen von den jeweiligen Kollegen abhängig mit denen man halt zusammenarbeitet, inwiefern man sich selbst einbringen kann und inwiefern das (… - 2s), ja, auch gefördert und gewertschätzt wird von den anderen und natürlich auch von der Leitung der Station. Aber ich denke auch, dass man oft auch seine Stärken gar nicht so

einsetzen kann, weil man so Zeitdruck hat durch den ganzen Personalmangel und den vielen Patienten. Ich find, da ist man häufig so gestresst, da ist man dann in so einem Tunnel drin, da kann man dann gar nicht mehr so wirklich empathisch sein oder wirklich sich kümmern oder humorvoll sein, da ist man einfach nur gestresst und versucht halt irgendwie seine Arbeit fertig zu bringen und mehr nicht (… - 3s). Ich glaub fast, das ist das größte Problem, dieser Zeitdruck bei uns (… - 2s). Das find ich immer so schade (… - 1s), aber gut, da will ich mich jetzt gar nicht reinsteigern. (… - 3s) Ich, äh, find manche Personen können aber auch einfach besser ihre Stärken einsetzen, die sind einfach von ihrer Persönlichkeit so (… - 3s), ja wie sagt man da? (… - 1s) Ja, Macher. Solche Macher sind das. Das sind einfach so ganz aktive Menschen und die machen einfach immer das Beste aus ihrer Situation und ich find das sind auch die, die es irgendwie leichter schaffen, ihre Stärken einzusetzen. Ja, ich mein halt, einfach sich auch persönlich einzubringen. Schau mal, ich hab da eine Kollegin, die ist so jemand. Die ist immer gut drauf, strahl fast, find ich. Die kommt immer motiviert in die Arbeit und ich find mit der bin ich auch immer schon gleich viel fröhlicher und motivierter zu arbeiten. Und ich find die kann das auch alles super einsetzen, ich find die „macht" das einfach. (… - 2s) Ja, wie beschreibe ich das jetzt am besten. (… - 3s) Ja, ich hab einfach das Gefühl, die weiß einfach, wer sie ist, was sie gut kann und handelt auch danach, setzt das um. Ja und das macht echt Spaß mit ihr (… - 3s). Ja und ich find die anderen, naja, die meckern viel und sind resigniert und sind da dann voll so Opfer ihrer Situation (… - 2s), aber halt auch immer, das ist ja dann nicht nur im Beruf, das sind die dann auch im Privaten, bei allem. Die sind voll in ihrer Opferrolle drin. Zum Beispiel dass die Nachbarn immer so laut sind, dass sie im Stau standen, dass der Termin zu lang gedauert hat. Man hat das Gefühl, bei denen läuft alles schlecht und immer sind andere schuld und sie sind die Opfer. Ich hab auch immer das Gefühl, (… - 2s), weißt du, wenn es im Leben etwas gibt, dass dir nicht passt, dann find ich hast du zwei Möglichkeiten: entweder du akzeptierst es und lässt es dann gut sein oder du änderst es. Ich find die Optionen gibt es. Aber für diese Menschen gibt es auch noch eine weitere Möglichkeit, nichts von beidem zu tun und nur zu meckern. Ich hab echt das Gefühl, dass die von sich selbst denken, sie können gar nichts tun. Die sind so richtig handlungsunfähig, denk ich mir manchmal. (… - 2s) Ich frag mich schon manchmal, wie man da so krass reinkommt. (… - 5s) Und die anderen (… - 2s), die sind da irgendwie anders (… - 2s), die versuchen immer das Beste und sind immer aktiv dabei, das Beste aus der Situation zu machen (… - 2s) und die find ich setzen ihre Stärken auch eher ein. Die, die meckern, manchmal sieht man bei denen auch nur noch ganz schwach, worin die gut sind oder was deren Stärken sind, das ist voll weit weg, aber die anderen, die setzen das aktiv ein und irgendwie halt auch immer, also auch zuhause, unter Freunden und irgendwie passt sich das Leben dann auch gefühlt daran an, gefühlt bekommen die dann auch immer die Möglichkeit, die Stärken nutzen zu können. Hm, ja gefühlt gestalten die ihr Leben halt auch

nochmal mehr nach ihren Vorstellungen und versuchen aus dem, was sie grad nicht ändern können das Beste zu machen, (… - 3s) vielleicht ist es auch das. Ja (… - 2s) also ich würd sagen, dass es in der Pflege generell je nach Stärke schon gut geht, es aber auch von den Kollegen und der Leitung abhängt, aber (… - 2s) auch von einem selbst, also inwiefern man da aktiv ist und (… - 2s), ja genau, halt der Zeitdruck, leider kommt es auch darauf an. (… - 3s) Ja genau.

I6: Okay, jetzt kommen wir noch abschließend zu einem etwas heikleren Thema. Du darfst bei diesem Thema ruhig nur so weit reingehen, wie du dich dabei wohlfühlst. Inwiefern würdest du denn die Patientensicherheit bei euch einschätzen?

P1.6: Haha oh (… - 2s), jetzt war ich schon gespannt, was du da jetzt ansprichst. Nein, das Thema ist okay. Da hat ich jetzt schlimmeres erwartet. Also, ich versteh schon, warum du das sagst, aber ich find das jetzt nicht schlimm, darüber zu reden. Ist ja auch wichtig, find ich. Nagut, also (… - 4s). Hm (… - 2s). Ich find das jetzt ein bisschen schwierig, zu differenzieren. (… - 2s) Ja, also ich find halt, in der früheren Station, also der Inneren, da war die definitiv schlechter. Ich find aber halt auch, da stand man schon auch mehr unter Zeitdruck. Wie gesagt (… - 1s), wir hatten da 38 Betten und waren zu zweit. Wie soll man das denn gut schaffen und immer alles richtig machen? (… - 2s). Also, ich mein, klar, wir versuchen natürlich immer das Beste für den Patienten zu machen. Aber naja, manchmal geht halt doch was unter. Wir versuchen uns natürlich gegenseitig zu unterstützen und auch mal zu erinnern oder auch mal in das Zimmer des anderen zu gehen und zu schauen, ob da alles okay ist. Aber manchmal hat man dann doch einfach keine Zeit und keinen Kopf. Weißt du, man muss ja auch immer alles dokumentieren. Mei, das find ich halt auch so ein Ding (… - 3s). Alles, also wirklich alles, muss dokumentiert werden. Sonst bist du als Pflegekraft nicht abgesichert, weil sonst wurde es nicht gemacht und du bist schuld. Und ich würd halt echt sagen, da geht fast 60-70% der Arbeitszeit drauf. Und da hab ich noch niemanden gewaschen, eingecremt, das Frühstück eingegeben, die Medikamente verabreicht, nichts. Da hab ich noch nichts von dem gemacht, dass ich eigentlich als meinen Job ansehen würde. Also, verstehst du? (… - 3s) Der Druck kommt auch ein bisschen daher find ich. Weil man könnte vielleicht schon 38 Patienten versorgen zu zweit. Vielleicht ginge das. Aber halt nicht, wenn man nebenher auch noch alles dokumentieren muss. Da beschweren sich vor allem auch die älteren Schwestern drüber, weil die sagen halt, man muss immer mehr dokumentieren (… - 3s), früher war dass anscheinend viel weniger und sie meinten halt auch, dass das ihnen schon auch den Spaß verdirbt, weil sie halt nicht mehr das machen, was sie eigentlich als Beruf machen wollten, (… - 3s) sie pflegen nicht mehr, sondern sie schreiben, also quasi Bürojob. Und ja, ich versteh das schon mit dem rechtlich abgesichert sein. Klar. Aber dennoch, muss es wirklich so viel sein? Also alles so

penibel und das ist halt so zeitfressend. Ich frag mich manchmal, ob man dass denn nicht auch besser lösen kann. (… - 3s) Keine Ahnung, die reden ja alle immer von Pflegerobotern. Sowas find ich ja gar nicht sinnvoll, aber die könnte man doch zum dokumentieren hernehmen. Dass die einfach neben einem herfahren und das aufschreiben, was man tut oder dass man es denen zumindest diktieren kann oder so, Siri gibt es doch auch. Das muss doch gehen. Also weniger, dass Pflege ersetzt wird durch Roboter, ich mein, das find ich ja total bescheuert, du willst doch als Patient auch von einem Menschen gepflegt werden (… - 2s), naja, aber ich mein, dass Roboter die Pflege unterstützen könnten, eben so mit dokumentieren, was halt immer so viel Zeit kostet und halt so unnötig Zeit kostet. Ja, also, weil ich finde halt, dass eben dadurch, dass man immer weiß, ja, ich muss dass noch dokumentieren oder ja, da klingelt schon wieder Patient XY oder ja, die Visite fängt gleich an, also das alles, da hat man immer noch was im Hinterkopf. Und dann arbeitet man dann halt doch unkonzentriert. Also dann passieren halt doch mal so Kleinigkeiten. Meist sind dass eh nur so Sachen, die dann einen selbst eher schaden, als dem Patienten, also zum Beispiel, dass Bett nicht hochfahren zum umlagern oder nicht die Unterlagen zum aufsetzen oder umdrehen nutzen. Also da geht ja einfach mein Rücken nur kaputt, aber dem Patienten passiert da eher mal nichts. Aber gut (… - 2s), kann schon sein, wenn ich mich dann verhebe und mir der Patient umfällt, dann ist das schon schlecht. (… - 2s). Vor lauter schnell schnell ist es mir auch schon mal passiert, dass ich einen Schlaganfallpatienten an die Bettkante gesetzt habe zum Frühstück und die sind ja halbseitig gelähmt oft. Und ich hole ihm gerade so das Frühstück und ich sehe so aus dem Augenwinkel, wie er langsam zur Seite kippt. Und ich mein, da ist jetzt nichts passiert, der ist einfach seitlich dann im Bett gelegen so halb sitzend noch und wir haben dann auch beide gelacht darüber. Aber dennoch, also das sollte halt eigentlich auch nicht passieren. Da muss man schon dran denken, dass der Patient halt fixiert werden muss mit einem Kissen, damit er nicht umfällt. Oder wenn man halt einfach aus Personalmangel und Zeitdruck nicht zu zweit einen schweren Patienten aus dem Bett hebt, sondern halt allein (… - 3s), ja ich hatte da echt schon so n 100kg Typ, den ich da allein heben musste und da hatte ich schon auch echt Angst, dass ich mit dem umfalle. Aber du hast halt auch echt keine andere Möglichkeit. Da ist halt dann grad einfach niemand da, der Zeit hätte zu helfen. Ja und dann find ich kommt ja auch dazu, dass man dann alles unnötige halt nach hinten schiebt und ich sitz dann nach zwei Uhr, also nach Ende der Frühschicht so oft noch da und dokumentiere das noch alles, weil ich das Vormittags gar nicht geschafft habe. Also das ging sich halt einfach nicht aus. Und dann machst du halt Überstunden oder, weil du dokumentieren musst. Und gleichzeitig weißt du aber, dass du dann teilweise in der Spätschicht bist, morgen aber gleich wieder Frühschicht hast, was man ja eigentlich eh nicht wirklich darf, aber es passiert halt, weil halt niemand da ist und dann sitzt du da und musst noch über die Zeit dokumentieren, obwohl du eh nur achteinhalb Stunden zwischen den Schichten

hast. Wann soll man da dann schlafen? Man braucht ja auch n bisschen Zeit, um zur Ruhe zu kommen zuhause. Und dann ist man find ich auch echt gerädert dann in der nächsten Schicht. Und da passiert sowas auch. Also eben so Kleinigkeiten halt, dass man mal vergisst Zucker zu messen oder mal das Medikament zu spät gibt. Es ist meist eh nie was super Fatales, irgendwie kann man das dann schon immer regeln, aber es passiert halt und es ist halt auch einfach unnötig. Es sollte halt nicht passieren. (… - 4s). Man wird halt einfach müder und unkonzentrierter durch den Schlafmangel, durch die vielen Schichten, aber halt vor allem durch die Überstunden. Und das ironische ist ja, man dürfte bei uns nur 20 Überstunden haben, weil das jetzt das Gesetz halt so sagt, damit die Pflege da „entlastet“ wird und nicht mehr so viele Überstunden hat. Ja, und was ist passiert? (… - 2s) Wir stempeln uns ja. Und ab 20 Überstunden werden die Überstunden einfach nicht mehr angerechnet. Was nun bedeutet, wir machen die Überstunden, werden aber nicht dafür honoriert, bekommen keinen Urlaub mehr dafür und auch kein Geld. Wow. (… - 2s) Ja, also das find ich haben sie schon richtig gut gelöst. Wie bescheuert ist denn das? Weißt du, und dann klatschen sie Beifall bei diesem Coronazeug. Also jetzt mal im Ernst, wo ist denn da bitte wirkliche Wertschätzung? Entschuldigung, aber das kannst du mir doch wirklich nicht sagen, dass da einer von denen, die da Beifall geklatscht haben wirklich wissen, was wir eigentlich normalerweise im Alltag leisten müssen und was wir dafür dann nicht bekommen. Wir kriegen die Überstunden einfach nicht mehr angerechnet, ja also so wirst du das Problem auch los. Wow. Ja, also verstehst du? Ich find da fühlt man sich einfach verarscht manchmal. Und irgendwie sieht das halt auch keiner, also die Regierung mit dem lieben Herrn Spahn (… - 2s), die sehen das nicht. Es gibt ja auch so viele Posts auf Facebook, wo Schwestern den auch direkt ansprechen und da passiert ja wirklich gar nichts. Und das Ding ist ja, also man verdient als Schwester jetzt auch gar nicht so schlecht. Also es geht wirklich. (… - 3s) Aber halt auch nur, wenn man Schichten macht und halt am Wochenende arbeitet. Dann bekommt man halt die ganzen Zulagen. Ohne die? Ne, also ohne die wär das nicht so viel. Und ich find grad die Schichten und die Wochenenddienste sind das, was eben das ganze so anstrengend macht. Also grad dadurch werd ich müde und grad durch die Schichten und das Wochenende find ich sammelt man auch die Überstunden an. Weil zum Beispiel am Wochenende muss man halt mehr machen, weil da sind zum Beispiel die, die Frühstück bringen nicht da. Das muss man dann auch machen. Und der Hol- und Bringdienst ist auch nicht da, also muss man auch das alles machen. Und das fängt ja in der Spätschicht schon an, dass die nicht mehr da sind. Also ich find, grad da sammelt man das halt an. (… - 4s) Ja und ich find halt mit so vielen Überstunden, da ist man einfach müde, also selbst wenn man dann mal genug geschlafen hat, ich find man ist einfach so jobmüde. Man hat so viel gearbeitet, so viel mehr gearbeitet als eigentlich geplant war und man wird dann einfach müde. Aber man hat ja trotzdem nur 30 Tage Urlaub, weil überstundenfrei gibt es ja eh nicht, weil man kein Personal hat,

die werden wenn überhaupt ausgezahlt. Und ja, dann ist man einfach müde. (… - 2s) Also halt immer irgendwie. Und wenn man mal aus‘m Urlaub kommt, dann ist halt der erste Tag meist gleich wieder so stressig, dass Entspannung eh wieder weg ist. Also ich find mit dem Zeitdruck ist man einfach immer so unter Strom, da kann man gar nicht wirklich entspannt sein und ich find dann schläft man halt generell nicht so gut und dann ist man halt einfach unkonzentrierter und dann passieren einfach Fehler und wenn man dann halt auch nicht die Kollegen hat, die die Zeit haben, da mal drüber zu schauen, dann wird das schwierig. Also ich find schon, dass die Unterstützung durch das Team da ganz wertvoll sein kann, also dass man da eben immer Unterstützung und Fürsorge bekommt und auch Dinge offen ansprechen kann, also alle Fehler, die vielleicht passiert sind auch ansprechen kann und um Hilfe fragen darf und dass man sich da so auch im Team einbringen kann und halt auch integriert wird vom Team. Also einfach, dass da alle mitsprechen können, alle alles ansprechen können und sich alle unterstützen. Ich hab schon das Gefühl, dass macht es besser, also dass da weniger passiert. Das merk ich jetzt auch auf der Intensivstation. Das hilft schon einfach. Aber der Zeitdruck bleibt da dennoch nicht aus. Da gibt’s einfach zu wenig Personal und zu viel zu tun, zu viel zu dokumentieren (… - 3s). Das hört ja leider durch ein gutes Team nicht auf. Naja, also generell passt es schon, also es könnte echt schlimmer sein, aber der Zeitdruck ist da schon echt n Faktor find ich. Schade eigentlich.

I7: Nun hast du ja schon angesprochen, dass sich der Zeitdruck und auch das Team auf die Patientensicherheit auswirken kann, denkst du, dass es auch persönliche Faktoren, wie zum Beispiel die angesprochenen Faktoren wie das Einbringen der eigenen Stärken oder auch Wohlbefinden und Motivation sich auf die Patientensicherheit auswirken?

P1.7: Hm (… - 2s), generell würd ich sagen ja. Also gefühlt wirkt sich ja immer alles auf alles aus. Ne, aber im ernst. Also ich würd schon sagen, dass jetzt jemand, der mit Spaß bei der Arbeit dabei ist, dem es gut geht und der motiviert ist und alles (… - 3s), ja also klar, die arbeiten dann schon besser würd ich sagen. Wie ich ja auch vorher meinte, wenn man selbst weniger Stress hat, dann kann man sich auch mal eher auf jemand anderen konzentrieren und halt auf dessen Bedürfnisse eingehen. Und ich glaub auch, dass dann weniger Fehler passieren. Weil (… - 2s), ja, also wenn man sich mal jemanden anschaut, der vielleicht echt gestresst ist, Zeitdruck hat, sich grad nicht wohl fühlt und das alles zieht ja auch die Motivation runter, oder? Und dann find ich eben, dass man dann schon auch einfach mit so einer „Kein-Bock“-Einstellung in das Zimmer reingeht und halt auch einfach nur das nötigste macht und halt keinen Deut mehr. Aber ich find, dass passiert schon auch dann, wenn man nicht gewertschätzt wird. Also zum Beispiel seitdem man über 20 Überstunden nichts mehr angerechnet bekommt, da haben schon viele aufgehört, sich Mühe

zu geben oder extra Arbeit zu machen, weil die halt auch sagen: „Ja, meine Arbeit wird ja eh nicht gesehen oder honoriert, das ist ja egal“. Ist ja klar, dass die dann auch nicht mehr mehr machen. Versteh ich. Geht mir ja ähnlich. (… - 2s). Und ich find das alles zieht ja die Motivation schon ordentlich runter. Also gerade dieser Stress durch das Dokumentieren, wo man eigentlich auch manchmal echt nicht weiß, warum man das tut, dann diese Überstunden und das man da nichts dafür bekommt, da find ich ist man einfach unzufrieden und ich find da hat man keinen Bock mehr. Und ja, dann macht man seine Arbeit auch schlechter. Ja, stimmt. Klar, es gibt immer so n paar Menschen, die sind einfach super ordentlich und sorgfältig, egal wie es denen geht, die sind einfach so. (… - 3s) Das ist ja dann vielleicht auch so eine Stärke, wie du vorher meintest. Also mit der kann man sicherlich noch n bisschen was retten, aber ansonsten, wenn Motivation und eben so diese Zufriedenheit in der Arbeit weg ist und ich find, das passiert bei uns fast automatisch durch dieses ganze stressige Zusatzzeug, dann passieren Fehler eher mal. Da hat man einfach keine Lust mehr, diese Extradinge zu machen und natürlich auch keine Zeit dafür. (… - 3s) Also ja, ich find schon, dass da die Person schon auch n bisschen mit reinspielt. Eben wenn du da sehr sorgfältig ist, dann geht das mal eher noch, aber generell, wenn man einfach durch das alles, was ich vorher meinte, auch einfach die Motivation verloren hat, dann (… - 2s), ja also ich find da wird’s dann echt schwierig. Man kann echt noch n bisschen was kompensieren, wenn man generell eher so der engagierte oder vielleicht gut gelaunte Typ ist, definitiv, aber halt auch echt nicht mehr alles. Leider.

I8: Ja, gut, ich wäre mit meinen Fragen am Ende. Haben wir noch etwas nicht angesprochen, worüber du gerne reden möchtest?

P1.8: Ui. Jetzt habe ich am Ende schon noch ganz schön gehatet irgendwie. (… - 2s). Da hab ich mich dann doch noch echt reingesteigert. Oh man (… - 2s). Weißt du (… - 2s), die Pflege ist wirklich ein toller Beruf, ich lieb das wirklich. Sonst hätte ich mir das ja nicht ausgesucht. Aber es ist schon wirklich schade, wie der Beruf und halt auch diejenigen, die den ausüben (… - 2s) und das ist ja ein wichtiger Beruf, ge? Es kann ja wirklich sein, dass wir alle mal auf Pflege angewiesen sind. Ich find, das ist wirklich ein wichtiger Beruf. Also ich find, es ist schade, dass der Beruf und die, die den ausüben, so kaputt gemacht werden, sei es durch Zeitdruck, Stress, Überstunden, Dokumentieren, man macht einfach den Beruf nicht mehr so, wie man sich vielleicht vorstellt, wie er halt sein sollte. Und das find ich schade. Der Beruf an sich ist toll. Ich hoffe nur einfach, dass sich da irgendwann mal was tut (… - 2s). Ja, weil es ist ein wichtiger Beruf einfach.

I9: Hast du denn sonst noch Fragen?

P1.9: Hm (… - 2s). Nein, eigentlich nicht. Sonst frag ich dich einfach so nochmal! (… - 2s) Oh warte, doch! (… - 2s) Meinst du, ich darf das dann alles mal durchlesen, also so deine Arbeit, zu was du kommst, also was da rauskommt?

I10: Ja klar! Also ich würd dir eh das Transkript des Interviews nochmal zukommen lassen, damit du da nochmal drüberschauen kannst, ob das für dich passt und die fertige Arbeit bekommst du dann sehr gerne, aber das wird noch ein bisschen dauern.

P1.10: Ne, gar kein Problem. Das interessiert mich nur, vielleicht hast du ja auch nochmal neue Ideen oder was, was wir anders machen können. Naja, mich interessiert die Arbeit einfach.

I11: Sehr gerne, das können wir machen. Dann danke ich dir für deine Offenheit und auch für deine Zeit und wünsche dir noch einen schönen Tag!

P1.11: Danke eher, dass ich so offen reden durfte und dass du mich gefragt hast für das Interview, das hat mich echt gefreut und bin echt gespannt.

B.4 Transcript of the interview with P2

Interviewerin (I):	Felizitas Löffler
Interviewpartnerin (P2):	Examinierte Pflegekraft, 50-55 Jahre alt, weiblich, 3 Jahre Ausbildung und nun seit 37 Jahren in der Klinik, seit etwa 20 Jahren neben der Pflegetätigkeit nun auch in der Leitung tätig
Interviewsituation:	am 31.07.2021 um 16 Uhr (Länge 01:28:33 Std.) als persönliches Gespräch (vorherige Bekanntschaft, da wir in derselben Station gearbeitet haben) im Rahmen meiner Masterarbeit zum Thema Anwendbarkeit von Charakterstärken und deren Auswirkung auf das Arbeitsklima, das Wohlbefinden, das Arbeitsengagement und die Patientensicherheit unter Pflegekräften. Allgemein sehr entspannte Atmosphäre, haben sehr offen geredet und viel gelacht.

I1: Wie würden Sie Ihre momentane Arbeitssituation beschreiben?

P2.1: Die Arbeit als solches (… - 3s) gefällt mir sehr, ich habe einen sehr großen Einblick in der Einrichtung, wo ich tätig bin. Angefangen von der Tätigkeit eine Einrichtung, über Einrichtungsleitung, über der Pflegedienstleitung und über die Tätigkeiten der Pflegefachkraft. Dadurch, dass ich nun mal Jahrzehnte in der Pflege gearbeitet habe, liegt mir immer noch sehr am Herzen zu sehen, wie und was die Schwestern arbeiten. Die Arbeit, wie gesagt macht mir immer noch Spaß sonst wär ich jetzt nach drei Jahrzehnten nicht mehr dabei, aber ich sehe und stell leider fest, dass die Entwicklung (… - 3s), die momentan die Pflege durchmacht ist nicht immer als positiv zu sehen.

I2: Wie meinst du das genau mit dieser Veränderung?

P2.2: Als ich gelernt habe, da ist man zur Arbeit gekommen und man war motiviert, die Arbeit hat Spaß gemacht, wenn die Vorgesetze was gesagt hat, man hat das umgesetzt, Team war da, man hat gemeinsam gearbeitet. Jetzt hat man so das Gefühl, da die Motivation ist (… - 3s) kaum vorhanden. Das heißt, wenn es zu Situationen kommt, und in der Pflege haben wir Pflegenotstand, und wenn jemand ausfällt und es heißt: „Du hast zwar morgen frei, aber morgen fällt jemand aus, kannst du arbeiten?“, dann heißt es „Nö“. Also die Bereitschaft, Kollegialität zu zeigen, okay bevor meine Kollegin morgen alleine steht, ich komm. Und ich teil mir jetzt den Dienst irgendwie mit meinen Kollegen auf. Da wird gar nicht nach einer Lösung unbedingt gesucht oder bzw. die Lösung liegt vor, aber ich bin nicht bereit da mitzumischen, weil mir viel wichtiger ist das Privatleben. Verstehe ich schon, aber in dem Beruf als examinierte Pflegefachkraft, ich ich kann nicht einfach sagen, so jetzt bin ich zuhause, mir ist jemand krank geworden und da bleibt der Betroffene

ungepflegt, bleibt liegen. Wir haben eine gewisse Verpflichtung, eine Fürsorgepflicht. Als Pflegekraft hat man eine Fürsorgepflicht für die Patienten. Deswegen ist der Patient da, weil ihm fehlt was, deswegen ist er in meiner Obhut. Und und da ist verändert, ich hab gelernt, aus Überzeugung, ja, und ich war voll dabei und mittlerweile hab ich so das Gefühl, vielleicht weil die Arbeit mehr wird auf weniger Leute ist die Bereitschaft nicht mehr so gegeben. Und und das ist sehr belastend. Die entsprechenden Dienste abzudecken, was ich auch feststelle, und das hat vielleicht auch mit dem Pflegenotstand zu tun. Wir haben einen sehr großen Anteil an Pflegepersonal, das nicht unbedingt der deutschen Sprache mächtig ist. Und in der Pflege musst du leider verstehen, was dir akustisch gesagt wird, verstehen, was du liest und was du schreibst (… - 2s). Und äh, was bringt mir das, wenn diejenige versteht, aber sie selber kann nicht weitergeben, was von dem Arzt oder von der anderen Schwestern mitbekommen hat, die Kommunikation weitergeben. Und Dokumentation schriftlich muss nun mal auch stattfinden. Und wenn man nun mal seine Dokumentation schreibt und die ist nun mal für den Nachfolger nicht nachvollziehbar, dann bringt mir die Dokumentation nichts mehr. In der Pflege heißt es, was nicht dokumentiert ist, ist nicht gemacht worden. Weil ich muss mich mit meiner Dokumentation somit auch enthaften. Und wenn ich nichts schreibe, da habe ich es nicht gemacht. Und wenn irgendwas passiert ist, was ich schreiben muss und manchmal muss ich eben einen Bericht schreiben über mehrere Zeilen und ich bin nun mal der Sprache in Schriftform nicht mächtig, dann wird das sehr schwierig. Und das ist auch wieder so etwas, ich hab mit vielen Schülern zu tun, mit vielen Schulen. Und da heißt es, wir haben in der Schule viele Schüler, die der deutschen Sprache nicht ausreichend mächtig sind, da müssen wir Deutschunterricht zusätzlich anbieten. Und wir müssen alle Schüler zum Examen zulassen und fast niemanden durchfallen lassen. Das heißt, wenn man noch eine 4 Komma noch was hat, hat man immer noch bestanden. Und dadurch resultiert dann auch die entsprechende Pflege. Mit einer geringen Quantität kann ich keine hohe Qualität erwarten. Und das ist das, womit wir zu kämpfen haben. Einerseits haben wir kein Personal, also wird schnell welches beschaffen (… - 2s) aber die bekommen nicht ausreichend Zeit, um also ja, eine Sprache zu lernen. Das wird mir niemand sagen, dass man innerhalb von einem Jahr, eine Sprache nun mal fließend lernen kann und die haben, die kommen das jetzt die Balkanländer oder aus Russland, die bekommen 3-4 Monate einen Crashkurs und dann heißt es, ja mach mal (… - 3s) um eine Sprache zu lernen, braucht man schon, ich sage mal, 2 Jahre und dann kann man sagen, so jetzt beherrsche ich die Sprache. Da ist unser Manko. Und Manko, was auch noch ist, es sind nicht ausreichend junge Menschen, die bereit sind, diesen Beruf zu ergreifen. Weil (… - 3s) Weihnachten Dienst, Silvester Dienst, Dienst am Abend, wenn die Freunde nun mal ins Kino gehen, muss ich zum Nachtdienst oder bin ich noch im Spätdienst, Wochenende wo die Party ist, muss ich zur Arbeit. Und wenn man sich bedenkt, was für Entlohnung, ja, es wurde uns viel versprochen (… - 2s),

hm (… - 2s) Anerkennung ist immer noch finanziell angesehen. Und Anerkennung als solches unser Beruf als Pflegefachkraft ist unabhängig davon Krankenschwester oder Altenpfleger, das ist jetzt alles in einem Beruf erfasst worden als Pflegefachmann/ -frau, das hat einen oder bzw. gar kein Image (… - 4s) und wir sind auch nicht organisiert durch eine Gewerkschaft oder so, die hinter uns stehen würde und die Politik lässt uns seit über 35 Jahren auch allein. Corona hat das ganze jetzt aufgedeckt und was hat sich getan? Geklatscht haben sie für uns (… - 3s) schön, aber mit Klatschen komme ich nicht weiter. Klatschen kann ich vielleicht bei Sportevent, wo ein Tor gefallen ist oder jemand hat nun mal ein Ass gemacht beim Tennis, toll. Aber nicht, wenn man mit Menschen zu tun hat. Wie es mir momentan geht? Ja (… - 2s) mir gefällt mein Beruf immer noch. Ich arbeite darin immer noch gern. Ich würde mir wünschen, dass es vielleicht auch irgendwann besser wird, jetzt bin ich schon seit 35 Jahren dabei und es wird nicht besser, aber die Hoffnung stirbt zum Schluss. Hm.

I3: Jetzt hast du schon relativ viel über deine Stimmung geredet. Wie würdest du das Arbeitsklima unter den Pflegekräften beschreiben?

P2.3: Also, die Stimmung hängt immer davon ab, inwieweit die Führungsebene nun mal auch ein Team führt. Hab ich ein (… - 2s) ja (… - 2s) Stationsleitung, Bereichsleitung, die nun mal sehr (… - 1s) fähig ist, die auch führen kann, die einen kollegialen Führungsstil hat, die auch nun mal ein Team führen und zusammen führen kann. Ein Team entwickeln kann. Die auch nun mal mit einer Schülerin, die ist gerade im 1. Ausbildungsjahr, muss sie ganz anders führen, als eine Mitarbeiterin, die seit 20 Jahren dabei ist. Aber wenn sie weiß, jeden einzelnen Mitarbeiter von da abzuholen, wo er steht. Und daraus ein Team und jeden seine Stärken rufen und Schwächen zu arbeiten, da wird Teamführung, Teamgeist wird gegeben und der eine ist für den anderen da und da wird auch die Stimmung bombastisch. Das hab ich jetzt erlebt. Ich hab ein Team übernommen, zerstritten, keine wollte mit dem anderen reden, einer auf dem anderen und dann haben wir gemeinsam angefangen zu arbeiten (… - 1s) so (… - 2s) auf einmal ist ein Teamgeist gekommen, die gehen einmal die Woche entweder Kegeln oder gehen ins Kino hab ich mitbekommen haben sie sich verabredet. Nächste Woche wollen sie bei irgendjemandem Grillen, das wächst dann. Aber man muss einfach wissen, wer als Führung dabei ist und inwiefern ich, die einzelnen Personen zu Wort kommen lasse. Und ich muss auch jeden einzelnen zu Wort kommen lassen. Wenn eine Idee angebracht wird. Nicht sagen, das wird jetzt so gemacht. Es gibt bestimmt genug Tätigkeiten, die gemacht werden müssen, weil es vorgegeben wird. Ob es jetzt die Expertenstandards sind, ob das jetzt überhaupt Standard von jeder Einzelnen Einrichtung sind, aber es gibt genügend Sachen, die man gemeinsam erarbeiten kann, muss, darf, kann. Und da soll jeder seine Idee anbringen und jeder zu Wort kommen, dass

sich jeder äußern kann. Und wenn da auch so eine kleine Schülerin oder sogar Praktikantin feststellt hoppla mein Wort wird gefragt und es zählt was, da bekommt der Mitarbeiter eine ganz andere Einstellung zu arbeiten, dann er gern zur Arbeit, er ist motiviert. Es funktioniert (… - 2s) gute Führung und Team funktioniert auch. Und die Führung muss jeden Einzelnen oder sollte jeden einzelnen Mitarbeiter kurz analysieren, wie gehe ich mit ihm um, das ist also auch sehr individuell. Jeden also dort abholen wo er steht und jeder steht woanders. Ich muss sie zuerst kennenlernen, an sie rankommen, ich muss deren Vertrauen erst erarbeiten als Führungskraft. So, und dann muss ich sie gemeinsam auf einen gemeinsamen Nenner bringen. Das ist eine Arbeit, wenn ich Glück habe, das kommt immer darauf an, inwieweit die Mitarbeiter auch passiv oder aktiv sind. Inwieweit sie wollen mitarbeiten oder sagen, ne nicht mein Ding. Und da kommt die Führungskraft. Da ist es deine Aufgabe. Und wenn das funktioniert, entwickelt man ein Team. Also ich kann sagen, in meiner Arbeit, in meinem Team mit fünf Abteilungen und da gehört auch die Hauswirtschaft dazu, die Ärzte und auch die Pflege. Es funktioniert. Man muss mit dem Mitarbeitern reden, auch unangenehme Sachen klären, Transparenz. Transparenz (… - 2s) ich sag immer wieder Kommunikation, Transparenz, aber auch wertschätzender Umgang mit dem Mitarbeitenden und es funktioniert. Da muss nicht immer, extra Boni sein, was weiß ich, zum Geburtstrag ein 100€-Schein, wenn die alle zwischenmenschliche Faktoren funktionieren, funktioniert das auch. Das hat mir das jetzt wieder gezeigt, das funktioniert.

I4: Ja voll schön, dass das bei dir so gut klappt. Vorhin hast du die Stärken angesprochen, die man nutzen kann als Person. Was macht denn deiner Meinung nach, eine Person besonders geeignet für den Beruf der pflege?

P2.4: (… - 4s, ausatmen, … - 2s) Das sollte jetzt nicht (… - 2s) Nächstenliebe. Ja? Also ich muss, soziale Intelligenz und soziale Kompetenz muss da sein. Das heißt, derjenige muss in der Lage oder sollte in der Lage sein, sich in den Patient versetzen zu können. So, ob das jetzt jemand, der nur mit gebrochenen Bein ist oder der mit Bauchschmerzen, ich muss mich versetzen können, dass es dem nicht gut geht. Welche Sorgen hat der Patient? Er hat jetzt vielleicht gerade Bauchschmerzen, hat aber jetzt Zuhause sein Kind, das die Mutter versorgt (… - 2s), da muss ich einfach auf den Patienten zugehen. Ich muss Vertrauen erwecken. Vertrauenswürdig sein. Ich muss dem Patienten das Gefühl geben, ich bin jetzt für dich da, lass dich fallen. Rede mit mir, hilf mir, dich besser zu verstehen. Auch im Bereitschaft zu zeigen, ich will dir auch helfen. Ähm, ich muss empathisch sein, auf jeden Fall. Das ist wichtig. Was wichtig ist, dass der Patient bekommt das Gefühl, ja ich vertraue dir und ja, sie hat mir jetzt auch geholfen. Das heißt, nur sagen, reicht nicht, ich muss dafür auch was tun. Wenn jemand Schmerzen hat und ich sage ich bringe eine Tablette und nach drei Stunden komme ich immer noch nicht. Verstehst du? Ich muss da auch einfach

Vertrauen erwecken, zuverlässig sein. Aber der Patient muss mir auch sagen, wo habe ich Schmerzen, wie stark sind die. Ich werde den Arzt gleich holen und mit ihm reden und der Arzt gibt mit entsprechende Anweisung. Und der Patient bekommt das mit. Vielleicht hat mich die Pflegekraft dann auch anders hingelegt. Die Bauchschmerzen sind besser geworden. Das heißt, sie weiß, was zu tun ist. Ich vertraue ihr. In dem was sie mir sagt und in dem was sie tut, das heißt auch, meine Handlung muss vertrauenswürdig sein. So, glaubwürdig sein. Ich muss auch selbstbewusst trotz allem bleiben und was ich auf jeden Fall muss haben ist lernen zwischen privat und beruflich zu trennen. Das heißt, in dem Beruf begegnet man auch sehr viel unangenehme Sachen, der Tod gehört dazu. Genauso wie eine Geburt. Weil in dem Moment, in dem wir auf die Welt kommen, ist auch irgendwo meine Zeit abgelaufen, daher gehört der Tod dazu. Aber ich muss lernen, in dem Moment, wo jemand stirbt, ich darf mich nicht emotional hineinknien. Weil dann sterbe ich mit. So (… - 2s) ich muss mitfühlend sein für die Angehörenden. Aber ich darf mich da nicht mit rein manövrieren. Also nicht mitleiden. Sonst gehe ich mit jedem Patient, den ich über die Jahre begleite, ein Stück mitsterben und dann gehe ich zugrunde. Oder da seh ich die, ein Kind wird operiert und es sieht nach der OP nicht gut aus, die Mutter bricht zusammen. Ich bin selbst Mutter, ich weiß, dass das weh tut, aber ich darf nicht meine gefühlte als Mutter mit reinbringen sondern ich bin jetzt Krankenschwester, ich tröste sie, ich verstehe sie, aber ich darf nicht meine Emotionen mit dazu nehmen, sonst gehe ich zugrunde. Also diese Mauer, sollte jede ein klein bisschen um sich herum haben um sich selbst zu schützen. Es ist nun. mal bewiesen, dass eine Krankenschwester im Durchschnitt 7-8 Jahre nach dem Examen arbeitet, weil sei ausgebrannt ist. das ist nicht viel. Sie ist ausgebrannt, weil der Job als solches verlang sehr viel. Kopf muss du haben, in den Händen musst du‘s haben zu Fuß musst du schnell sein und oft musst du auch Multitasking fähig sein, weil da steht die Visite, da kommen Teller und da klingelt jemand. Da wird also von allen Sinnesorganen was von dir verlangt und dann noch diese emotionale, diese unangenehme Tätigkeit mit dem Patienten, das Elend: da stirbt jemand, ein Bein wird gebrochen, muss amputiert werden. Das sind alle so Schicksale, die sollst du dir anhören. Mitgefühl zeigen, Verständnis, aber du selber darfst dich nicht hineinbeugen, sonst gehst du zugrunde. Und du gehst aus dem Patientenzimmer und du machst die Tür zu, so hab ich das gelernt, existiert der Patient nicht mehr, für mich. Für die Akte ja, für die Übergabe an die anderen Schwestern, ja. Aber in dem Moment wo ich meine Arbeit verlasse, bleiben die Probleme im Krankenhaus. Das ist dass, was ich gelernt hab durch meinen Mentor, als ich begonnen habe. Ich hab eine Ordensschwester die ich angelernt habe und die hat mir dann gesagt, wenn du hierher kommst, gibt’s keine Mama, keinen Freund, keine Freundin, da ist der Arzt, der Schwester, der Patient mit. Dann nimmst du dein Päckchen wieder mit und da ist weder die Mama, noch der Freund, die Freundin und das ist nun mal was eine Krankenschwester lernen muss, wir begleiten ein Leben lang verschiedene

Rollen in unserem Leben. Einfach das zu lernen, dass das auch ein Job ist wie jeder andere. Und einen Job mach ich in meinen 7 stunden und dann lass ich die Rolle der Krankenschwester im Krankenhaus. Denn ansonsten mental das schafft man das nicht immer. Man schleppt dann die Probleme mit nach Hause und nicht jeder macht über Jahre hinweg macht, verarbeitet das. Ich kann über meinen Beruf jederzeit reden, aber ich hab heute frei und was bei mir momentan im Krankenhaus passiert, interessiert mich nicht. Weil ich hab frei. Und diese freie Zeit, muss man haben. Weil auch die Schwester braucht die Zeit, um sich zu regenerieren. Um wieder Kräfte zu sammeln und für den nächsten Tag wieder voll einsatzfähig zu sein. Und wenn ich jetzt frei habe und ich bin in Gedanken nur bei der Arbeit, dann kann ich nicht abschalten. Wie soll ich dann erholt und regeneriert sein für den nächsten Tag? (… - 2s) Ich meine (… - 1s) ich glaub (… - 2s) ich müsste mal schauen wie viel Burn-out-Erkrankte angestiegen sind. Das find ich nun mal wichtig. Oh, und Feli, ganz wichtig (… - 2s), Authentizität. Dass man sich selbst treu bleibt, man selbst ist und so ganz offen und ehrlich den anderen begegnen kann. Das ist ganz wichtig.

I5: Hast du das Gefühl, diese Stärken und Eigenschaften unterscheidet sich von einer typischen Pflegekraft?

P2.5: (… - 5s) Hm (… - 6s) Dass sie mehr arbeitet wie sein soll. (… - 4a) Dass dass merk ich, dass die (… - 4s), die gibt mehr von sich, als was von ihr verlangt wird, aber die geht dann auch eher zugrunde. Das ist dieses typische Helfer Syndrom. (… - 3s) Also im Pflegeberuf ist dieses Syndrom enorm ausgeprägt und je länger eine arbeitet desto schlimmer wird es, aber sie geht auch teilweise selbst zugrunde. Das nein sagen. Sie können nicht nein sagen. Ich erwische mich auch selbst dabei „Warum hast du jetzt wieder ja gesagt?“ (ärgerlich). Aber es ist wirklich so. Als typische Pflegefachkraft, Helfer Syndrom, enormes Helfersyndrom, nein sagen nicht können, und dann sind noch so ein paar typische, die Rauchen viel, Kaffeetrinken viel, das ist wirklich so, und oft genug stelle ich auch wieder fest, also, ich finde, wenige attraktive Krankenschwestern, eher so (… - 2s), die einfach an sich nicht darauf achten, ob ich jetzt gepflegt aussehe oder nicht, lieber Gott jetzt hast du mich so gemacht, jetzt renne ich den ganzen Tag mit Birkenstock und Leggings und T-Shirt rum und das ist auch das Image, das wir nach außen haben. (… - 5s) Und und, diese, ich finde dieses Image muss besser gepflegt werden. Aber du sagtest ja Stärken, oder? Das ist ja mehr äußerlich gerade (… - 2s). Ja, also zu viel helfen und nicht nein sagen können. Das ist definitiv typisch. Und und die Nächstenliebe ist auch typisch. Also man muss schon auch ein bestimmter Typ Mensch sein, um in der Pflege zu landen, ge, das macht nicht jeder. Das sucht man sich schon aus, weil man gern mit Menschen zusammenarbeitet, denen gern hilft und gern was soziales machen will. Also Helfersyndrom, nicht nein sagen

können, Nächstenliebe also empathisch sein und sozial. Das ist die typische Krankenschwester, ja?

I6: Es gibt ja so ein paar persönliche Stärken, die man haben kann. Also zum Beispiel sehr fair agieren oder wie du vorher gesagt hast empathisch sein oder ganz andere Stärken wie zum Beispiel Kreativität oder Weisheit. Hast du das Gefühl, man bekommt die Chance, diese Charakterstärken, die vielleicht nicht den entsprechen, die du genannt hast, die aber durchaus persönliche Stärken sein können im Krankenhaus einzusetzen?

P2.6: Eine große Rolle spielt der Mentor, inwieweit er dich einarbeitet und inwieweit er erkennt, was deine Stärken sind und dich auch ein bisschen aus der Reserve lockt. Wo er dir die Möglichkeit zeigt, komm beweis dein können, inwieweit er dir nun mal die Richtung vorgibt. Und somit ist es auch wichtig, dass die Mentoren oder Praxisanleiter, der auch wirklich seine Arbeit versteht und auch die Menschen lesen kann bzw. die Schüler, die die jetzt gerade lernen. Aber auch die schule, die nun mal jungen Menschen das beibringen, aber das bleibt ein kleines bisschen auf der Strecke, denn (… - 1s) äh, wenn hm (… - 2s) hast du vielleicht mal die Möglichkeit dich mal belesen, es werden nie die 25 oder 30 Schüler, die jetzt eine Ausbildung begonnen haben in voller Zahl beenden. Wenn 25 beginnen und 12 beenden, da ist es viel. Ja? Also eine (… - 2s) die dann im Laufe der drei Jahre eine 50%ige Rate ist normal, das ist nicht viel. Und dass da versucht, die Schule und auch die Mentoren oder die Praxisanleiter, den Rest noch zu behalten unabhängig davon, ob sie die Qualifikation haben oder nicht, spielt keine Rolle, weil das Krankenhaus mit jeder Kraft versucht, einen zu halten. Also ich kann dir sagen, als ich angefangen habe zu lernen, in meinem Krankenhaus waren damals 65 Plätze zur Verfügung. Ein Vorstellungsgespräch da waren wir 120. Ich musste noch ein Jahr Praktikum machen, was ich gar nicht so schlecht fand. Jeder von uns wurde auf verschiedenen Stationen eingesetzt, in dem einen Jahr sind schon von sich aus 30 gegangen, weil du lernst in dem einen Jahr Begegnung mit dem Tod, Begegnung mit ganz vielen unangenehmen Sachen, egal ob das jetzt Stuhlgang, erbrochenes, Blut ist oder ganz schlimme Wunden. So, und der ein oder andre sagt, da ist mir schlecht geworden, ich kann das nicht ne, ne, ne, ne, ich kann das nicht, das ist nichts für mich. So, und nach einem Jahr waren wir auf einmal nur noch 85. Und dann dann war die ein oder andere noch nicht volljährig, das musst du für den Beruf sein. Die mussten also noch ein bisschen warten. Die Lösung fand ich gar nicht so schlecht. Wir sind dann 65 zur Ausbildung gegangen. Beendet haben 58. Das sind zwar 10% weniger, das stimmt. Das sind gerade die, die auf den Medizinstudiumplatz gewartet haben, aber denen wurden auch was angerechnet für das Studium, weil er bringt ja gewisse Kenntnisse mitbringt. (… - 2s) Wenn ich 65 plätze habe aber 58 beenden, weiß ich vielleicht war da irgendjemand der auf den Platz gewartet hat, ich hab den weggenommen und es nicht

beendet, vielleicht der der es nicht bekommen hat, bessere Chancen, deswegen fand ich, diese ein Jahr Praktikum gar nicht so schlecht. Weil in dem Beruf konnte ich dann sagen, das ist was für mich, nein, das ist nicht was für mich. Nein, die die mir in den Händen gestorben ist, das war mir schlecht oder ich hab die Leiche gesehen (… - 2s) für mich ist das alles normal, aber das muss man auch lernen. Und als junger Mensch hat man damit gar nicht so Berührung und das lernt man in dem einen Jahr. Und was ist jetzt? Du meldest dich auf der Schule, ich möchte Pflegekraft werden. Ja, sofort, hier hast du den Vertrag, fang an. Weil die gibt's nicht auf dem Markt, also nimmt man alles, was nur hallo sagen kann. Und dann wundert man sich, dass jemand sagt nach zwei Jahren: nein. Jetzt war zwei Jahre alles gut und jetzt war ich auf der Chirurgie und so viel gebrochene und so viele böse Wunden, was ich da gesehen habe, das pack ich nicht (… - 5s) Und wenn dann noch ein Mentor ist, der auch nicht so labil ist oder ein Praxisleiter der jetzt gerade auch kurz nach der Ausbildung ist und hat nun mal seine 2 Jahre Praxisbegleitung nur hat, der weiß gar nicht wie die betroffene Person begleiten soll oder (… - 1s) packen ihn dort abholen kann wo er gerade steht und zu bewegen, weiterzumachen. Deswegen auch da spielt eine große Rolle, wer begleitet mich, wer ist mein Mentor, wer ist für mich auch als Ansprechperson. Auch ein Schüler muss ich ganz anders begleiten, junge Menschen, die machen ihre Pubertät durch, die sind noch gar nicht gefestigt in ihrem Leben. Da kommt so viel beruflich, die müssen sich nun mal auf der Station ganz anders darstellen, ganz andere Leistung erbringen, Verantwortung tragen. In der Schule wird auch verlangt, die muss man wissen, wie man mit denen umgeht und da spielt eine sehr große Rolle inwieweit man Praxisleiter oder mein Mentor mich begleitet und auch die Menschen abholen wo sie stehen. Also ich bin mir sicher, aus jedem kann man was rausholen, wenn man genug Zeit hat (… - 1s). Wenn man genug Berufserfahrung und Hintergrundwissen als Mentor hat und sich auch die Zeit nimmt wenn Probleme auftreten oder wenn ich sehe, dass es irgendwie, hm, aus der Situation kein schönes Ergebnis kommt. Oder wo ich merke, der Schüler weint jetzt und ist unglücklich oder ihn bedrückt was und er kommt mir seit ein paar Tagen mit so einem Gesicht in die Arbeit. Eine Wesensveränderung ist aufgetreten, jetzt wird es Zeit, mit ihm zu reden. Jetzt ist Zeit, nochmal was vorgefallen ist zu bearbeiten. Denn man muss auch die Zeit haben, unangenehme Sachen, wenn der Arzt dich blöd angeredet hat oder jemand gestorben ist oder er hat was Böses gesehen, was er nicht verarbeiten kann. Jeder ist da ja anders. Genauso kann ich auch, wenn ich beobachte, wenn ein Schüler total desinteressiert mit einer Sache umgeht, ist die Frage, macht er das, weil er nicht anders mit der Situation umgehen kann, deswegen macht er auch das Interesse zu und verstellt er sich? Das wäre eine Aufgabe der Führungskraft mit ihm darüber reden, du hast gesehen, da ist ein Trauerfall, warum hast du jetzt nicht mehr Mitgefühl gezeigt, ja weil ich wusste nicht, was ich tun soll. Das heißt, er wusste aus der Situation nicht heraus. Dann muss ich ihn vielleicht das nächste Mal, wenn sowas ist sagen, ich gehe

mit dir, ich zeige dir, wie ich es gemacht hätte. Oder gehst du mit der anderen Schwester und beobachte, was sie gemacht hätte, das ist das was fehlt. Wir haben teilweise zu wenig personal, die die Menschen noch besser auf den Beruf vorbereiten. Die Schule, das sind Bücher. Das ist nur Theorie. Du musst das auch anwenden können, um es verfestigen zu können. Sie lernen nur, das ist nur die Theorie, nur Bücher, die theorie ist trocken. Praxis das ist ein anderes paar Schuhe (… - 2s) Und in der Praxis, es fehlt uns massenweise an Pflegefachkräften, auch da fehlt an Fachkräften, die die Schüler entsprechend abholt und begleitet. Und die ersten Jahre braucht man, um begleitet zu werden (… - 2s). Ich hab nach der Ausbildung. Ich wollte nie auf die Intensivstation. (… - 1s) Als ich ausgelernt war, und uns war klar, dass jeder von der schule im Krankenhaus übernommen wird. Als ich damals vor meiner PDL saß, ich wollte in die Orthopädie, und sie meinte: ich hab aber nichts für dich. Ich hab nur was auf der Intensivstation. Oh ne, Intensivstation ist nochmal ein Stock höher. Und da hat sie mir einen Kompromiss gemacht: Wir machen es so: Probezeit hatte ich sowieso nicht, weil ich im Krankenhaus gelernt hatte. Nach 3 Monaten sitzen wir hier nochmal. Und dann wirst du mir sagen, ob du bleibst und wenn du mir sagst, werde ich alles machen, dass du auf die Orthopädie kommst. Gut. Ich bin also als frisch examinierte auf die Intensivstation gekommen und ich hatte dort einen Mentor. Drei Monate lang. Ich hab die Dienste gehabt, die er auch hatte. Der erste Monat hab ich hinter ihm gestanden. Ich durfte nichts machen ohne ihn zu fragen und er hat nur geguckt was er macht, Fragen stellen, Fragen stellen, Fragen stellen. Ich musste nur Fragen stellen. Sagte, du kannst fragen was du willst und du guckst mir nur zu. Wir sind jetzt zu zweit. Einen Monat lang. Im zweiten Monat durfte ich neben ihm stehen. Wenn wir, wir sind zum Beispiel zur Visite gegangen und da wurde ich zum Beispiel schon mit eingezogen zur Visite. Und im dritten Monat stand er hinter mir und hat geguckt, was ich in den 2 Monaten gelernt hab. So, und nach 3 Monaten hat er gesagt, du bist soweit, du kannst jetzt alleine arbeiten oder nein, du bist noch nicht so weit und du brauchst noch ein paar Tage. Das waren 3 Monate an Einarbeitung. Was bekommst du jetzt? 3 Tage? Wenn das überhaupt funktioniert. Und dann wird sogar schon geredet: „Boah, die wurde eingearbeitet“. Nach 3 Monaten saß ich bei meiner PDL und hab gesagt, ich bleibe. Weil ich hatte eine perfekte Einarbeitung. (… - 1s) Wenn du Führerschein lernst und du hast einen Lehrer, der dir gut erklären kann, der Geduld hat, ja, der auch dir Vertrauen schenkt, dass du auch fahren kannst, der Ruhe ausstrahlt. (… - 2s) Gehst du mit einem ganz anderen Gefühl und fährst du mit einem ganz anderen Gefühl, als wenn du einen Lehrer hast, dem das egal ist, hauptsache er bekommt sein Geld, der keine Geduld für dich, der nichts erklären kann, der dich hinterher auch noch anpflaumst, wenn du was nicht richtig gemacht hast und so ist das nun mal auch im Beruf. Fehler passieren, ohne frage, auch in der Pflege. Aber ich muss dann auch nicht nur sagen, jetzt ist ein Fehler passiert, wer ist dran schuld, sondern warum kam es zum Fehler (… - 1s). Und warum ist zu so einem Fehler, wie können wir es

vermeiden, dass es nächstes mal nicht mehr passiert. Und es gibt nichts schlimmeres, als ‚Du bist dran schuld', nein, wir waren gemeinsam im Dienst, es ist was schief gelaufen, das nächste Mal wird besser und wir lernen alle daraus. Fehler sind dazu da, um unsere Qualität zu verbessern. Qualitätsmanagement bedeutet nichts anderes als unsere Fehler (… - 1s) auszukorrigieren oder auf den Fehlern das besser zu machen. Deswegen kann jeder lernen, aber da muss auch der andere willig sein, der muss auch bereit sein ein bisschen mehr zu geben und der Mentor muss auch gut genug sein, um die Schwächen und die Stärken der Schüler zu sehen und herauszulocken.

I7: Hast du das Gefühl außer dem Mentor auch das Arbeitsumfeld eine Rolle spielen kann?

P2.7: Ja. Also nicht nur ein Mentor, sondern auch das gesamte Team. In der pflege das gesamte Team ist dazu gehört nicht nur jetzt die examinierte Schwester, der Schüler, der Krankengymnast, die Ärzte, die spielen für mich auch eine Rolle. Ich hab in meinem gesamten Berufswerdegang nur positives zu berichten. Es gab zwar auch ein paar Idiotien von Ärzten, aber durch die Intensivstation hab ich gelernt, dass zu einem Team gehört nicht nur der Herr Doktor oder der Chefarzt sondern auch die Stationsschwester, die Fachkrankenpfleger und der Chefarzt. Bei uns war immer eine Visite ohne Schwester geht die nicht. Und auch unsere Stationsärzte, wenn die ein Krankheitsbild, boah, das haben wir noch nie gehabt, da hat man sich gemeinsam hingesetzt und hat am Krankheitsbild nochmal erklärt, wie es verläuft, man hat eine Schulung gemacht. So und nicht von oben herab der Herr Halbgott in Weiß von diesem Image mussten ganz viele Ärzte herabgehen. Wenn der Herr promovierte keine Krankenschwester hat, dann kann er nun mal auch keine Patienten aufnehmen und entsprechen pflegen und gesund machen. Und da musste was geändert werden. Aber auch zu einem Team gehören aber auch die anderen Krankenschwestern und Pfleger, ja (… - 6s) und und find ich auch Schnittstellen wenn ich in einem Krankenhaus denke, man hat mit so vielen Abteilungen nebenher zu tun, angefangen von der Aufnahme, Ambulanz und auch die Schwester in der Ambulanz, wenn etwas ist und mir in Ruhe erklären kann, da arbeite ich ganz anders. Alles gehört zusammen (… - 1s), Kooperation. Das ganze Team muss funktionieren. Und und und da ist auch das Wohlbefinden und die Zufriedenheit der Mitarbeiter höher. Aber das muss jemand auch erkennen und jemand muss es vielleicht auch sehen, wenn in einem Team etwas vielleicht nicht funktioniert. Und wenn jeder nur mit seiner Arbeit beschäftigt ist und alles nur schnell schnell gehen muss. Und man geht nur mit so Augenklappen, dann wird das nicht erkannt. Das ist aber gerade mit dem Pflegemangel und der Zeitmangel ein Problem. Da arbeitet man bis 5 Uhr nachmittags, aber eigentlich hast du nur bis 2 Zeit, weil da deine Schicht aufhört. Und man geht nur so mit einem Tunnelblick und schaut nicht links und rechts und sieht nicht, dass da vielleicht jemand frisch examiniert ist oder nicht so lange im Beruf

ist, die fühlt sich dann auf der Strecke alleine gelassen und sie vor lauter Arbeit vielleicht kann sie sich auch nicht organisieren, das ist auch ein sehr wichtiger Faktor in der Pflege. Sich organisieren zu können, strukturieren. Also Struktur, Organisation, das muss funktionieren. Der eine hat es, der andere hat es nicht. Ja? Und ich muss auch, ich geb dir ein Beispiel: (… - 2s) In der Pflege ist es so, wenn ich , ich bin jetzt zuhause. So, ich hab jetzt warum ist mein, damit du es verstehst, warum ist mein ähm meine äh meine Wäschekammer oben, jeder sterbliche hat seinen Waschraum im Keller, warum ist meiner oben? Das Haus wäre groß genug, ich hätte auch im Keller genug Platz. Aber ich hab es oben. Weil der Laufweg kürzer ist. Überleg dir mal, Darias Zimmer war im 1. Stock, Nicklas' Zimmer ist im 1. Stock und unser Schlafzimmer auch. Da zieht man sich um, da schläft man, da produziert man die meiste Wäsche. Jeder macht aber einen Waschraum im Keller. Das heißt ich renn jetzt von oben mit der Bettwäsche, die ich frisch beziehen will in den Keller und nehme sie danach wieder mit hoch. Nein, ich nicht, weil ich spar mir die Wege. Und das ist das, was man in der Pflege lernen muss, sich Wege zu sparen. So, wenn ich jetzt nach oben gehe, ich gehe nicht nur mit einer Tasse oben, das gehört nach oben, das auch, ich nehme alles gleich mit und auf dem Weg nach oben kann ich noch das, das und das. Mit dem geringsten Aufwand das meiste erreichen, das ist Organisation. Damit ich mein Ziel schnell erreichen kann. Und wenn ich kein Organisationstalent bin, da komm ich in Bredouille mit der Zeit und und ich komm dann auch mit meiner Arbeit nicht über die Runden und wehe wenn ich jetzt nun mal, du warst auch im Krankenhaus, da bekommt man oft genug so einen Tagesablauf, was zu machen ist. Jetzt stell dir vor, ich schreib dir einen Tagesablauf mit meiner Berufserfahrung, mit meiner Organisation und dann kommst du als Neuling: ‚Boah, das schaff ich niemals!', weil diese kleinen Kniffe der Organisation stehen da nicht drauf. Da steht nicht drauf, dass wenn du ins Labor gehst, gehst du kurz vorbei ins Röntgen und da, da stehen sie nicht drauf, da rennst du einmal ins Labor und einmal dorthin, das heißt, du machst wesentlich mehr Wege. Das ist Organisation. Organisation muss auch jemandem beigebracht werden. Das ist ein Prozess, der länger dauert. Bis auch bei einem Klick macht. Wenn du damit aber noch nie groß in Berührung kamst und dann wird dir das erst im Beruf beigebracht, dann fällt dir das schwer. Deswegen find ich, was du vorher gefragt hast, was alles zum Pflegeberuf dazu gehört: Empathie, gehört auf jeden Fall dazu, soziale Kompetenz, soziale Intelligenz, Mitgefühl, ja, das gehört dazu, aber auch eine gewisser Abstand um sich selber zu schützen, ich muss mich organisieren können, ich muss mich strukturieren, also, und ich muss nicht nur bis jetzt denken, sondern ich muss bis morgen denken, also vorausschauend. Prävention betreiben. So feine Wörter. Bei mir hieß es damals in der Ausbildung vorausschauend denken. Das heißt und was auch noch ist, was sehr wichtig ist in dem Beruf und das ist das, was die Schule anscheinend nicht beibringt, ich weiß es nicht. (… - 2s) Jetzt stell ich fest in den letzten Jahren. Ich habe gelernt, wenn ich pflegerisch eine Tätigkeit machen möchte (… -

1s) und aus irgendeinem Grund hab ich mein Pensum mein an Arbeit nicht beenden können, weil ein Notfall gekommen ist, da wird die Arbeit auf den nächsten übertragen. Ja? Der hat dann zwar mehr zu arbeiten, aber ich mit meinem Notfall hatte auch genug zu tun. Ich leider muss feststellen, wenn ich dann komm und habt ihr auch die Arbeit die die heute morgen nicht gemacht jetzt erledigt: ‚Warum sollte ich? Das war nicht in meiner Arbeit?!". Diese Sprüche hab ich auch schon bekommen. Andererseits ich hab auch gelernt, ah wir haben morgen ruhig, ach wisst ihr was, heute nachmittag müssen sie das und das machen, komm wir machen das schon. Das heißt, manchmal muss ich meine Arbeit auf den Spätdienst zum Beispiel übertragen, aber manchmal sind Tage, da ist morgens nicht los, da kann ich vielleicht dem Spätdienst schon was abnehmen. Die eine Hand wäscht die andere. Kollegialität. (… - 2s) und nicht nur du du du, nein. Und da sollte die Pflege auch lernen. Pflege ist nicht nur ich, ein Beruf. Teamwork ist das, ganz genau. Im Teamwork heißt es nicht, dass jeder perfekt den Pflegeplanung machen und jeder muss den perfekten (… - 1s) nein, Teamwork bedeutet ich bin sehr gut in dem, aber dafür nicht so gut in dem und gegenseitig ergänzen wir uns. Der eine kann das sehr gut der andere das, und gemeinsam sind wir stark. So wie der schwächste in einem Glied schwach ist, so schwach ist das Team, ich darf mich nie messen am besten, sondern muss mich am schwächsten messen. Organisation, Struktur, vorausschauend denkend, Kollegialität und sich selber organisieren. Sich als Person.

I8: Was denkst du hätte es für Auswirkungen, wenn sich eine Pflegekraft optimal mit ihren Charakterstärken einbringen würde?

P2.8: Also (… - 1s) als erstes find ich wäre die Pflegekraft zufriedener, ausgeglichener, die würde mit einer ganz anderen ähm Einstellung zur Arbeit gehen. Aber was mir da nie aus'm Kopf geht ist der Zeitdruck. Denn wenn ich weiß, ich kann eine Arbeit ohne Zeitdruck erledigen, das heißt ich hab nicht nur 10 Minuten, sondern ich hab für eine Tätigkeit eine gute halben Stunde und ich werde da nicht unterbrochen, das heißt ich bin weniger gestresst. Und wenn ich weniger gestresst bin, dann kann ich auch mehr mein Ding machen und mich mehr einsetzen. Ich hab dann viel mehr Zeit, was wirklich sorgfältig zu machen, zu scherzen, jemand freundlich zu begegnen. Medikamente stellen, das hast du bestimmt damals auch gemacht. Da heißt es: ‚Maria, du bist heute für Medis stellen zuständig. Mach dein Büro zu, damit keiner stört' und gleichzeitig ‚Maria kannst du helfen?'. Was macht Maria? Lässt Medis stehen und hilft. Dann kommt sie zurück und sieht: „Oh, wo war ich jetzt?" Unter Zeitdruck entstehen Fehler. Man kann seine Arbeit nicht in Ruhe beenden. Wenn ich aber weiß, dass ich für meine Medikamente keine halbe Stunde hab, sondern 45 Minuten und ich mit ganz Gelassenheit gehe ich an die Arbeit und kann es so ordentlich machen, wie ich will, ich werde trotzdem in meinem 30 Minuten fertig, weil ich hab

sorgfältig alles überprüft, ich wurde nicht unterbrochen, ich wurde nicht gestresst und ich hab die 30 Minuten und ich hab 15 Minuten gewonnen und kann meiner Kollegin helfen. Also es wäre Zufriedenheit, ich wäre zufriedener, weil ich hab meine Arbeit zu meiner Einstellung richtig gemacht und konnte dabei mir treu bleiben, es sorgfältig machen, etwas so machen, wie es mir Spaß macht, vielleicht mit einem Patienten Scherze machen, die Medis überprüfen. Das strahl ich dann auch nach außen somit geh ich auch mit anderen ganz anders um. Jetzt hab ich meine Arbeit so gemacht, wie ich mir das immer gewünscht habe, ich konnte mich so einbringen, wie ich mir das immer vorstelle. Also strahl ich diese, diese Euphorie nach außen. Was ist die Folge daraus? Ich hab weniger Bauchschmerzen, weniger Krankmeldungen, ich hab weniger Lücken im Dienstplan, wenn die Schwester nun mal ohne Probleme das hab ich auch oft genug gemacht, wenn ich wusste, meine Damen haben Frühstück und da hieß es immer, die dürfen nicht gemeinsam Frühstück machen, weil es muss immer jemand erreichbar sein. Isst du Frühstück gern allein? Also ich nicht. Was hab ich also gemacht? Mädels, ihr macht jetzt Frühstück, gebt mir eure Telefone, ich bin jetzt erreichbar, sollte etwas sein, ich geh auf die Glocken, und ihr macht jetzt eine halbe Stunde Frühstück. Sie wüssten ganz genau, sie können in Ruhe ihr Frühstück nehmen, in Ruhe ihren Spaß haben beim Frühstück und lachen und dann geht man ganz anders mit einer ganz anderen Motivation an die Arbeit. Aber das sind so Kleinigkeiten, das steigert die Motivation. Du hast aber nicht die Zeit und das ist das, was der Pflege auch fehlt, die Zeit. Und dann kommt noch dazu so Faktoren: zeit fehlt, was wir vorher in acht Stunden mit drei Schwestern gemacht haben, machen wir jetzt mit zwei Schwestern. Das heißt die Arbeit (… - 1s) rechnen wir jetzt mal mit Arbeit als 100%, machen drei Stück, das heißt jede macht 33% (… - 1s) jetzt hab ich aber 100% und es machen nur zwei das heißt jede von denen muss 50% machen, das heißt, das ist das doppelte, fast das doppelte, ja? Die Arbeit ist nicht weniger geworden, die ist gleichgeblieben (… - 1s). Das Personal. Dann hab ich noch Personal, das motiviert ist, da flutscht die Arbeit, das merkst du sofort, hast du ein personal das motiviert ist, organisiert ist, strukturiert ist, das nun mal über Hintergrundwissen verfügt, da flutscht die Arbeit, aber stell dir vor du hat Personal, das der deutschen Sprache nicht mächtig ist. das heißt wenn ich den Befund durchlese weiß ich Bescheid. Die liest das dreimal, wenn ich nur einmal brauche und das dauert und dann kommt sie trotzdem und fragt was da drinsteht. Also nimmst du dir wieder Zeit, weil du willst, dass sie etwas lernt und erklärst es. In zwei Minuten mach ich das und mit ihr brauche ich dann zehn Minuten. Also das kostet mich wieder Zeit. Das demotiviert sie vielleicht auch. Das ist ja auch frustrierend. Musste ich wieder dahin gehen, gestern auch schon, heute wieder, das hemmt sie wieder. Dann kommt Visite: ‚Nein, ich kann das nicht gut'. Sie trauen sich dann gar nicht mehr. Das sind alles so Kleinigkeiten, wenn ich jetzt von fünf Schwestern hab, die vielleicht nur eine schwach ist, dann können es die vier

ausgleichen. Aber wenn ich nur eine hab die sehr gut und vier die schwach sind, die gleicht das nicht aus, ok?

I9: Du hast vorher Fehler angesprochen, das letzte Thema ist etwas heikel, also sprich an, was für dich ist okay. Wie würdest du denn die Patientensicherheit bei euch einschätzen?

P2.9: Also, ähm (… - 2s) hm (… - 1s). Unser Ist-Zustand, wenn ich jetzt die letzten acht Monate denke, nein, es ist niemand aus dem Bett gefallen oder gestürzt, da sind schon die Sicherheitsfaktoren, die ich verneinen kann. Und es auch, ähm, auch niemand beim pflegen der Schwester aus dem Bett gefallen. So, aber (… - 1s) ich weiß, dass es genügende Einrichtungen sind, wo immer wieder solche Fehler passieren. Jemand stürzt oder es werden nun mal, ähm, bestimmte, ähm, Unfälle im Bett passieren, dass irgendwelche Hände eingeklemmt werden, weil Gitter und so weiter und da spielen nun mal auch mehrere Faktoren mit: A, was für Ausrüstung hab ich, Bettgitter oder Betten. Es gibt Betten diese Niederflurbetten, das heißt ich kann die ganz niedrig runterfahren und dann kann ich vor dem Bett noch eine Matratze hinlegen, dass er sich nicht verletzt, wenn er fällt. Aber so ein Niederflurbett kostet wieder. Nicht jede Einrichtung kann sich sowas erlauben. Gehen wir mal weiter, Gitterbettgitter anbringen, wenn erforderlich ist, ja, aber es gibt Bettgitter und Bettgitter und die sind auch abhängig von Geld. (… - 1s) Ja, und Verletzung wo dann auch die Schwester auch beteiligt war, nehmen wir an, sie lagert einen Patienten und sie wird abgelenkt, weil das Telefon gerade klingelt. (… - 1s) passiert sehr oft, weil sie gerade nun mal im Multitasking ist, weil sie die Schichtleitung ist und jetzt nun mal telefonieren muss und gleichzeitig einen Patienten pflegen. Oder beim Umsetzen vom Bett auf den Rollstuhl sie war unachtsam und hat sie Bremsen nicht eingesetzt und er rutscht weg. Warum hat sie die Bremsen nicht reingemacht? Weil nun mal das Telefon geläutet hat. Bin ich wieder der Ansicht, wären sie zu zweit, wär es nicht passiert. Hätten wir mehr Personal, würde es nicht passieren. (… - 1s) Da kommen wir wieder was vorher zu dritt gemacht haben, wenn es jetzt auf einmal zu zweit passieren muss, irgendwo passieren Fehler und die Fehler passieren dann leider auf Kosten der Patienten, nicht nur auf Kosten des Personals, sondern auf Kosten der Patienten. Was kann auch sein? Vielleicht ist sie übermüdet weil sie mittlerweile den 10. Dienst schiebt. Hat man sich darum überhaupt mal Gedanken gemacht? Wir haben zwar alle unser Arbeitszeitgesetz, aber wie oft wird dieses verletzt? (…. – 1s) weil wir unsere Fürsorgepflicht, weil (… - 1s) es muss funktionieren. (… - 2s) was könnte man noch machen? (… - 2s) Wir sind so gut in der modernen Technik, Computer und ich kann mir auch vorstellen, dass es irgendwie so, dass man das entwickelt, wenn (… - 1s) entweder die Betten etwa breiter wären, dass derjenige sich besser drehen kann, vor allem bei starkem Übergewicht. Oder dass da irgendwie Sensoren wären, dass da ein Alarm gehen würde, wenn jemand zu nah am Rand wär, wie

Parksensoren beim Auto. Ich weiß ja nicht, das das könnte ja eine Lösung sein. Aber man weiß ja selber, dass das Gesundheitswesen knapp bei Kasse ist. Ich glaub bei der Bundeswehr wäre das jetzt was anderes, obwohl bei den ganzen Bundeswehrkrankenhäusern, die sind wesentlich besser ausgestattet mit den ganzen Hilfsmitteln. (… - 1s) Die haben (… - 1s), ähm, was auch noch vielleicht, äh, helfen würde, wenn dann so eine Schwester mehr Zeit für die einzelnen Patienten hätte. Wenn der Patient weiß, ich läute und jetzt kommt jemand nach fünf Minuten, da brauch ich mich nicht selber bemühen, aber wie ist es oft genug, ich muss jetzt auf Toilette und es kommt niemand. Also versuch ich alleine, obwohl mein gesundheitlicher Zustand das gar nicht mehr erlaubt aufzustehen. Und was passiert dann? Dann fall ich hin. Weil wieder die Arbeit nicht auf drei sondern auf zwei verteilt ist. Oder oder (… - 1s) also (… - 1s) ich ich (… - 1s) kann es nur sagen, meine Anfangszeit, wo ich weiß, da war ich auf der Station, wo ich gelernt habe, da waren wir 42 betten und es waren drei examinierte und drei Schüler. So, (… - 1s) morgens und nachmittags waren sie nur zu viert. Am Morgen war immer mehr zu tun. Ich weiß jetzt, dass dieselbe Station nun mit einer Schülerin und einer Examinierten läuft. Das ist sportlich und die wissen, was sie machen. Und ich weiß, dass es in Pflegeheimen genauso läuft. Und deswegen, wenn man dann so, 10-12 Leute versorgt hat, dann weiß man, was man so am Mittag gemacht hat. Und das ist nicht nur jetzt die Grundpflege zu versorgen, sondern das ist nun mal Frühstück bringen, Tabletten bringen, vielleicht Frühstück einreichen, zur Untersuchung fahren, Tabletten verabreichen, Visite kommt, Anrufe und Angehörige kommen, man muss sich nun mal auch bewusstwerden, wie so ein Tag von einer Krankenschwester oder Pflegefachkraft aussieht. Die fängt an um sechs Uhr und die ist getaktet bis um halb drei, da ist keine fünf Minuten Luft. Und wehe, wenn was dazwischenkommt. Und und (… - 1s) ja (…. – 1s) vielleicht sollten wir mal öfter unsere Politiker als Praktikantin, Spahn liebend gern mal unseren Krankenhaus stecken.

I10: Hast du auch das Gefühl, dass neben dem Zeitmangel und Personalmangel auch noch weitere Faktoren Einfluss auf die Patientensicherheit haben?

P2.10: Ja, ähm, also ich find das gesamte Team hat Einfluss. Wenn man zusammenhilft und man sich gegenseitig unterstützt, passieren weniger Fehler, man hilft sich, Teamwork. Und es hilft natürlich auch, wenn man so Fehler offen ansprechen kann, weil oft kann man sie eh schnell lösen gemeinsam. Ja (… - 2s) und halt auch der Umgang unter den Kollegen allgemein. Ich find, wenn alle (… - 1s) ja kollegial, wertschätzend miteinander umgehen, das merken die Patienten auch. Weil da geht man ganz anders auf den Patienten zu. Wenn man besser gelaunt ist, begegnet man dem Patienten ganz anders. Und da ist man viel motivierter und beachtet dann auch viel mehr die Sicherheit (… - 2s) für sich und den Patienten. Ähm (… - 2s) wenn du die Zeit (… - 1s) nimm mal an, du bist krank. Wenn du

weißt, da ist jemand, der jederzeit kommt, der dir gerne hilft, freundlich ist, der dir nun mal das Kissen wechselt, wenn du nach ihm rufst, der kommt sofort. Das gibt die Sicherheit. Das heißt, die Schwester war da, hat mir essen gebracht, Medikamente gebracht, dann geht es schon etwas besser. Aber wenn du ganz allein bist, ich bräuchte das Medikament jetzt, aber dann ist da niemand oder nur eine mies gelaunte Schwester. Dann fühlst du dich verlassen. Ich geh nun mal ins Krankenhaus, weil da Personal sein soll, was mir hilft. (… - 2s) Da ist zwar Personal, aber ich bin nicht die einzige, der sie helfen müssen. Aber sie hat nicht die Zeit für mich. Also was mache ich? Ich werde als Patient unzufrieden, weil ich läute jetzt schon seit was weiß ich für wie viele Male, und ich hab so Bauchweh und die Schwester kommt nicht oder war davor so schlecht drauf, dass ich mich gar nicht traue und dann steh ich auf versuch es selbst zu machen und dann versagt mir der Kreislauf. Oder andersrum, ich muss ganz dringend auf Toilette und und ich bin doch nicht so schnell zu Fuß, aber das ist ein menschliches Bedürfnis und wir wurden so erzogen und da ist die Toilette und dann versuch ich aufzustehen, ja, aber ich bin zu schwach, aber dieser Drang ist stärker als zu wissen, dass ich umfallen könnte. (… - 2s) Würde ich vielleicht nicht seit zehn Minuten schon warten, bis die Schwester und jetzt kommt eine Schwester wirklich nach fünf Minuten und jetzt kommt eine Schwester die Zeit hat, die nicht gestresst ist, die ausgeglichen ist: ‚Ja hallo, Herr Müller, Sie haben geläutet, kann ich ihnen behilflich sein?' - ‚Ach, Schwester, Gott sei Dank sind sie da, ich muss mal.' – ‚Ach das machen wir, kein Problem.' – ‚Ach, die hat nicht geschimpft, ach Gott sei Dank, meine Rettung.' Die gleiche Situation (… - 1s), der Patient läutet wieder, fünf Minuten rum, acht Minuten rum, zehn Minuten rum, er kann nicht mehr, jetzt kommt die Schwester: ‚Ach, Herr Müller, ach, Sie läuten schon wieder, was ist denn los, ich muss weiter, die Visite wartet.' (… - 1s). Wie kommt das bei dem Patienten an? Ich hab ein Bedürfnis, aber die hat keine Zeit für mich, aber ich brauch sie. Verstehst du? Also das nächste Mal wird er gar nicht läuten, weil das wird e sich gar nicht trauen. Und dann passieren wieder Fehler, weil er es selbst versucht. Mein Befinden reflektiert auf den Patient und wenn ein Patient schon lange im Krankenhaus ist, der nun mal selten durch Corona Besuch bekommen hat oder gar keinen Besuch bekommen hat, bist du als Krankenschwester die einzige Person, mit der er noch im sozialen Kontakt treten kann und wenn du ihm dann auch noch so kommst, dann kommt er sich irgendwann total unerwünscht vor. Und du weißt selbst, jede Krankheit kann nur so gut behandelt werden insoweit der Patient selbst aktiv von sich aus daran arbeitet. Warum werden depressive Menschen schneller krank. (… - 1s) Ich hatte vor Jahren (…. – 1s). Ich komm zur Arbeit und meine Bereichsleitung sagt mir, die Patientin in raum fünf ist verstorben. Dann sag ich gut, ich geh mich verabschieden, das gehört dazu. Da hab ich gefragt, da meinte meine Leitung, sie würd gern mit, sie traut sich nicht allein. Dann sind wir gemeinsam hin, wir haben uns verabschiedet und haben ihr den letzten Gruß und die letzte Würde erwiesen und wir hatten an dem Tag Frühlingsfest

oder irgendsowas (… - 1s) und ich bin rein, mit Würde und bin ich raus hab die Tür zu gemacht und hab ein Frühlingsfest gefeiert. Reagieren situativ. Und dass sollte vielleicht auch, wir hatten sie Voraussetzung einer Pflegekraft. Wissen (… - 1s), wie ich mich situativ verhalten muss. Da war angebracht: würdig und ruhig und bisschen trauernd, sich verabschiedend, aber die die jetzt draußen im Zelt feiern, da kann ich nicht die Feier vermasseln nur weil sie verstorben ist, das gehört zum Leben. Ich hab die Tür zugemacht und dieses Gesicht, was ich hatte mit voller Würde und vielleicht auch ein bisschen traurig, hab ich im Zimmer gelassen und hab zugemacht und hab mit den anderen ihr Frühlingsfest gefeiert und hab gelacht und hab gesungen. (… - 1s) Ich hab mich situativ verhalten. (… - 2s) So wie ich jede Mitarbeiter führen muss, jeden einzeln individuell, wo er gerade steht abholen so sind auch die situative (… - 1s), der Situation angemessen muss ich mich verhalten und es kann sich nicht jeder so auf einmal umschalten, dass muss man lernen. Gestern war ich auf der Gynäkologie und ich hab mich gefreut mit den ganzen Müttern, weil die die ganzen kleinen Babys haben, dann wurde ich versetzt nächster Tag auf die Chirurgie und da hatte ich lauter Leichen. So schnell ist es nun mal in dem Beruf. Und da ist wiederum eine gewisse Mauer, ich muss mich selber schützen, wenn ich mich schütze als Mauer, wenn ich damit weiß, umzugehen, kann ich lange in dem Beruf bleiben. Ich bin Dinosaurier. Ich hab mit 17 angefangen, Feli, und ich bin immer noch dabei und ich bin immer noch gern dabei, ich hab immer noch Spaß, mit Menschen umzugehen, ob das jetzt die Krankenschwester, der Pfleger, ich hab genauso gern meine Schüler, die hab ich liebend gern, weil die bringen mir immer was neues mit, deswegen wenn wir jetzt ganz kurz zum Team: ich hab die Erfahrung gemacht, ein durchwachsenes Team das heißt, nicht nur junge frisch nach dem Examen, weil sie bringen das Know-how, weil sie gerade gelernt haben, sondern auch auf der anderen Seite die Berufserfahrung, die die Routine bringen, die die Erfahrung bringen, die die die Ruhe bringen, und die zu mischen, funktioniert wunderbar. Aber da müssen sich die alten Hasen auch von den jungen was sagen lassen und gegenseitig auch Respekt zeigen. Wenn das nicht da ist, funktioniert das auch nicht. Dann fühlt man sich nicht wohl. Ich hab die Erfahrung bisher immer gemacht, wenn die jungen das frische, gerade haben sie das so gelernt, gut, und die alten so: ‚Stress dich nicht, Ruhe, Routine'. Aber gegenseitige Wertschätzung ist wichtig und vor allem Akzeptanz und Respekt. Denn mit Respektlosigkeit würde ich nichts erfahren. Und eben die Führungskraft, eben wie weit diese in der Lage ist das Team nicht einzeln sondern so wirklich jeden umarmend fast schon und auf jeden einzelnen einzugehen. Nicht umsonst heißt es, der Fisch stinkt von Kopf. (… - 1s) Es (… - 1s), Führungskraft. Deswegen (… - 1s) du kannst eine Führungskraft haben, die sehr jung ist, aber die wirklich nun mal auch schon gute Erfahrung gesammelt hat. Du kannst eine Führungskraft haben, die erfahren ist, 40, 50 plus aber hat überhaupt keine Kompetenzen in der Führung. Auch das muss man lernen. Und Führung ist nicht gleich Führung. Ich hab dann diese Laissez-faire-Führung, die diktatorische

Führung, ja? Also, äh (… - 1s), jede muss sich nun mal finden und das ist noch lange nicht gesagt, dass meine Führung auch beim Team ankommt. Muss man sich dann nun mal wirklich im Team ein bisschen antasten, wo steht mein Team, in welcher Phase befindet es sich, das gehört dazu. Viel Arbeit.

I11: Ja, gut, ich wäre mit meinen Fragen am Ende. Haben wir noch etwas nicht angesprochen, worüber du gerne reden möchtest?

P2.11: Hm (… - 4s). Es ist ein schöner Beruf. Ich finde es nur schade (…. – 2s), nach dieser neuen Reform, die wir in diesem Beruf bekommen haben, dass es nur noch einen Berufszweig geben wird, es wird nicht mehr Krankenschwester und Altenpfleger geben (… - 1s), sondern das haben sie jetzt in einen Topf gemacht. Aber das geht so: du fängst die Ausbildung an und ich glaub nach ein oder eineinhalb Jahren (… - 1s), zuerst sollte sie vier Jahre dauern, ist aber geblieben bei drei. Also zur Hälfte wird eine Prüfung abgelegt, von dem, was du bisher gelernt hast, machst du schriftlich. Eine schriftliche Prüfung absolviert. Und (… - 1s) nach der Prüfung musst du dich entscheiden gehst du als Pflegefachkraft in die Klinik (… - 1s) oder ins Pflegeheim, somit unterscheidet sich dann dein Lehrmaterial. Die eine spezialisiert Krankenhaus und die andere Altersheim, Pflegeheim und jetzt kommt es aber (… - 1s), wenn du dich entschieden hast Pflegeheim, da hast du dann wirklich nun mal für Pflegeheim, da hast du nicht im Krankenhaus arbeiten. Entscheidest du dich für das Krankenhaus, darfst du jedes Mal ins Pflegeheim. Das heißt, es ist immer noch diese Ausbildungsstandard ein Krankenhauspflegekraft ist mehr wert, höher als eine Pflegekraft im Altersheim. Also was passiert? Alle wollen Krankenhaus lernen, im Krankenhaus verdiene ich besser, hm? Und wenn ich im Krankenhaus-Richtung gehen möchte, sind mir alle Türen offen. Im Pflegeheim mach ich mir automatisch mehrere Türen zu. Ich würde mir wünschen, von der Politik, dass sie sich dem Problem (… - 1s) Pflege (… - 1s) bisschen mehr annimmt und sich bewusst dessen sind, dass es kein leichter Job ist. und dass sie bisschen mehr uns Unterstützung bieten würden. Wären wir jetzt IG-Metall und wären wir unter der Voraussetzung arbeiten, da wären alle von IG-Metall auf der Straße und würden streiken und die Politik würde sagen, dass können sie nicht machen. Aber wir haben keine Lobby. Und es ist auch niemand, der uns vertritt. Und die Politik, egal, welche Regierung schiebt uns immer mehr beiseite, weil wir sind eine sehr sehr sehr kranke Institution. Und nur durch diese Mitarbeiter, die sehr noch ja, idealistisch sind, also ich hab auch noch Ideale, sonst wäre ich nicht so lange. Und ich hoff mir jedes Mal, dass es morgen besser wird. Sonst geht man schon längst zugrunde. Und deswegen glaub ich auch nicht, dass wir uns in der nächsten zwei drei oder vier Jahren wirklich erholen. (… - 1s) Ich glaub eher nicht, weil jetzt kommt noch das, was man schon seit Jahrzehnten aber auch schon weiß, dass diese geburtsstarken Jahre gehen jetzt zur Rente. (… - 1s) Und wenn wir zehn

Schwestern gehen, weil sie zur Rente gehen, berufserfahren, routiniert, verlässlich, organisiert, strukturiert. (… - 1s) Wenn mir zehn gehen und wenn wir zwei nachbekommen, meinst du das die zwei schließen die Lücke von den acht oder von den zehn die gegangen sind? Nein. (… - 1s) Niemals. (… - 1s) Die sind frisch examiniert, die mussten erst noch so vieles lernen. Da muss ich jeden einzelnen lernen und beibringen. (… - 2s) Aber vielleicht hilft uns die Regierung ja irgendwann mal. (… - 2s) Vielleicht machen die sich ja irgendwann mal Gedanken, dass man bis 67 im Pflegeberuf zu arbeiten, nicht möglich ist. Stell dir vor bis 67 als Pflegefachkraft zu arbeiten. Du pflegst, du hebst, du drehst, du lagerst. Also arbeitest du körperlich. Punkt 1. Du schreibst, du musst Voraussetzungen am PC haben, da heißt, du arbeitest mit Köpfchen, du machst Verbände, wieder mit Köpfchen und du rennst, vom Zimmer zu Zimmer. Das heißt, du arbeitest nicht nur körperlich, mit Kopf und mit Händen. (… - 1s). Irgendwann soll die Pflege das mit Rollator die Tabletten verteilen? Und dann ist der Patient schneller als sie mit ihrem Rollator. Da sollte man sich Gedanken machen, wenn eine Schwester mit 20 eine Ausbildung beginnt, dass sie mit 55 oder 58 im Grund genommen, da hat sie 38 Jahre schon gearbeitet, die ist fertig. Die ist wortwörtlich fertig. Burnout und so weiter.

I12: Ja, das ist in der Tat ein wichtiger Punkt. Ich hoffe auch, dass sich da etwas ändert! Hast du noch offene Fragen?

P2.12: Nein, von meiner Seite nicht. Dankeschön, dass ich so offen reden konnte, ich hoffe ich konnte dir etwas näherbringen, meine Sicht, ja? Wie gesagt, ein schöner Beruf, abwechslungsreicher Beruf, verantwortungsvoller Beruf, ich hab’s gern gemacht, sonst wäre ich nicht mehr dabei. Man lernt immer wieder dazu, man hat nicht mit einer Seite von Berufsgruppe Arzt zu tun, du hast auch zu tun mit so (… - 1s) Krankengymnasten zu tun, du hast auch andere Schnittstellen, Pfarrer, Seelsorge (… - 1s). Das ist zwar alles soziale Berufe, aber trotzdem (… - 1s), du hast viel mit Angehörigen zu tun, das heißt, also das ist sehr breitgefächert. Deswegen ist es schön, es wird nicht langweilig, aber es ist verdammt stressig. Wäre es weniger Stress auf mehr Personen, wäre das super machbar.

B.4 List of categories

Stressors/Strains

What stressors and strains does a nurse encounter in her everyday working life?

- **Shortage of staff**

  There is a shortage of nurses to cover the existing work.

  "There is no time. What we previously did in eight hours with three nurses, we do with two nurses now. That means the work (… - 2s). Let's count, all work is a 100%, divided by three means everyone does 33% (… - 1s), but now I have 100% and only two, that means each of them has to do 50%, that is double the amount, almost double, isn't it? The work has not become less, remained the same (… - 2s)." (P2, p. 13, 466-471)

- **Inefficient staff**

  Staff which lacks competence or cannot work completely independent due to a lack of language skills.

  "And we have to allow all students to take the exam and almost no one should fail. That means, if you have a four point something, you still passed. And this results in the corresponding care." (P2, p. 2, 48-51)

- **Overtime**

  Working beyond the contractually regulated period of time.

  "You work until five in the afternoon but actually you would only have until two because your shift ends at this point." (P2, p. 11, 367-368)

- **Shift work**

  Working in shifts with early, late and night shifts.

  "Because (… - 3s) Christmas, you have to work, New Year's Eve, you have to work, evenings, you have to work, when all my friends go to the cinema, I have to go to the night shift or I am still in the late shift, when all parties are, I have to work." (P2, p. 2-3, 60-63)

- **Perception of lack of time**

  Perception of time as too short for getting done all work activities.

  "But you don't have the time and that is what nursing care lacks, time." (P2, p. 13, 464-465)

- **High workload and problematic way of working**

  A very high workload and, in addition, a type of work in which a lot of things has to be done at the same time and one is frequently interrupted.

  "And that's why when you've taken care of ten to twelve people, by lunchtime, you know what you've been doing. And that is not just about the basic care, but bringing breakfast, bringing pills, perhaps submitting breakfast, bring them to examinations, administering pills, doctor's visit, calls and relatives come. You have to be aware of how a day of a nurse looks like. It starts at six o'clock and is clocked until half past two, there is no time in between. And woe if something comes up." (P2, p. 15, 537-544)

- **Emotional burden**

  High emotional burden due to the perception of suffering of all patients.

  "And then there is this emotional, unpleasant work with patients, all the misery: someone dies, a leg is broken and has to be amputated. There are so many bad fates you should listen to, show compassion, understanding, but you must not get involved, otherwise you will perish." (P2, p. 5, 166-170)

Consequences of Stress and Mismatching Demands

Consequences on mental and physical health as well as performance from constant job strain.

- **Conflict between expectations and reality**

  Discrepancy between what you expect from yourself and how you would like to do your job and the lack of opportunities to fulfill them.

  "You would like to take care of patients, you would like to take your time, but you just can't. And yes (… - 2s), I also think that you always live in such a conflict that you know

that the patient actually needs more to get well and not just the most necessary things, but you just can't because there are other patients waiting as well." (P1, p. 2, 38-41)

- **Lack of sleep**

  Lack of (restful) sleep for regeneration.

  "And then you sit there and still have to document things over time, even though you only have eight and a half hours between the shifts. When should you sleep? You also need a little time to relax at home. And then you're really exhausted in the next shift." (P1, p. 10, 328-331)

- **Mood and well-being of nurses**

  Emotional condition and well-being of nurses.

  "Just the stress resulting from documenting, where sometimes you really don't know why you are doing that, then, this overtime and that you don't get anything in return, I think you're just dissatisfied." (P1, 408-411)

- **Work Engagement and motivation**

  Work engagement and motivation of a nurse within working context.

  "[…] we had 38 beds and there are quite a few who need a lot of care […] (... - 2s) and that takes time (... - 1s) and […] there were two of us. And that has affected the mood (… - 1s), most nurses did not like coming to work, more than half talked about the fact that they no longer want anymore and would like to work something else. (P1, 5-10, translated into English)

- **Thoroughness of working**

  To what extent a nurse works conscientiously and does things according to (safety-) regulations.

"And then I often find myself working uncleanly, sometimes not moving down a bed when I should to protect my back or forget to disinfect my hands as soon as I leave or enter a room." (P1, p. 2, 45-48)

- **Emotional encounter of the patient**

  How the nurse encounters and is acting with a patient.

  "Above all, I notice that I am often annoyed by the patients and cannot be benevolent and kind to them at all, but always doing all work just as quick as possible (… - 5s), which is such a shame." (P1, p. 2, 48-50)

(Work-Related) Resources

Resources partly related to work that are associated with positive consequences at work such as enhanced well-being and can buffer stress-related negative impacts on health and well-being.

- **Socio-moral climate**

  Prevalence of a socio-moral climate at work.

  "But I also think that it always depends a bit on the respective colleagues with whom you work together, to what extent you can contribute yourself at work and to what extent that (… - 2s), yes, is also promoted and values by others." (P1, p. 6-7, 209-212)

- **Political and social appreciation and support**

  Monetary and governmental support as well as social status of the profession

  "Seriously, where is the appreciation? Sorry, but you cannot tell me that one of those who applauded really know what we normally have to do in everyday life and what we are not getting for it. Our overtime hours are not counted anymore, so that's how you get rid of the problem. Wow. Yes, do you understand? I think, you just feel ripped off sometimes." (P1, p. 10, 344-350)

Well-Being

Mood at work and within the team and of the person interviewed in relation to work as well as mental and physical well-being of patients.

- **Mood and well-being of nurses**

  Emotional condition and well-being of nurses.

  "Yes, the whole atmosphere is much better there, too. So, all in all, I think you notice it. You can really notice it in general, and I also recognize it by myself. I am really happy to work there now. It is really good for me and I have a lot more fun at work again (… - 4s), exactly. (P1, p. 4, 108-111)

- **Well-being of patients**

  Emotional condition and mood of the patients.

  "You're in the hospital and you're not feeling well there, you're alone a lot, maybe something hurts or you're scared because you don't even know what will happen next. So, you're just not doing well there. And then the nurses are just rushing, nobody has time. And nobody there is really nice or seems like they're really interested. That's terrible." (P1, p. 2, 51-55)

- **Recovery of patients**

  Speed of a patient's recovery and health status.

  "And I really had the feeling that patients recovered faster. They just felt better (... - 3s), well, simply because someone took the time." (P1, p. 1, 16-18)

Work Engagement and Motivation

Motivation and work engagement as well as fun of nurses at work.

- **High work engagement and motivation**

  Highly motivated, you like coming to work and sometimes do a little more than is expected.

"And I have the feeling that the nurses there like to go to work and also have much more energy (… - 1s) or motivation." (P1, p. 4, 107-108)

- **Little work engagement and motivation**

  Little motivated, think about leaving and do not want to do more than is expected.

  "And all of that reduces motivation, doesn't it? And then I think that you just go into the patient room with an attitude of don't want to do anything and just do the bare minimum and nothing more." (P1, p. 11-12, 400-403)

Socio-Moral Climate

Extent of prevalence of a socio-moral climate at work.

- **Open confrontation with conflicts**

  Opportunity to openly address conflicts and mistakes.

  "And here you clarify everything immediately, you can also address something, if something didn't go well or you made a mistake." (P1, p. 4, 98-99)

- **Respect**

  Mutual respect, appreciation, care, and support given.

  "Yes (… - 2s) and also the general interaction among colleagues. I think that when everyone (… - 1s) treats each other in a friendly and appreciative manner, the patients notice that, too." (P2, p. 15-16, 554-556)

- **Open communication and participative cooperation**

  Opportunity for all employees to participate within decision-making processes and being able to questions general norms, rules or procedures within the company.

  "And that you can get involved within the team and be integrated by the time. Simply that everyone can participate, everyone can address everything, and everyone supports each other." (P1, p. 11, 378-380)

- **Allocation of responsibility**

  Trustful allocation of tasks to employees according to their competencies.

  „And the physicians really trust in us that we can do a lot of things, for example taking blood samples for CRP, dealing with medication at one's own discretion, preparing patients for the operations independently (… - 3s). Yes, I just have the feeling that they trust in me and my competencies." (P1, p. 3, 78-82)

Character Strengths

Character strengths being important to have as a nurse for feeling well at work.

- **Love**

  Valuing close relations with others especially when caring is reciprocated.

  "Yes, I think empathy is very important. Simply that you can empathize with someone else (… - 1s), that you can take care of someone else. I mean therefore it is called care, right? So, you should be able to be there for someone else, empathize with their situation and should be able to build a certain bond, but still be able to stay in an 'as-if'-perspective […]" (P1, p. 4, 117-122)

- **Kindness**

  Doing favors for others, taking care, helping.

  "But I think what all nurses have somehow in common, is wanting to help. Maybe we all have a bit of a helper syndrome, we are all way too good." (P1, p. 4-5, 133-135)

- **Self-regulation**

  Regulating what one feels and does, being disciplined, controlling one's appetites and emotions.

  "[…] also, a little that I can get along well with my emotions and can regulate them and not let others feel them. Well, I think that is very important." (P1, p. 5, 151-154)

- **Honesty**

  Presenting oneself in a genuine and authentic way.

  "Very important (… - 2s), authenticity. That you remain true to yourself, that you are yourself and that you can encounter other people openly and honestly." (P2, p. 6, 191-193)

- **Social intelligence**

  Being aware of motives and feelings of other people and oneself.

  "[…] social intelligence and social skills are necessary. This means that the person must be able or should be able to put himself in the patient's shoes. No matter if it's someone who's leg is broken or someone with a stomachache, I have to be able to imagine that things are not going well for this person. What worries does the patient have? He might have a stomachache right now, but at home he also has his child being cared for by the mother (… - 2s), so I just have to approach the patient." (P2, p. 4, 128-134)

- **Teamwork**

  Working well as a member of a group, being loyal.

  "That's teamwork, exactly. When it comes to teamwork, it doesn't mean that everyone should do the care planning perfectly and everyone has to do everything perfect, no. Teamwork means, I'm very good at this, but not so good at this and we complement each other. One can do this very well, the other one that and together we are strong." (P2, p. 12, 420-423)

- **Humor**

  Liking to laugh and tease, bringing smiles to other people.

  "And well, what always helps me is humor. Just be able to laugh about everything that goes wrong. Many of us have that and I really have to say that it makes everyday life a lot easier. Often so many stupid or disgusting things happen and just laughing about them with my colleagues (… - 2s), yes, that just helps." (P1, p. 5, 157-161)

- **Prudence**

  Being careful about one's choices, not taking undue risks, not do things regretted later.

  "[…] so, and I don't have to think just until now, I have to think until tomorrow, so looking ahead. Practice prevention." (P2, p. 12, 403-404)

Factors Influencing the Applicability of Character Strengths

Factors enhancing or reducing the applicability of character strengths within the working context of a nurse.

- **Socio-moral climate**

  Prevalence of a socio-moral climate at work.

  "But I also think that it always depends a bit on the respective colleagues with whom you work together, to what extent you can contribute yourself at work and to what extent that (… - 2s), yes, is also promoted and values by others." (P1, p. 6-7, 209-212)

- **Leader**

  Which leadership style a leader applies at work and how a leader reacts to the employees.

  "The leader plays a major role. To what extent he introduces you to your work and to what extent he recognizes what your strengths are, he breaks through your reserve. Where he gives you the possibility to show your abilities and to what extent he directs you in a certain direction." (P2, p. 7, 226-229)

- **Personality**

  To what extent the personality plays a role in the applicability of one's own character strengths at work.

  "I, uh, think some people are able to apply their strengths more easily, just in terms of their personality (… - 3s), how do you say that? (… - 1s) Yes, doers. These are doers. They are just very active people and they always make the best out of their situation and, I think, they are also the ones who somehow manage to apply their strengths more easily." (P1, p. 7, 220-225)

- **Perception of lack of time**

  Perception of time as too short for getting done all work activities.

  "But I also think that you often are not able to apply your strengths at all because you are under such time pressure due to the lack of staff and the large number of patients. I think you are often so stressed that you are in such a tunnel vision, you are no longer able to be empathetic or really care or be humorous, you are just stressed and just try to finish your work somehow and nothing more." (P1, p. 7, 213-218)

Patient Safety and Quality of Care

Amount of errors reducing the safety of patients and nurses.

- **Patient safety**

  Likelihood of errors reducing the safety of the patient's health.

  "Or when moving the patient from bed to the wheelchair, she was careless and did not use the brakes and he slips away." (P2, p. 14, 505-507)

- **Safety of a nurse**

  Likelihood of ways of working and behavior reducing the safety of the nurse's health.

  "Usually, these are just things that are more likely to harm you than the patient, for example, not heightening the bed to move the patient or not using a pad to turn him around. Well, that is just my back which breaks, but nothing happens to the patient." (P1, p. 9, 303-307)

- **Well-being of a patient**

  Emotional condition and mood of the patients.

  "You're in the hospital and you're not feeling well there, you're alone a lot, maybe something hurts or you're scared because you don't even know what will happen next. So, you're just not doing well there. And then the nurses are just rushing, nobody has time.

And nobody there is really nice or seems like they're really interested. That's terrible." (P1, p. 2, 51-55)

- **Recovery of a patient**

  Speed of a patient's recovery and health status.

  "And I really had the feeling that patients recovered faster. They just felt better (... - 3s), well, simply because someone took the time." (P1, p. 1, 16-18)

Factors Influencing Patient Safety and Quality of Care

Which factors reduce or enhance the safety of patients and the quality of care?

- **Perception of lack of time**

  Perception of time as too short for getting done all work activities.

  "But I also think that you were under more time pressure. As I said (… - 1s), we had 38 beds and there were two of us. How can you do everything well and always do everything right? (... - 2s)." (P1, p. 8, 268-270)

- **Shortage of staff**

  There is a shortage of nurses to cover the existing work.

  "Or if you simply are not able to lift a heavy patient out of bed with two people but just stand alone due to the lack of staff and time pressure (… - 3s), yes, I really had a 100 kilogram guy that I had to lift alone and, then, I was really afraid that I'll fall over with him. But you really have no other option. There is simply no one there who has time to help." (P1, p. 9, 315-320)

- **High workload and problematic way of working**

  A very high workload and, in addition, a type of work in which a lot of things has to be done at the same time and one is frequently interrupted.

"Yes and injury involving a nurse, let's assume she is laying down a patient and she is distracted because the phone is ringing (… - 1s), happens very often because she is multi-tasking, because she is leader of the shift and now has to make a phone call and care for a patient at the same time." (P2, p. 14, 501-505)

- **Lack of sleep**

  Lack of (restful) sleep for regeneration.

  "So, I think with the time pressure you are always so tensed, you can't really be relaxed and then I think you don't sleep so well and then you are simply less concentrated and then mistakes happen easily […]." (P1, p. 11, 370-372)

- **Mood and well-being of nurses**

  Emotional condition and well-being of a nurse taking care of the patient.

  "Because you approach the patient in a completely different way. When you are in a better mood, you treat the patient very differently." (P2, p. 16, 556-557)

- **Work engagement and motivation**

  Work engagement and motivation of a nurse within working context.

  "And then you are much more motivated and pay much more attention to safety (... - 2s) for yourself and the patient." (P2, 557-559)

- **Socio-moral climate**

  Prevalence of a socio-moral climate at work.

  "Well, I think that the support of the team can be very valuable, so that you are always supported and cared for and can also address things openly, for example, address any errors that may have happened and ask for help and that you can get involved within the team and be integrated by the team. So, simply that everyone can participate, everyone can address everything, and everyone supports each other. I already have the feeling that this makes it better, that less [errors] happen there." (P1, p. 11, 374-380)

- **Equipment and monetary resources**

  Quality and features of the equipment used in the hospital.

  "What kind of equipment do I have, bed rails or beds. There are beds, these low-floor beds, which means, I can move them downwards very low and then I can put a mattress in front of the bed so that he cannot injure himself if he falls out of bed. But such a low-floor bed costs. Not every institution can afford that." (P2, p. 14, 496-500)

- **Emotional encounter of the patient**

  How the nurse encounters and is acting with a patient.

  "Above all, I notice that I am often annoyed by the patients and cannot be benevolent and kind to them at all, but always doing all work just as quick as possible (… - 5s), which is such a shame." (P1, p. 2, 48-50)

- **Thoroughness of working**

  To what extent a nurse works conscientiously and does things according to (safety-) regulations.

  "And then I often find myself working uncleanly, sometimes not moving down a bed when I should to protect my back or forget to disinfect my hands as soon as I leave or enter a room." (P1, p. 2, 45-48)

- **Non-compliant patient behavior**

  Patient is doing things on his own even though being not able to, according to his health status.

  "So, I try to get up on my own, even though my health condition no longer allows it. And what happens then? Then I fall." (P2, p. 15, 529-530)

Possible Solutions

Possible solutions that could improve the working conditions.

- **Technical improvement of the equipment**

  Improvement of the technical possibilities of the equipment used.

  "Or that there were sensors somehow, that there would be an alarm when someone is too close to the borders of the bed, like parking sensors on a car." (P2, p. 15, 520-521)

- **Artificial Intelligence**

  Artificial intelligence and robots that could possibly help the nurses.

  "Sometimes I ask myself whether there isn't a better way to solve this. (… - 3s) I don't know, everybody is always talking about nursing robots. I do not find that sensible at all, but you could use them for documentation. That they just always come with you and write down what you do or that you can at least dictate them everything or something, Siri does exist, too. That has to work. So, less that care is being replaced by robots, I mean, I think that's totally stupid, you want to be cared for by a person as a patient (… - 2s), well, but I mean that robots could support care, just like documenting what always costs so much time and what is unnecessarily wasting time." (P1, p. 9, 290-299)

- **Supervisor support**

  The possibility of a leader helping and supporting the employees by taking over some of the work.

  "Do you like having breakfast alone? I do not like it. So, what did I do? 'Girls, you have breakfast now, give me your phones. I am available, should anything happen. I'll go to the rooms that ring the bell and you will have breakfast for half an hour now. So, they knew that they can have breakfast in peace, that they could have fun and laugh in peace and then you go back to work in a completely different way with a completely different motivation." (P2, p. 13, 458-464)

Eidesstattliche Erklärung

Ich versichere hiermit, dass ich die vorliegende Masterarbeit selbstständig verfasst und keine anderen Hilfsmittel als die angegebenen benutzt habe. Die Stellen, die anderen Werken dem Wortlaut oder dem Sinn nach entnommen sind, habe ich in jedem einzelnen Falle durch Angabe der Quelle, auch der benutzten Sekundärliteratur, als Entlehnung kenntlich gemacht. Die Arbeit wurde bisher weder in gleicher noch in ähnlicher Form einer anderen Prüfungsbehörde vorgelegt und auch noch nicht veröffentlicht.

12.01.2022

Datum

Unterschrift