

## ORIGINAL ARTICLE

# A Phenomenological Study of Nurse Managers' and Assistant Nurse Managers' Experiences during the COVID-19 Pandemic in the United States

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## Abstract

**Aim:** To understand the experiences of hospital nurse managers and assistant nurse managers during the COVID-19 pandemic in the United States.

**Background:** Little research has been published about the experiences of nurse managers during the COVID-19 pandemic. Experiences of front-line nurses have been well documented. This is the first phenomenological study to date in the United States on experiences of hospital nurse managers during the COVID-19 pandemic.

**Design:** Phenomenological qualitative approach.

**Methods:** Thirteen managers, seven nurse managers and six assistant nurse managers were interviewed about their experiences using audio-video teleconferencing and a semi-structured interview guide. Consolidated Criteria for Reporting Qualitative Research criteria for reporting qualitative research were used.

**Results:** The four major themes that emerged were as follows: being there for everyone; leadership challenges; struggles, support and coping; and strengthening my role. There were 11 subthemes.

**Conclusions:** A major focus of nurse managers during the pandemic was psychosocial support of front-line nurses while at the same time experiencing stress and exhaustion themselves.

**Implications for nursing management:** More attention on the psychosocial needs of nurse managers, interventions to allay their exhaustion and provisions for readily available support are warranted.

## KEYWORDS

COVID-19; nurse managers, leadership, phenomenology, qualitative research

## 1 | INTRODUCTION

Internationally, the COVID-19 pandemic has had worldwide implications for nursing. During the pandemic, the need for hospitalization of severely ill patients has influenced the significant focus in the media and professional literature on nurses and the care they provide. The experiences of nurse managers, those who supervise front-line nurses and manage units of COVID-19 patients, have not been investigated. One can speculate that some of the health

consequences well reported in the literature faced by front-line nurses are also experiences of nurse managers. In particular, human suffering and death were experienced by all nurses (Cui et al., 2020; Sun et al., (2020)). Added to these consequences is the added responsibility that nurse managers had for resource management, humans and equipment, during this resource-challenged event. This study is, to date, the first qualitative phenomenological study in the United States whose aim was to explore and interpret the experiences of nurse managers' and assistant nurse managers' roles during

the COVID-19 patient hospitalization. Direct care nurses' experiences, internationally, caring for COVID-19 patients, that have been well published (Galehdar et al., 2020; Kacklin et al., 2020; Karimi et al., 2020) may influence nurse managers' experiences. This study contributes to the present gap in the research literature on the specific experiences of nurse managers during the COVID-19 pandemic that has been overlooked to date. It provides information on unique experiences on which nursing management can draw in planning for similar crises in the future.

## 2 | BACKGROUND

The COVID-19 virus' aetiology, pathology, transmission, treatment and consequences for front-line nurses have been well published. In the United States, the first infection was noted in January 2020, and March through September 2020 was identified as the first 'surge'. Because little has been published about the role of nurse managers during the pandemic, it is unknown whether the research findings on front-line nurses' experiences also describe nurse managers' experiences. For example, in quantitative and qualitative study findings, emotional consequences of caring for COVID-19 patients, anxiety, depression and stress, are well known to be prevalent in front-line staff in several countries (Han et al., 2020; Kacklin et al., 2020; Kang et al., 2020; Karimi et al., 2020; Sun et al., (2020)).

Important qualitative findings from a number of published studies, undertaken in different countries, on the experiences of front-line nurses during the pandemic revealed significant themes (Galehdar et al., 2020; Kacklin et al., 2020; Lee & Lee, 2020). While these investigations were not focused on nurse managers, their experiences may be similar within the same context.

One relevant theme, the impact of uncertainty, that related to nursing care during the pandemic, has been attributed to continually changing protocols for practice interventions; this may also be experienced by nurse managers (Sadati, Zarei, Shahabi et al., 2020; Sun, Wei, Shi et al., 2020). Emotional and physical exhaustion, as well as nurses' fear of contagion in other qualitative studies, was also a prevalent theme in the research findings (Arcadi et al., 2021; Cui et al., 2020; Liu et al., 2020). In most of the qualitative studies reviewed, researchers found front-line nurses experienced an eventual positive outcome of their caring, that of promoting personal and professional growth (Cui et al., 2020; Karimi et al., 2020; Lee & Lee, 2020).

The role of nurse managers during COVID-19 has been briefly discussed in the literature in editorial and commentaries. In a recent editorial reflection about nurse managers' experiences in Singapore during the pandemic (Goh et al., 2020), a focus was on the nurse managers' added task to their routine management, one of caring for their staff and their psycho-emotional health. Relevant to the role of nurse managers, one study on nurse employees found that workplace conditions, such as organisational support, organisational preparedness, workplace safety and

access to supplies and resources, were associated with higher scores on all of the adverse mental health outcomes measured in this investigation (Farinaz et al., 2021).

Published editorials and commentaries have presented criteria for effective leadership during the pandemic and the need for courageous leaders with strong knowledge (Daly et al., 2020; Shingler-Nace, 2020). Importantly stressed was that nurses at the front line of the COVID-19 pandemic need and deserve strong leaders because their leaders will be at the decision-making table to ensure the interests of nurses are served (Daly et al., 2020). Nurse managers are specifically responsible for decisions during the pandemic regarding both staff and patients, planning nursing care and the oversight of front-line nurses who provide this care.

Research is necessary for the profession to respond effectively to COVID-19 hospitalizations (Lake, 2020). To date, no qualitative phenomenological studies have reported the experiences of nurse managers' roles during the pandemic. Furthermore, there are no known published research studies to date on the experiences of nurse managers during the pandemic in the United States.

## 3 | METHODS

### 3.1 | Aim

The aim of this study was to explore and interpret the experiences of hospital nurse managers during the COVID-19 pandemic in the United States. This study adhered to the *Consolidated Criteria for Reporting Qualitative Research* (COREQ) guidelines developed to evaluate qualitative research reports (Tong et al., 2007).

### 3.2 | Philosophical approach

Interpretive phenomenology guided this study's design and methods. The study utilized Smith's (1996) and Smith et al. (2009) interpretive phenomenological analysis (IPA), an *inductive* approach used to design the study based on phenomenology, hermeneutics and ideography. Ideography refers to being concerned with particulars and focusing on the meaning of something for a given person (Beck, 2021). The key principles of this approach are that research is focused on the experience of the participant and researchers have an intense interpretive engagement with the description provided by the participant. The steps for analysis are outlined in this study's methods. The COREQ criteria also include statements documenting the researcher's background (Tong et al., 2007).

### 3.3 | Personal statement

My relevant professional experience over the last thirty-five years as a female, doctorally prepared nurse includes significant

contributions, research, publications and teaching especially related to qualitative research. I was not personally known to the participants, nor did I know them. In my role as a nurse scientist, I had *not* personally cared for COVID-19 patients. Importantly, my background as an experienced mental health advanced practice nurse assisted with the attention to the sensitivity needed in interviewing nurses about this emotional experience. Thus, it was important to use face-to-face interviews for data collection rather than an audio telephone method (Webber-Ritchie et al., 2021). The teleconference, video approach, allowed me develop rapport with each participant and provided me with the method to be alert to participants' possible anxiety as they relived potential emotionally traumatic experiences. Therefore, I could respond should this arise as outlined in this study's ethical considerations.

### 3.4 | Recruitment of participants and ethical considerations

Approval for the research was obtained from the Health System's Institutional Review Board (IRB) for the use of Human Subjects where the research was undertaken; this system also employed the researcher. Flyers were then placed in three major hospitals that were part of this large 23-facility system located in the Mid Atlantic area of the United States. The study used a purposive method to obtain a sample. The flyer used for recruitment outlined that the study participants should be nurse managers (NMs) or assistant nurse managers (ANMs), who had worked during the COVID-19 pandemic, and that their participation was voluntary. The flyer described their participation as a 60- to 75-min audio-visual interview that focused on their experiences during the COVID-19 pandemic. Confidentiality was assured, and contact information for the researcher was provided on the flyer. Recruitment focused on obtaining a mix of both NMs and ANMs.

Three hospitals in this one large health care system were chosen for recruiting because they had admitted the majority of the patients with COVID-19 during March 2020–September 2020. The recruited participants were considered a whole sample regardless of the facility employing them. Nurse managers were assigned to oversee a unit that cared for COVID-19 patients either an ICU unit or medical surgical unit that had been converted to a COVID-19 patient unit. They reported to a director of nursing. Assistant nurse managers were assigned to each shift and reported to the unit nurse manager.

Once potential participants contacted the researcher expressing interest, the researcher sent the consent form via email. The approved consent document included all of the required assurances for confidentiality and anonymity and ensured no employment reprisal for participating. It also describes the participant's role in a teleconference, that the teleconference would be recorded on a secure platform/site and that access from a non-work computer to ensure privacy was necessary. The consent form also stated that there was no incentive provided for participation. A section of the consent document described the possibility of participants' emotional

reaction during the interview because of the sensitive nature of the study topic, and described the planned referral for available counseling should this be necessary during or after the interview.

The Institutional Review Board required verbal recoded consent from each participant. Verbal informed consent was then obtained during the teleconference prior to data collection. This allowed for a discussion and clarification of the nature of the questions that would be posed during the interview. In particular discussed was participants' possible emotional response during the interview, or following it, given the sensitive nature of the topic.

### 3.5 | Data collection

Data were collected, and interviews took place from October through November 2020. Demographic information was collected verbally. The demographic and informed consent data were completed in the first 10–15 min of the teleconference. The participants accessed the teleconference from their own home personal devices. Each interview lasted approximately an hour, and each participant was interviewed only once.

The semi-structured interview guide focused on 10 open-ended questions about the nurse managers experiences such as 'Tell me about what was meaningful to you about your role during the pandemic' and 'How did your role change?' Some of the items were the result of qualitative research published on direct care nurses' experiences. Anecdotes conveyed by nurse managers to nurses in administration throughout the system, and shared with me prior to the study's development, influenced some of the questions. Probe-type questions, following initial responses to questions, allowed for more in-depth descriptions of managers' experiences (Smith & Osborn, 2003). The interviews were automatically recorded by a secure teleconference platform and downloaded as transcripts for subsequent coding. Interviews continued until redundancy in the themes was achieved, following the 13th interview (Sandelowski, 1986).

### 3.6 | Data analysis

The steps in coding qualitative research data were followed using two major processes, an iterative approach and data reduction. Iterative analysis implies moving back and forth with data within each transcript and across transcripts. Reduction involves a certain reflective attentiveness that must be employed for phenomenological understanding to occur; it is not just a research method (van Manen, 2016). Coding for data reduction was undertaken by the researcher and not computer software-assisted.

Smith et al.'s (2009) approach to analysis was followed: (1) reading and rereading the transcripts; (2) initial noting of meaningful phrases making descriptive comments regarding what participants related and conceptual comments at a more interpretive level; (3) developing emergent themes in each transcript; (4) searching for connections across transcripts; and (5) looking for patterns at

which point higher order themes and superordinate themes are explained. During this step, a table for representation of these may be developed.

### 3.7 | Methodological rigour

Beck (2021) identifies specific criteria originally described by Whitmore et al., (2001) related to the researcher and the rigour of the research itself, which were carefully followed. *Credibility* refers to the accuracy of the findings, and the recoded interviews ensured this. *Authenticity* involves that the portrayal of the findings is that of the participants. The researcher kept a reflexive journal to ensure her biases were attended to throughout to ensure integrity and mitigate threats to researcher bias. *Criticality* was practised throughout in that the researcher frequently stopped to review the reflexive journal especially related to alternative hypotheses. The researcher had no direct familiarity with COVID-19 patients, so therefore potential related to participants' experiences was somewhat limited. However, it is noteworthy that using the reflexive journal, potential hypotheses related to findings because of prior published research that was read by the researcher were examined for their possible bias.

In addition to using the COREQ criteria for evaluating qualitative research reports, a 32-item checklist (Tong et al., 2007), the researcher adhered to criteria outlined by Beck (2021) regarding the use of interpretive phenomenological analysis in a report: (1) the themes identified should be well represented in the analysis and

supported by excerpts from participants; and (2) evidence, the verbatim quotes, should be from more than one participant.

## 4 | RESULTS

### 4.1 | Description of participants

Thirteen nurses, seven nurse managers (NM) and six assistant nurse managers (ANMs), of whom ten were females and three were males (Table 1), participated in the study. They had from 2 to 36 years of experience in nursing. Regarding assignments, nine worked on critical care units and four on medical surgical units. They reported working between two and five months on units caring only for COVID-19 patients.

### 4.2 | Themes

The four major themes and their respective subthemes from which they evolved, with examples of supporting verbatim phrases, demonstrating reduction, appear in Table 2. Each of the subthemes within its overarching theme is described with examples of supporting text from the participants' transcripts. In order to maintain as much anonymity as possible, with only 13 participants, each of the verbatim phrases reported here does not include demographic descriptors such as the age or unit assignment of the respondents.

Position	Age range years	Sex	Unit	Years in nursing	Years in present position	Months working with COVID-19
Nurse manager	51-60	M	ICU	30	4	3
Nurse manager	31-40	M	ICU	8	2	4
Nurse manager	31-40	F	ICU	10	2	3
Nurse manager	41-50	F	Med Surg	15	6	2.5
Nurse manager	31-40	F	ICU	15	8	4
Nurse manager	41-50	F	Med Surg	20	3	4
Ass't nurse manager	21-30	F	Med Surg	6	4	3
Ass't nurse manager	31-40	M	ICU	8	3	5
Ass't nurse manager	21-30	F	ICU	4	1	4
Ass't nurse manager	31-40	F	ICU	9	4	4
Ass't nurse manager	21-30	M	ICU	6	1.5	5
Ass't nurse manager	31-40	F	Med Surg.	7	1	3
Ass't nurse manager	31-30	F	ICU	7	2	4.5

**TABLE 1** Demographics of study participants

**TABLE 2** Themes, subthemes and phrases

Themes	Subthemes	Examples of CODED phrases
I. Being there for everyone	1. Carrying the burden	I was there for everyone else...no one for me Staff burnout—most concerned me I worried about them but I kept it inside The hardest thing is seeking help for yourself. I had to absorb all their concerns
	2. Reliance on me	My job was 24/7 without a doubt I had to go to work because I knew they (staff) needed me I felt guilty when I wasn't there If I wasn't there, I worried the staff would not have what they needed When I was home I was always texting to see if things were ok
II. Leadership challenges	1. A different kind of support	Making sure they knew they were supported Searching for the little things I could do for them Helping them with death and no time to grieve Supporting in death and their worries – ‘what am I doing wrong’
	2. Revamping my approach	Taking a patient assignment It doesn't have to be perfect—it just needs to get done My leadership style became situational
	3. Staff's resistance and fears	A new nurse left, I felt like I failed her Working with millennials is different—they are young Fear of contagion influenced staff 's resistance to assignments Accepting I was the punching bag at times
III. Struggles, support and coping	1. Physical and emotional toll	I was stress eating and gaining weight; The isolation was difficult for me; Depression set in I worried about my own family Anxiety at times overwhelmed me

(Continues)

**TABLE 2** (Continued)

Themes	Subthemes	Examples of CODED phrases
	2. Professional support	The other managers were great—I had a good rapport I felt a lot of support from my director—she was there with me It meant a lot that our CEO came by
	3. Personal coping	My wife made it easy for me to concentrate on work The little things my fiancé did kept me going I got a puppy and that helped Individual counseling helped
	IV. Strengthening my role	1. Reflections on learning I have learned to delegate more It's not that I became callous, but I learned not to sweat the small stuff I found team nursing worked I can delineate my responsibilities better I honed my leadership skills 2. Rewarding influences For me, seeing patients recover added to my strength Positive feedback from staff definitely influenced me and my role Seeing what the travel nurses gave up helping us was inspiring 3. Work that needs attention going forward We need better organization in assignments Better communication with families Support services need to be accessible and available earlier on

4.2.1 | Being there for everyone

In this theme, participants reflected on the meaning of their role as managers and their relationship to front-line or direct care nurses. Two subthemes were as follows: (a) *carrying the burden* and b) *reliance on me*.

With respect to *carrying the burden*, the participants worried about their staff, their health and burnout. They related keeping this worry inside and described that they ‘had to absorb all the

staff nurses' concerns'. They reported not seeking help themselves and carried this burden alone. Many reported more communicating with staff around their fears and anxiety, needing to comfort those who were crying and encouraging those who were afraid to work with COVID-19 patients. The fear of contagion was especially prevalent in the beginning when so much about the virus was unknown.

*Reliance on me* as a subtheme involved worry and guilt, which dominated participants' thinking when managers were not at the hospital. Many described the reliance their staff had on them especially because of the uncertainty in protocols. This resulted in the need for constant communication through emails, text messages and teleconferences. One assistant manager said 'every time I was not at work I was still thinking about it'. One nurse manager related a view of reliance:

My job was 24/7. I went to work because I know the staff needed me. If I wasn't there, I worried that they would not have what they needed and know about the new directives. At home, I was always texting them to see if things were okay.

(NM)

#### 4.2.2 | Leadership challenges

Within this theme, managers explained the meaning of their role as a leader and its challenges, during the period of the pandemic. Three subthemes were as follows: (a) *a different kind of support*; (b) *revamping my approach*; and (c) *staff's resistance and fears*.

For nurse managers, supporting the staff before the pandemic usually related to planning their scheduled time or providing resources. However, the role was now focused on a different kind of support, that of emotional support. The managers related comforting their nursing staff when, for example, they had no time to grieve for an expired patient for whom they had cared. Nurses' feelings of defeat were expressed often, and managers provided encouragement such as searching for little things that they could do for them. One manager posted thank you messages from families, patients or community organisations on a display board. Another said he comforted a new nurse with little experience who was concerned that the care she was providing was not up to her usual standards telling her 'it doesn't have to be perfect—it just needs to get done'. Another assistant manager said 'I had to keep telling them don't sweat the small stuff'. This ANM described her the focus on the staff's emotions:

My biggest concern and was just the emotional stuff the staff was going through. They would do post mortem care on one patient which was so emotional for them, and then immediately have to go to take care of all of the others they were assigned to. I would try to help them---make sure they took a break even for

5 minutes, or I would do their meds, anything I could to help them with their emotions.

(ANM)

At the same time, the participants described how this support changed their usual work. They *revamped their approach* to their 'new' role and its tasks and approached the unit's work differently. Many described putting aside their usual office paperwork and taking on patient care assignments because it was necessary. Managers described a focus now on needing to 'manage' supplies and materials, such as protective equipment, ventilators, a new and large part of their changed role. Constant communication about changes in nursing care protocols also became central to their work. Often, nurse managers related how communication was critical and subsumed a great deal of their time.

Communication became a central focus of my work. It was constant I had to keep everyone informed—communication came from the top-down and was critical. Protocols were always in flux. We used texts, e-mails and written flyers to help.

(NM)

The *fear and resistance* the direct care nurses had caring for patients with COVID presented the managers with a significant challenge. In some instances, they related a feeling of having failed because they could not, in every instance, allay nurses' fears and the staff's inclination to resist assignments. One manager said, 'I had to tell them, my hands were tied', regarding assignments to care for pandemic patient. Another manager related being able to transfer two nurses from his unit because of her fears and resistance. While they had empathy for the staff, they were cognizant that there were patients who needed care. One manager related an experience with a new nurse who decided to leave nursing:

There was a young nurse, just through orientation, and she was so competent. I saw so much potential in her. I had such hopes for her, but she decided to quit and leave nursing. I felt like I had failed her. I still think about her and what else I could have done.

(NM)

#### 4.2.3 | Struggles, support and coping

The actual work as a nurse manager or assistant nurse manager meant *struggling, finding support and ways to cope*. They described seeking support both professionally and personally for what they termed their emotional issues. Three subthemes were identified: (a) *the physical and emotional toll*; (b) *professional support*; and (c) *personal coping*.

The pandemic's consequences from long working hours and exhaustion, supporting staff who at times was draining and experiencing human suffering and death were described as an *emotional toll*

on them. The participants interviewed described physical exhaustion and feeling depressed at times. Physical symptoms such as weight gain and an inability to sleep were discussed; many mentioned that isolation from their friends and families was difficult and added to 'feeling down' and depression. They described facing extreme exhaustion. Two managers contracted COVID-19 and fortunately had mild symptoms. Most related never taking any time off such as vacations, and most worked extra shifts. The emotional and physical toll was captured by this nurse manager:

I was tired all the time, really just exhausted. Managing during this time took its toll on my mental health. I wouldn't say depressed, but I felt down. Physically I had body aches. I had zero energy.

(NM)

Managers found *professional support* through discussions with their peers, other nurse managers. The assistant nurse managers described their managers as supportive and available even though some were on opposite shifts. Many unit managers noted that their directors of nursing often made rounds and that other administrators, such as the facility's CEO, came by regularly just to see how they were doing. Positive feedback from direct care nurses also served to lift their low morale.

I am so thankful for my staff. We work as a team. I appreciated even the little things that helped, like a staff member coming to clean a room. The team had to pitch in when 'lines' (IVs) needed to be started and we did not have enough providers who do this.

(ANM)

The participants used different coping strategies for their anxiety, depression and overall stress. They related family support was helpful, especially from spouses. Some mentioned that exercising and going to the gym, usual ways of reducing stress, were no longer available to them because of the COVID restrictions in place and they needed to search for other strategies. This became difficult because of the long working hours. One said:

Coping was an issue. Usually I would go to the gym or exercise. I needed to feel better about myself. Working 12 or 16 hours a day did not leave me much time for that. I relied a lot on my wife. She was a *god send*. She was so patient.

(NM)

One manager related engaging in professional counselling and found this helpful. One interviewee said getting a puppy was 'both distracting and exercise'. Another manager commented on hospital support and intervention programmes that had been established later during the pandemic surge:

While there were some interventions they set up for stress, these were not specific and took time that I did not have. I did use the *Lavender Team* a couple of times. I had to make sure I had time off to attend any programs and that was so difficult for all of us.

(NM)

#### 4.2.4 | Strengthening my role

Nurse managers were able to evaluate their role and its changes during the pandemic and found some meaning in these experiences. Subthemes within this theme were as follows: (a) *reflections on learning*; (b) *rewarding influences*; and (c) *work that needs attention going forward*.

All of the interviewees freely recounted ways in which their experiences positively influenced their role. They *reflected on learning* such as learning to use more of a specific management task such as delegating. Other nurse managers reported changes in the way they related to staff, for example being more appreciative of them or including them in rationales for decision-making. New strategies they acquired that focused on the unit's functioning included the use of team nursing. This was described by one manager as a needed change to the usual assignments of patients to one nurse as this method was not workable during this crisis. Developing and working as a team was a successful strategy. Leading by example was often mentioned as managers described taking bedside assignments.

One thing I realized that I will do differently was because in this role we are kind of autonomous. The staff does not usually see the big picture—the whole hospital. Now I see they need to be included in why decisions are made ---going forward I plan to do more of this.

(NM)

Overall, the participants remarked they experienced *rewarding influential* outcomes during the pandemic that related to interpersonal situations. Seeing patients recover was an important reward. The managers mentioned positive feedback from staff or their nursing directors as noteworthy. Several interviewees believed that there were other staff members who significantly contributed to their feeling positively about patient care during the pandemic. One group of nurses, identified as 'travel nurses', who came to help from across the country, were highly regarded.

I couldn't believe they came to help. It was amazing. Even though they had to get up to speed, they never complained. They wanted to be here. The fact that they left their families and homes to help us was so rewarding.

(ANM)



While the end of the first surge brought some relief, managers began to plan for a possible second surge and what *needed their attention going forward*. They reflected on necessary changes that focused on patient outcomes and improvements. Most of the changes they described related to better organisation, especially regarding unit preparation and staff assignments. Study participants realized that preparation was not possible for this first experience; however, looking ahead, they wanted to be better organised with staff and resources. Managers also believed that although communication with families improved over time, they wanted more technical support for patients' ability to contact their families. Importantly, more attention towards all nurses' self-care was an important suggestion.

I don't think nurses do such a good job of taking care of themselves. I'm making sure, now that things are less hectic, that they are taking days off. We need to get better at providing programs for stress that are easily accessible for all of us and well publicized.

(ANM)

## 5 | DISCUSSION

Because this was the first study to date published on the experiences of nurse managers during the COVID-19 pandemic in the United States, it is not possible to compare this study's findings with other research outcomes on nurse managers' experiences. However, the managers' experiences in this study paralleled some of the findings on the experiences of direct care or front-line nurses in published studies. Exhaustion because of the long hours was expressed by both groups. While front-line nurses in some studies believed they were not doing enough for patients and felt defeated (Galehdar et al., 2020; Liu et al., 2020), managers in this study also described feeling defeated if they could not allay the staff's anxiety and fears, and in one case, feelings of defeat involved a nurse leaving the profession.

In this study's findings, the new role of nurse managers during the pandemic focused on the emotional well-being of their staff, an increased need for continual and constant communication. Direct care nurses in published research experienced consequences of caring for pandemic patients such as anxiety, depression and fear (Han et al., 2020; Kang et al., 2020). However, qualitative studies published to date have not described a relationship with nurse managers as mitigating direct care nurses' emotional consequences. Yet, in this present study, this role was a significant one for nurse managers. Participants viewed one of their major tasks as being responsible for the health of their staff and the reliance of the staff on them. This difference, in comparison with other findings, can be explained in that all of the phenomenological studies to date have been conducted in other countries; these countries may have different manager/staff relationships and oversight responsibilities. However, there has been a focus in editorials about

the importance of the mental health of nurses during COVID-19 (Maben & Bridges, 2020).

Nurse managers in this study faced resistance by some direct care nurses to assignments to care for COVID-19 patients; this was primarily because of uncertainty about the virus and fear of contagion. This was noted only in the beginning of the US pandemic surge when knowledge about the virus was limited. Supporting this, in a recent quantitative study's findings on front-line nurses' experiences, fear and unwillingness were mitigated through an increase in knowledge about the virus (Nashwan et al., 2020).

The need for constant communication about the uncertainty of nursing interventions regarding ever-changing protocols was highlighted in many published investigations on direct care nurses. In the present study, managers related the importance of top-down communication especially to allay nurses' fears. In many reported studies, the fear regarding direct care nurses' uncertainty regarding protocols for care of patients with COVID-19 influenced fear and anxiety (Cui et al., 2020; Lee & Lee, 2020).

In some reported study findings, concerns and anxiety about having enough equipment and supplies dominated direct care nurses' experiences especially surrounding fear of contagion (Sun et al., (2020), Liu et al., 2020). While the manager participants in this study added to their tasks the increased management of COVID-19-specific resources, a lack of protective equipment was not a significant concern for them. One published study on workplace factors influencing nurses' mental health outlined participants' negative responses about organisational factors that increased mental health problems. One of these factors cited was access to supplies and safety (Farinaz et al., 2021). However, in the present study, nurse managers did not mention a shortage of, or problems with, accessing supplies.

While there are no reported investigations on nurse managers' experiences during the COVID-19 pandemic to date, applying information from studies on direct care nurses, while similar, may undervalue and under-represent the unique experiences and role of nurse managers. More research is warranted that would validate the findings from this study.

### 5.1 | Limitations

This study included 13 nurse managers, and interviews ceased when the subthemes became redundant; however, more than 35 participants contacted the researcher to volunteer, and it is unknown whether their perspectives might have differed from those who were interviewed. Only three facilities within this large health care system of 23 facilities, and located in one geographic area were used for recruitment and nurse managers' perspectives on their experiences; other systems and facilities admitting and caring for patients with COVID-19 may differ in nursing care.

Only one researcher coded the transcripts; however, this is consistent with the philosophical approach chosen in which the researcher is considered as a co-creator of the findings. This study



was also conducted in the United States; therefore, nurse managers' experiences in other countries, given that health care systems differ, should be considered when evaluating the findings for application.

## 6 | CONCLUSION

This study was undertaken because the experiences of nurse managers during the COVID-19 pandemic had been overlooked to date in the research literature. In this study, nurse managers experienced a significant focus and responsibility for the well-being of their staff especially allaying their anxiety and fears. The participants' changed role revolved around the need for constant communication with direct care nurses especially about continually changing protocols for patient care and the need to allay nurses' uncertainty about these changing interventions. This investigation highlighted the physical and emotional toll that managers faced with long working hours and little time off. They found some support from peers and a sense of appreciation from the facility's nursing administration. In this study, the pandemic experience resulted in new learning experiences especially related to leadership tasks for the managers, and gave them the opportunity to incorporate these into their role. More research is warranted that would validate the findings from this study and support these findings through quantitative research investigations.

## 7 | IMPLICATIONS FOR NURSING MANAGEMENT

The findings from this study underscore important implications for nursing management. A significant finding was the new task nurse managers faced because of the pandemic, meeting the psycho-emotional needs of their staff. The ways they described this support were the personal interactions they had to allay fears and resistance. Nursing administration needs to provide specific strategies and support programmes to which managers can refer staff. Particularly noteworthy was the lack of self-care practised by the participants in this study. There were not organised support systems for their own emotional exhaustion and isolation. A concerted effort on providing regular time off to mitigate exhaustion must be part of administrative planning going forward.

### ACKNOWLEDGEMENT

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### CONFLICT OF INTEREST

The author/ researcher declares no conflicts of interest.

### ETHICAL APPROVAL

This study was approved and determined as exempt status by the IRB, Northwell Health System: # 20-0415.

### DATA AVAILABILITY STATEMENT

Author elects to not share data.

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