"I don't think there's necessarily a one size fits all". Negotiating competing priorities in nurse shift scheduling: a qualitative study

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Abstract

Background: The nursing workforce globally faces significant challenges, including burnout, stress, and absenteeism, exacerbated by unsafe staffing levels and suboptimal working conditions. In England, many nursing staff express intentions to leave their roles, driven by work-life imbalance. This study explores how the preferences and constraints of nursing staff, nurse managers, and hospital directors interact to influence shift scheduling decisions within the NHS, aiming to identify strategies that reconcile individual wellbeing with organisational imperatives.

Methods: This qualitative study employed framework analysis, guided by the Thomas-Kilmann Conflict Mode Instrument (TKI) to understand conflict management approaches in shift scheduling. Data were collected through semi-structured interviews with 17 nursing staff, five nurse managers, and six hospital directors across five diverse NHS Trusts in England. Interviews were conducted remotely, transcribed verbatim, and analysed to identify key themes and patterns.

23   **Results:** Three primary themes were identified: Balancing Choice with Consistency,

24   Predictability, and Flexibility; Adequate Rest and Recovery Between Shifts; and Enjoyment and

25   Engagement at Work. The study found that collaborative and compromising conflict

26   management approaches were most effective in preventing potential conflicts from escalating

27   into actual conflicts. Flexible and predictable scheduling was crucial for enhancing nurse

28   wellbeing and retention, while rigid policies often led to increased turnover and reduced morale.

29   The study also highlighted the importance of considering external constraints, such as caring

30   responsibilities, which can limit the effectiveness of workplace solutions.

31   **Conclusions:** Effective nurse shift scheduling requires a blend of conflict management

32   strategies, with an emphasis on collaborative and compromising approaches. By prioritising

33   flexible scheduling and proactive communication, healthcare organisations can better support

34   their nursing workforce, enhancing both individual wellbeing and organisational efficiency.

35   These findings have significant implications for improving the sustainability and quality of

36   healthcare service provision.

Key words

Introduction

41   The nursing workforce globally faces escalating challenges of burnout, stress, and

42   absenteeism, alongside persistent concerns regarding unsafe staffing levels and suboptimal

43   working conditions (1). This widespread workforce depletion poses a significant threat to the

44   sustainability and quality of healthcare service provision. In England specifically, a substantial

45   proportion of nursing staff have expressed intentions to exit their current roles or leave the

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46   profession entirely (2). Work-life imbalance has emerged as a predominant factor influencing

47   departure decisions among nursing professionals (2), with established associations between

48   unfavourable shift patterns and compromised work-life balance (3,4).

49   Healthcare organisations, particularly within the National Health Service (NHS), face the

50   complex challenge of balancing organisational imperatives for cost-efficiency through

51   optimised rostering with the imperative to support staff wellbeing through appropriate work

52   scheduling. This tension has become increasingly salient as evidence suggests that prioritising

53   financial and efficiency metrics at the expense of staff considerations has contributed to

54   declining morale and increased sickness rates among nursing personnel (5).

55   The relationship between shift scheduling autonomy and employee wellbeing has been

56   established in broader occupational literature. Meta-analytical evidence indicates that flexible

57   work arrangements incorporating greater personal choice correlate with improved physical

58   health outcomes and reduced absenteeism (6). Within nursing-specific contexts, empirical

59   investigations have predominantly demonstrated positive outcomes associated with increased

60   scheduling choice, including reductions in sickness absence, burnout rates, turnover intention,

61   and work-life conflict (4,7–10). However, the literature is not entirely consistent, with some

62   studies reporting equivocal findings regarding the relationship between scheduling autonomy

63   and nursing staff wellbeing (11,12).

64   A notable gap exists in understanding the complex interplay between competing priorities and

65   preferences that shape shift pattern decisions across organisational hierarchies. Emmanuel et

66   al. (3) conducted an extensive qualitative investigation revealing that nurses' shift pattern

67   preferences predominantly relate to non-work commitments, schedule predictability, and

68   temporal flexibility. Similarly, recent qualitative research by Booker et al. (13) highlighted that

69   nurses prioritise shift patterns compatible with personal circumstances, sometimes potentially

70   compromising evidence-based fatigue management principles.

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71   To conceptualise how preferences and constraints interact across organisational levels

72   (nursing staff, nurse managers, and hospital directors), we employ the Thomas-Kilmann

73   Conflict Mode Instrument (TKI) (14) as our theoretical framework. This well-established model

74   delineates five distinct approaches to conflict management: collaborating, compromising,

75   accommodating, avoiding, and competing. The TKI framework has been extensively utilised to

76   analyse conflict management strategies within nursing contexts (15), providing a robust

77   theoretical foundation for our analysis. In the current study, the application of the TKI

78   theoretical framework gives the analysis an innovative perspective on a widely discussed topic

79   that is rarely addressed from the lens of conflict management.

80   In our conceptualisation of conflict, we distinguish between two fundamental forms: potential

81   conflict and actual conflict. Potential conflict encompasses discordant needs, priorities, or

82   preferences that create latent conditions for disagreement without necessarily manifesting as

83   overt discord. Actual conflict represents the explicit expression of these conflicting priorities

84   through observable disagreement, characterised by interpersonal tension or frustration.

85   Importantly, the presence of conflicting priorities does not inevitably precipitate actual conflict.

86   These conceptual distinctions align with seminal conflict theory (16,17) and have been applied

87   to understanding workplace dynamics within nursing environments (18).

88   Our study aims to explore how the preferences and constraints of nursing staff, nurse

89   managers, and hospital directors interact and collectively influence decision-making processes

90   regarding shift patterns. Through examining these complex interactions, we seek to identify

91   approaches that might better reconcile the potentially conflicting priorities of individual

92   wellbeing and organisational imperatives in nursing workforce management.

Methods

Study Design

This study adopted an interpretive qualitative approach to understand competing priorities in nurses shift scheduling across different participant groups with data analysis guided by framework analysis. Framework analysis provided a systematic and flexible approach to managing and analysing qualitative data for both inductive and deductive thematic development (19). A subtle realist ontological position was selected acknowledging that the social world exists independently of individual perspectives while recognising that understanding is shaped by unique experiences and interpretations (20). This allowed for interpretation of diverse perspectives that acknowledged individual and broader social experiences across participant groups. Crucially, TKI served as a guiding theoretical framework, providing concepts that informed the development of our themes and subsequent interpretation of findings, particularly in relation to understanding conflict management.

Ethical Approval

In accordance with the Declaration of Helsinki ethical approval was granted by the Health Research Authority (IRAS ID: 327884) and the University of Southampton ethics committee (ID: 81204).

Participants

A purposive stratified sampling framework was used to ensure diversity in settings by geography and healthcare specialty. The study advertisement was distributed through the National Institute for Health and Care Research (NIHR) Research Delivery Network. Local research and Development (R&D) offices that contacted the research team were considered for inclusion.

116 Five diverse NHS Trusts were recruited, representing the North, Midlands, East, and South of

117 England. Two specialised in Mental Health, one in Paediatrics, and two were general NHS

118 Foundation Trusts. Within each Trust, the R&D team or local Principal Investigator advertised

119 the study through tailored recruitment channels. Eligible participants included nursing staff

120 (registered nurses, nursing associates, and healthcare support workers) working shifts in

121 inpatient settings, ward managers in inpatient settings, and hospital directors working in Human

122 Resources or Finance. Participants self-selected to participate in the study, which means

123 individuals with stronger opinions, available free time, or interest in the £20 voucher received as

124 compensation for the interview time, may have been more likely to volunteer. From those who

125 volunteered, participants were purposively approached to ensure diversity of staff roles. In our

126 study, we ensured that paying participants was ethically sound. We respected their time and

127 effort, promoting social good and inclusivity. Our payment scheme was designed to avoid

128 exploitation, offering fair compensation without undue inducement. We maintained

129 transparency about payments, fostering trust and autonomy. This approach valued participants'

130 contributions and supported diverse, equitable research participation.

131 All participants provided informed consent either online or via audio prior to data collection

132 occurring.

Data Collection

134 Interviews were conducted remotely via Microsoft Teams video calls between October and

135 December 2023. Participants joined from their preferred locations, which included workplace

136 offices and home environments

137 Semi-structured interviews were conducted with 17 nursing staff working shifts (including

138 registered nurses and healthcare support workers), five nurse managers, and six hospital

139 directors.

140 The interview guides were developed for this study based on the research objectives and are

141 included in a supplementary file. Topics included experiences and perceptions of nurse shift

142 patterns, typical shift patterns, satisfying and challenging aspects, ideal shift pattern factors,

143 non-negotiables in shift patterns, and descriptions of well-being and work-life balance. No pilot

144 testing of the interview guides was conducted, but questions were refined iteratively as the

145 study progressed. All interviews were audio-recorded via Microsoft Teams and transcribed

146 verbatim by HRB. Field notes were made during and after interviews to capture contextual

147 information and non-verbal cues. Data collection continued until saturation was reached in

148 nursing staff responses, with no new themes identified. The group interview format for hospital

149 directors was deliberately chosen despite the potential for social desirability bias. This

150 approach aimed to foster more candid exchanges among directors from different trusts, with

151 the expectation that peer observations would encourage greater openness and generate richer

152 insights.

Research Team and Reflexivity

154 The primary researcher (HRB) conducted all interviews. HRB is a female researcher with

155 previous experience in qualitative data collection and analysis. The researcher had no

156 established relationships with participants prior to study commencement. Participants were

157 informed only that the researcher had a professional interest in nurse shift patterns. The

158 researcher introduced herself, her credentials, and the purpose of the research during

159 recruitment. Throughout the data collection process, HRB maintained a reflective journal to

160 enhance awareness of potential personal biases that might influence the interview process or

161 data interpretation.

Data analysis

Framework analysis was employed following the approach described by Ward et al. (19). The analysis process involved:

1. Transcription and familiarisation with the data through repeated reading

2. Initial coding of transcripts

3. Development of a working analytical framework

4. Application of the framework to all data

5. Charting data into the framework matrix

6. Interpretation of the data

Initially, themes were organised deductively according to known attributes related to nurse shift scheduling (shift patterns, rostering, pay, wellbeing, and life outside of work). However, after team discussion, these themes and sub-themes were inductively reorganised into three overarching themes.

Three researchers (HRB, CDO, and PG) were involved in data analysis. Regular meetings were held to discuss code and theme development, enhancing analytical rigour. HRB led the data analysis, maintaining a clear audit trail that preserved the connection between codes, themes, and original transcripts. This approach facilitated collaborative theme development (21).

Trustworthiness and Transparency

To ensure trustworthiness, criteria from Lincoln and Guba (22) were followed:

Transferability: Purposive sampling techniques were used to select diverse NHS Trusts and participant roles. Socio-demographic data were collected (Tables 1 and 2), showing variety in years with current employer and years in current role. However, gender and country of training

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185 were relatively homogenous, but this is reflective of the national workforce. In the NHS, nurses

186 are predominantly female (89.4%), and the majority have English nationality (71.3%) (23,24).

187 **Reflexivity:** HRB maintained a reflective journal throughout data collection and analysis to

188 acknowledge potential personal biases and other biases such as recruitment and social

189 desirability bias. These reflections enhanced transparency in the findings.

190 **Confirmability:** Multiple researchers (CDO and PG) discussed code and theme development

191 during regular meetings. The coding structure evolved through collaborative analysis, with a

192 clear audit trail preserving the connection to original data. A coding tree of the agreed themes is

193 available in a supplementary file.

194 **Credibility:** Nurse leaders across the five participating Trusts reviewed the study findings,

195 confirming that results resonated with their experiences and perspectives. No formal

196 participant checking of transcripts was conducted.

197 To support transparency, the consolidated criteria for reporting qualitative research (COREQ)

198 checklist (25) was completed and is available as supplementary file.

Findings

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200 Individual interviews with nursing staff and nurse managers lasted between 20-55 minutes.

201 Hospital directors participated in one group interview lasting 55 minutes. Socio-demographic

202 data were collected. While participants showed varied lengths of time with their current

203 employer and in their current role, as detailed in Tables 1 and 2, gender and country of training

204 were relatively consistent. This consistency reflects the composition of the national nursing

205 workforce; NHS nurses are overwhelmingly female (89.4%) and largely of English nationality

206 (71.3%) (23,24).

207 Table 1. Nurse Staff and Nurse Managers Characteristics (n=22)

Sex			Country of Training		
Female		20	UK		14
Male		2	Non-UK		4
NHS Setting			NA		4
Community & Mental Health		10	**Work Pattern**		
General Hospital		10	Full Time		21
Paediatrics		2	Part Time		1
			Years with Current Employer		
Job Role			0 to 3		4
Senior Manager		1	4 to 6		7
Ward Manager		3	7 to 9		3
Nurse Practitioner/Specialist		2	9 +		8
Nurse Team Leader/Senior Staff Nurse		3	**Years in Current Role**		
Staff Nurse		6	1		6
Nurse associate		3	2		6
Health Care Support Worker		4	3		4
			4		1
			Over 5		5

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209   Table 2. NHS Director Characteristics (n=6)

Years with Current Employer	
0 to 3	2
4 to 6	0
7 to 9	0
9 +	4
Years in Current Role	
1	1
2	2
3	0
4	1

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Over 5	2
NHS Setting	
Community & Mental Health	2
General Hospital	2
Paediatrics	2

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211 This study identified three key themes related to nurse shift scheduling preferences and their

212 impact on wellbeing and organisational functioning: (1) Balancing Choice with Consistency,

213 Predictability and Flexibility; (2) Adequate Rest and Recovery Between Shifts; and (3) Enjoyment

214 and Engagement at Work. These themes are analysed through the TKI to understand how

215 different conflict resolution approaches—competing, collaborating, compromising, avoiding,

216 and accommodating—manifest in nurse shift scheduling contexts.

217 Theme 1: Balancing Choice with Consistency, Predictability and

218 Flexibility

219 Nursing staff valued having a consistent shift pattern that aligned with their individual

220 preferences while also allowing for predictability and flexibility in scheduling. Three key

221 attributes were identified as essential components of effective shift scheduling. Within this

222 theme, various TKI conflict management modes were identified as stakeholders navigated

223 competing priorities:

224 Consistency in Shift Patterns

225 Nurses strongly emphasised the need for consistent shift patterns rather than "sporadic" (ID8;

226 ID10) or "random" (ID9) shifts. Mixed day and night shifts were particularly problematic, causing

227 disorientation and difficulty in planning personal activities: "*It's all shuffled and there's no*

228 *routine in your life…When you work when you have a routine in your life… I go out to my friends…*

229   *I go to gym...I reboot*"(ID7). What constituted a "consistent" schedule varied based on individual

230   circumstances. For some, consistency meant specific days off for childcare, while for others, it

231   meant predominantly working night shifts: *"I actually was doing most night shifts when I*

232   *returned to work after maternity leave because my husband was doing day shifts, was working*

233   *nine to five. So I had to do night shifts just to balance who takes care of our baby"* (ID30). Failure

234   to accommodate these individual consistency needs led to staff turnover, as one nurse

235   manager noted: "*They lost about 3 qualified nurses to a different trust because they weren't*

236   *given...set days for...childcare*" (NM14).

237   When nurses strongly advocated for consistent shift patterns that met their personal needs,

238   they demonstrated a competing approach, prioritising their own concerns over organisational

239   flexibility. Organisations that failed to accommodate these needs experienced increased

240   turnover, suggesting that an avoiding approach to addressing nurses' scheduling concerns was

241   counterproductive. Successful nurse retention required managers to adopt at least a

242   compromising approach to scheduling conflicts.

243   Predictability in Scheduling

244   All stakeholders—nurses, managers, and directors—valued rosters being released well in

245   advance. Directors recognised operational benefits: "*The earlier that you can actually get them*

246   *approved, signed off, any vacant shifts uploaded to NHSP and filled with bank rather than having*

247   *to go out to agency, is a lot better*" (D4). For nursing staff, advance notice facilitated better work-

248   life planning: "*If you know what days you're working and which days you're off, then it's easier for*

249   *you to plan*" (ID2). Fairness was identified as a shared value across all levels, with

250   unpredictable, last-minute scheduling perceived as inherently unfair: "*We have a lot of*

251   *unfairness around rostering at those periods of time (i.e., Christmas, holidays) because they (i.e.*

252   *the rosters) are done at such short notice*" (D3). Directors characterised fairness as a "win-win"

253   that benefited both staff and the organisation, while nurses acknowledged that fairness

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254 sometimes required accepting less desirable shifts: "*If I could choose not to work weekends, I*

255 *probably would. But then that means someone else would have to work them, and that's not*

256 *fair*" (ID8).

257 Predictability in scheduling represented a collaborating approach where all stakeholders' needs

258 aligned. Both organisational efficiency goals and nurses' personal planning needs were served

259 by advance roster publication, creating a true "win-win." When nurses acknowledged the

260 necessity of working some undesirable shifts for fairness, they demonstrated a compromising

261 mode, showing willingness to partially sacrifice their preferences to ensure equitable

262 distribution of shifts among colleagues.

Flexibility in Management Approach

264 Nurse managers prioritised accommodating staff preferences to maintain workforce

265 satisfaction: "*If I make sure everyone's kind of like happy with the off duty that anxieties aren't*

266 *attached to that. Everyone's fairly happy then you've half the battle*" (NM14). This required

267 individualised approaches to staff management: "*It's about assessing the individual. I don't*

268 *think there is a blanket rule*" (NM3). Managers observed that accommodating staff preferences

269 improved attendance and retention: "*Once you get to know your workforce...you can play what*

270 *they want and then they're going to attend...my sickness went from double figures percentage to*

271 *like 2.3%*" (NM14). Flexible working arrangements enhanced staff satisfaction and work-life

272 balance: "*I do have agreed flexible working. Suits me and it suits my needs. I'm able to go to the*

273 *gym on a Monday night... I'm able to see family more...I'm able to, you know, go on holiday*"

274 (ID21). However, managers faced constraints in providing flexibility due to competing demands:

275 "*When we do the off duty, we have to make sure the ward is covered first and...only then, we can*

276 *honour those hours like you know the additional hours for the learning opportunity*" (NM11).

277 Directors acknowledged system-wide challenges: "*Now that the NHS are really pushing flexible*

278 *working it's really quite difficult to do that... Especially one of our significant challenges is term-*

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279   *time only contracts... Because if you have maybe nine nurses on one ward it's difficult to grant*

280   *them all term time only contracts, so it's about finding that balance*" (D2). Staff experienced

281   frustration when managers were inflexible to reasonable requests: "*Doing 2 long days were too*

282   *difficult for me in a row because I was hardly sleeping... I asked them if I'm working Monday a*

283   *long day, can I have a day off on Tuesday and work again on Wednesday... But it wasn't, it was*

284   *not possible*" (ID7). Directors' priorities focused primarily on safety and budget concerns, with

285   patient safety as "*the top priority*" (M4), followed by efforts to save "*money and make services*

286   *more efficient*" (M4). The nursing shortage had forced organisations to become more

287   accommodating of staff preferences: "*We didn't have night shifts only contracts, it was not*

288   *allowed, but now we have softened because we've realised, you know, we've gotta go with what*

289   *individuals want rather than it to be what the organisation wants. We're in a buyers' market and*

290   *that is what's pushing our behaviours*" (D3).

291   Successful nurse managers employed an accommodating approach when creating rosters,

292   prioritising staff preferences to improve satisfaction and reduce turnover. This approach

293   recognised that addressing nurses' needs yielded organisational benefits through reduced

294   sickness absence and improved retention. When managers' responses to staff scheduling

295   requests were inflexible, they demonstrated an avoiding conflict management style that

296   generated frustration among staff. The healthcare labour shortage has shifted organisational

297   approaches from competing (enforcing organisational policies) to more accommodating

298   strategies (accepting individual scheduling preferences), reflecting the "buyers' market" reality

299   where nurses have increased bargaining power.

300   ## Theme 2: Adequate Rest and Recovery Between Shifts

301   All stakeholders recognised that nursing work is emotionally, psychologically, and physically

302   demanding, making sufficient rest between shifts essential. Actual conflict arose when rosters

303   prevented adequate recovery, particularly when: Shift finish times were too late to allow proper

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unwinding before the next shift; insufficient rest was provided after intensive work periods; too many shifts were scheduled consecutively: "*That would mean that you have something crazy like 6 shifts together without a break*" (ID9). The availability of days off was highly valued by staff working long shifts: "*The days off, I think by doing long days it means I get more days off so I find that better for a work life balance*" (ID17). Recovery between shifts was crucial for adequate sleep; emotional recuperation; managing personal responsibilities; social connection with friends and family. Effective shift patterns positively impacted wellbeing: "*My wellbeing, I would say, is good when my shifts are within a sensible sort of pattern during the week... when I have weeks...when I had both weekends either side of three shifts, then a training day, then that's when my wellbeing sort of takes a bit of a toll and I feel like I don't have enough time to recover properly*" (ID9). Even with flexible working arrangements, some nurses—particularly those with childcare responsibilities—still struggled: "*So I do 3 long shifts a week... it tends to be 2 long days in the week and then... always a shift at the weekend, whether that's a day or a night.... It's not working for me at all at the minute. Just work life balance is horrible basically*" (ID6). Earlier finishing times for long day shifts were identified as a significant factor in improving work-life balance: "*Your adrenaline is going and then you get to like 7:00pm... and you're just like mentally drained. But then you still have two hours more to go, so it feels like it just goes on and on some days*" (ID13). Earlier finish times provided valuable recovery time: "*The times where you know if it actually finishes at half seven. And you go home... You'll get a couple of hours in the evening before you have to get up the next day*" (ID21). Some managers recognised that earlier finish times could align with organisational priorities: "*The end time of a shift pattern is a big difference in how people feel... my argument to get that time and pushed back is actually we save on budget*" (NM1).

Rest and recovery issues revealed tensions between organisational staffing needs and nurses' wellbeing requirements. When managers scheduled consecutive shifts without adequate breaks, they employed a competing approach that prioritised organisational coverage needs

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330   over individual recovery requirements. Nurses who accepted long shifts in exchange for more

331   days off demonstrated a compromising strategy, trading intensity for extended recovery periods.

332   The nurse manager who advocated for earlier finish times by connecting it to budget savings

333   exemplified a collaborating approach, seeking solutions that simultaneously addressed both

334   staff wellbeing and organisational priorities. For nurses with ongoing work-life balance

335   challenges despite flexible scheduling, the absence of viable solutions suggested an Avoiding

336   conflict resolution style from both organisational and individual perspectives.

Theme 3: Enjoyment and Engagement at Work

338   Nursing staff valued meaningful patient interactions and team collaboration: "*Interacting with*

339   *the patient more...spending more time with them and learning more about them...And actually*

340   *seeing...people... my manager...like doctors...just knowing how the ward works...it's much,*

341   *much better*" (ID18). These priorities were more consistently met among nurses working shorter

342   daytime shifts compared to those on long day or night shifts. Nurse managers emphasised the

343   importance of team cohesion: "*Everybody knows...we're gonna be here for this long together.*

344   *And we only have three people on shift which I think kind of reinforces that you need to be a lot*

345   *more of a tighter team because then if one person's upset or one person disrupts something*

346   *that can cause quite a big ripple effect*" (NM32). Nurses also acknowledged the trade-offs in

347   shift work to achieve job satisfaction: "*There's trade-offs, isn't there all the time between, OK, so*

348   *I'll work longer, but then I have more time off. So that there's never. I don't think there's*

349   *necessarily kind of a one size fits all, but it's about kind of balancing the trade offs to a point*

350   *where actually the job is satisfying*" (ID10). Conflicts were identified around shift start/end times

351   and handover periods. While a 30-minute handover was considered necessary for thorough

352   communication, this extended either the start or end time of shifts. Even with scheduled 15-

353   minute handovers, these often ran longer, resulting in delayed shift endings. A common shift

354   pattern described was 7am to 7:30pm (days) or 7pm to 7:30am (nights), with 30-minute

355 handovers. Some managers provided additional support through allocating "time off the floor"

356 for administrative work: "*It makes them feel appreciated about you know what they're doing*

357 *because it's not normal for a band 5 staff nurse to have a management day, and I think, well,*

358 *they need it though*" (NM14). They also offered career development opportunities through

359 personalised conversations: "*Have you thought about this course or that training opportunity*"

360 (NM32). However, organisational wellbeing initiatives were often perceived as inaccessible to

361 shift workers: "*Health and wellbeing department and they put on like lovely events…and they*

362 *forget about shift workers… I can't leave the unit for an hour and go on a lovely midday walk with*

363 *you. You know, we've got a staff gym just opened. It's open four till seven. I don't finish my shift*

364 *until half seven*" (ID6).

365 The tension between adequate handover time and shift length illustrated a compromising

366 approach where neither optimal communication nor ideal shift length could be fully achieved.

367 Nurses working long shifts or nights experienced reduced opportunities for meaningful patient

368 and team interactions, representing an avoiding approach to addressing this conflict between

369 shift structure and engagement quality. Managers who allocated "time off the floor" for

370 administrative work demonstrated an accommodating style that recognised nurses'

371 professional development needs despite organisational pressures. The disconnect between

372 organisational wellbeing initiatives and shift workers' realities reflected an avoiding conflict

373 management approach from the organisational perspective, where the fundamental

374 incompatibility between standard business hours and shift work scheduling remained

375 unaddressed.

376 In summary, the analysis of nurse shift scheduling through the TKI framework reveals how

377 different conflict management approaches shaped the experiences of nursing staff, nurse

378 managers, and hospital directors:

379 Competing approaches were observed when:

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380   •   Nurses strongly advocated for personal scheduling preferences

381   •   Organisations strictly enforced policies without accommodation

382   •   Managers prioritised coverage over adequate rest periods

383   Collaborating approaches were identified in:

384   •   Advance roster publication benefiting both staff planning and organisational efficiency

385   •   Managers linking earlier shift finish times to budget savings

386   Compromising strategies appeared when:

387   •   Nurses accepted working undesirable shifts for fairness

388   •   Staff traded long shift intensity for more days off

389   •   Balancing handover time against shift length

390   Avoiding conflict styles were evident in:

391   •   Organisations failing to address nurses' scheduling concerns

392   •   Persistent work-life balance challenges without viable solutions

393   •   Wellbeing initiatives that excluded shift workers

394   Accommodating approaches were demonstrated by:

395   •   Managers prioritising staff preferences to improve satisfaction and retention

396   •   Organisations adapting policies in response to nursing shortages

397   •   Providing "time off the floor" for professional development

398   This analysis reveals that effective nurse shift scheduling requires a sophisticated blend of

399   conflict management approaches, with greater emphasis on collaborating and compromising

400   strategies to balance individual needs with organisational requirements. The transition from

401   rigid organisational policies to more accommodating approaches reflects the evolving power

402   dynamics in healthcare employment, with nurses gaining leverage in a competitive labour

403   market.

Discussion

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405   Our study was the first to investigate how different priorities of nursing staff, nurse managers,

406   and hospital directors interact and shape nurse shift patterns. Using the Thomas-Kilmann

407   Conflict Mode Instrument (14), we identified patterns of potential conflicts, actual conflicts,

408   and occasional compatibilities across three primary domains of shift scheduling concerns.

409   Despite interviewing a variety of nursing staff and nurse managers, we developed three

410   overarching themes influencing nursing staffs' decision making in shift scheduling: Balancing

411   Choice with Consistency, Flexibility, and Predictability; Adequate Rest and Recovery between

412   Shifts; and Enjoyment and Engagement at Work.

413   Applying the TKI framework (14), our findings demonstrated how conflict management

414   approaches influenced scheduling outcomes. Collaborative and compromising approaches,

415   characterised by high concern for both self and others, prevented potential conflicts from

416   escalating. For instance, nurses' preferences could be met through collaborative compromises

417   that simultaneously supported the organisation's staff retention goals. This aligns with Pondy's

418   (17) model of conflict, suggesting latent conflicts become manifested conflicts when effective

419   management strategies are absent.

420   In contrast, avoiding (low concern for self and others), or competing (high concern for self, low

421   concern for others) approaches led to actual conflict and nurse attrition. Accommodating

422   approaches (low concern for self, high for others) were "too simplistic" for complex multi-

423   stakeholder priorities in scheduling, often leaving one party's needs unmet. When nurses

424   continuously accommodated organisational needs without reciprocity, their work-life balance

425   and wellbeing suffered, consistent with evidence on work time control (26) and links between

426   autonomy and wellbeing outcomes.

427   Recent qualitative work highlights features valued by nurses in shift scheduling such as roster

428   consistency, work time control, and flexibility (3), and preference acknowledgement (27). Our

429   research uniquely interprets how these overlapping principles interact using the TKI.

430   In the theme "Balancing Choice", consistency, flexibility, and predictability fostered

431   collaborative conflict management (14). Consistency set clear expectations as a foundation for

432   mutually beneficial solutions. Flexibility from nursing staff and managers allowed adaptation

433   and responsiveness to less desirable shift patterns and staff individual needs, exemplifying

434   compromise where both parties achieve partial satisfaction. Effective communication and

435   awareness between staff groups — core principles of constructive conflict management – could

436   manage expectations. Nursing staff could expect some consistency in their shift patterns for

437   their individual needs (addressing their concerns), but also accept give-and-take within

438   organisational constraints (addressing others' concerns). Predictability helped nurse managers

439   make less desirable shifts more acceptable through reducing uncertainty and providing fair

440   processes. This theme revealed an important paradox in nursing shift scheduling preferences:

441   they simultaneously desire individual autonomy (choice and flexibility) and structural reliability

442   (consistency and predictability). Our findings suggest that effective scheduling must address

443   both of these needs.

444

445   Our research also expands theoretical understanding of choice in nurse shift scheduling and

446   wellbeing. Our study consistently showed choice benefitted perceptions of wellbeing and work-

447   life balance, suggesting people feel better with more perceived choice. These results align with

448   most research exploring nursing staff choice in shift scheduling and wellbeing outcomes (i.e.,

449   more job satisfaction, less sickness absence, more work-life balance, less fatigue, less burnout)

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450 demonstrating positive associations between choice for shift scheduling and wellbeing

451 outcomes (4,7,10,28,29). However, our study revealed an important nuance: external

452 constraints, like caring responsibilities, sometimes meant nurses remained "stuck" regarding

453 work-life balance despite offered choice. These findings add novel insight to work-life balance

454 theory by highlighting workplace solutions' limitations when external factors constrain true

455 choice. A recent scoping review noted similar findings suggesting job satisfaction may be

456 sacrificed to balance personal demands (27). This illustrates the TKI accommodating mode,

457 where individuals sacrifice their concerns to satisfy others'—in this case, external

458 responsibilities. This theoretical insight may explain why some studies on choice for nurses in

459 shift scheduling and perceived wellbeing that did not adjust for lifestyle constraints outside of

460 work showed little effect (11).

461 Our results showed the importance of rest and recovery between shifts and enjoyment and

462 engagement at work. For example, actual conflict occurred—in terms of Pondy's (17) manifest

463 conflict stage—when there was not enough rest for nursing staff between shifts and too many

464 shifts were bundled together. Many nurses felt long days facilitated better rest and downtime.

465 Our data indicates nurses recognise that wellbeing impacts on their ability to provide quality

466 care sustainably, fostering job satisfaction—integrating professional values with personal

467 wellbeing. While one qualitative study expressed concern that complete autonomy in shift

468 choice could prioritise other needs over individual well-being (13), our "Rest and Recovery

469 between Shifts" theme showed how crucial rest and recovery were for nurses' work and

470 personal lives.

471 However, similar to other research (30,31), our findings also indicated a shortfall in positive

472 team dynamics, handover, and training opportunities with long day shift patterns. Our study

473 uniquely showed that although valuing these elements, nurses frequently prioritised

474 maintaining long day shift patterns for work-life balance. This represents a theoretical

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475   compromise where one professional value (team cohesion) is partially sacrificed for another

476   (work-life balance), consistent with the compromising mode in the TKI framework. These

477   attitudes may reflect a broader societal shift towards prioritising well-being and work-life

478   balance (6). Hospitals need to be ready to respond to these changing priorities. For example,

479   increased nurse advocacy for shift scheduling needs could shift power dynamics, prompting

480   more collaborative scheduling processes. When nurse managers provided "time off the floor"

481   for training, it supported quality care delivery. This represents an integration of competing

482   priorities rather than compromising—fully meeting the individual's development needs and

483   organisation's service needs, exemplifying the collaborative mode of conflict management.

484   Within the three overarching themes, we observed examples of when potential for conflict

485   remained as such (latent conflict in Pondy's (17) terms), with successful compromises from

486   different staff groups, and when it became actual conflict (manifest conflict). The most obvious

487   trend was when there was no flexibility at all—when complete rigidity on the priorities of

488   different staff groups (competing approach) resulted in actual conflict. For example, if only

489   rostering targets were considered in shift scheduling decisions, or if an individual with a non-

490   negotiable need faced inflexibility, actual conflict emerged. Sometimes a small tweak like an

491   earlier shift finish or specific shift pattern (e.g. no consecutive long day shifts), was enough –

492   representing compromise. However, gaining agreement for small changes in the organisation

493   could prove difficult, suggesting organisational resistance to change (32).

494   Even when compatibilities existed between nursing staff and the organisation, these were

495   underpinned by different priorities, creating latent conflict. For example, directors embraced

496   flexibility while acknowledging challenges but tended to be driven by operational factors, such

497   as reducing turnover, rather than being driven by staff wellbeing effects. These different

498   priorities and constraints perpetuated potential conflicts across the organisation, necessitating

499   compromises to avoid actual conflict, maintain service delivery and prevent unmanageable

500   nursing staff turnover. This aligns with Pondy's (17) cyclical view of organisational conflict,

501   where underlying structural factors and differing priorities ensure latent conflicts persist even

502   after manifest conflicts are resolved.

503   Our study showed that each staff group's understanding and upholding of the other staff groups'

504   priorities to an acceptable level helped maintain conflicts as potential, rather than overt. For

505   example, nurse managers noted improved staff retention and reduced sickness absence when

506   balancing nurses' preferred shift patterns with ward staffing requirements; nurses cited leaving

507   jobs when flexibility and roster balancing were absent. Effective communication that raised

508   awareness and adjusted expectations and fairness facilitated this flexibility—core components

509   of both collaborative and compromising conflict management approaches.

510   Our research reveals significant implications for improving shift scheduling across all levels of

511   nursing leadership and hospital management. Effective communication is essential for all

512   stakeholders and nursing staff benefit from clearly advocating their scheduling needs while

513   remaining open to negotiation (the essence of the compromising mode). Where locally

514   appropriate, nursing staff can request flexible scheduling options aligning with personal

515   circumstances and wellbeing.

516   Nurse managers should prioritise implementing flexible working arrangements and systematic

517   approaches for gathering and responding to shift pattern feedback. The theoretical basis for this

518   recommendation is that collaborative approaches—which seek to fully satisfy both parties'

519   concerns—produce more sustainable solutions than competing or avoiding approaches when

520   addressing complex scheduling conflicts. Our findings suggest particular attention to intensive

521   schedules, such as four consecutive long days, with consideration of modifications like

522   replacing the fourth long day with a shorter shift—a compromise that potentially improves both

523   wellbeing and retention.

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Hospital directors should reframe staff scheduling preferences as an organisational value not merely a retention compromise. This perspective shift recognises flexible scheduling as critical best practice. Specific scheduling modifications—such as earlier finishing times for long shifts and adequate rest periods—can significantly enhance nurse wellbeing, reducing fatigue and burnout.

At the systems level, our findings suggest that organisational policies proactively preventing potential conflicts—such as extending current NHS guidance beyond the six-week advance publishing standard—create conditions where collaborative approaches can flourish. Earlier roster publication demonstrably benefits staff work-life balance while affording managers more time to address roster gaps proactively, a collaborative solution meeting both individual and organisational needs.

Through the theoretical lens of conflict management theory, our research provides a framework for understanding not just preferred scheduling practices, but why certain approaches succeed while others fail, and how different conflict management strategies can transform potential conflicts into constructive outcomes for both individuals and organisations.

Limitations

As Burr (33) suggests, participants' awareness of being recorded and interacting with an unfamiliar researcher may have influenced their willingness to disclose complete and unfiltered perspectives. This social desirability bias potentially moderated responses, particularly when discussing sensitive topics such as disagreements with organisational policies or interpersonal conflicts with colleagues. To mitigate this limitation, the primary researcher leveraged extensive interviewing experience to establish rapport and create psychologically safe environments conducive to authentic disclosure. Furthermore, methodological rigour was enhanced through

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547   systematic reflective journaling, transparent analytical processes, and adherence to

548   established trustworthiness criteria (22) throughout data collection and analysis phases.

549   A further limitation of this study is its reliance on perceptions rather than objective behavioural

550   observations. The data refer to perceptions and are not triangulated with direct observation or

551   documentary analysis. While our findings provide valuable insights into perceived priorities and

552   constraints regarding shift scheduling across organisational hierarchies, they do not capture

553   actual decision-making behaviours and choices enacted by nursing staff, nurse managers, and

554   hospital directors. This distinction between perception and behaviour is particularly relevant in

555   organisational contexts where institutional constraints may create discrepancies between

556   expressed values and implemented practices.

557   The potential impact of regional variations in NHS Trust policies represents another limitation

558   affecting the transferability of our findings. While our purposive sampling strategy incorporated

559   geographical diversity across five NHS Trusts in England, organisational cultures, leadership

560   approaches, and policy implementations inevitably differ across healthcare settings. Moreover,

561   the findings may have limited transferability to international healthcare contexts with

562   fundamentally different workforce structures, regulatory frameworks, or cultural orientations

563   toward work-life balance. As is characteristic of qualitative inquiry, this research does not claim

564   universal generalisability but rather offers contextually situated insights that may inform similar

565   settings with appropriate adaptational considerations.

Conclusions

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567   Globally health care systems are losing nursing staff due to poor work-life balance. Our

568   research points towards the importance of choice for nursing staff in shift scheduling to

569   promote wellbeing and work-life balance. Our study shows that shift scheduling is a

570   contentious issue and is a point of potential and actual conflict between the organisation and

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571   nursing staff due to different priorities and constraints. The study reveals that collaborative and

572   compromising approaches are most effective in preventing potential conflicts from escalating

573   into actual conflicts. When nurses' preferences are reasonably met through collaborative

574   compromises, both individual wellbeing and organisational efficiency are supported.

575   Conversely, rigid scheduling policies and competing approaches often lead to actual conflicts,

576   resulting in increased turnover and reduced staff morale. Our research also expands the

577   theoretical understanding of choice in shift scheduling and its impact on nurse wellbeing. While

578   choice generally correlates with positive wellbeing outcomes, external constraints such as

579   caring responsibilities can limit the effectiveness of workplace solutions. This nuance highlights

580   the need for a more holistic approach to scheduling that considers both professional and

581   personal factors. In conclusion, effective nurse shift scheduling requires a sophisticated blend

582   of conflict management strategies, with greater emphasis on collaborative and compromising

583   approaches. By prioritising flexible scheduling and proactive communication, healthcare

584   organisations can better support their nursing workforce, ultimately enhancing the quality and

585   sustainability of healthcare service provision.

Declarations

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588   Ethical approval and consent to participate:

589   In accordance with the Declaration of Helsinki ethical approval was granted by the Health

590   Research Authority (IRAS ID: 327884) and from the University of Southampton ethics committee

591   (ID: 81204). All participants provided informed consent prior to data collection occurring.

592   Consent for publication:

593   Not applicable

594   Availability of data and materials:

595   The raw interview transcripts are not publicly available due to ethical restrictions and

596   participant confidentiality agreements outlined in the informed consent process. However,

597   relevant direct quotes from the interviews are presented within the manuscript. The interview

598   guide developed for this study and the final coding tree are available as supplementary files.

603   Authors' Contribution:

604   HRB conducted recruitment, data collection, transcription and the initial framework analysis;

605   HRB, CD and PG reviewed and compared the codes and the themes resulting in some themes

606   being modified, and new themes added. To ensure credibility in the analysis, all authors read

607   and discussed the framework analysis several times during the analysis process. HRB wrote the

608   initial draft, and CD and PG critically reviewed the draft. All authors have seen and approved the

609   final manuscript.

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