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RESEARCH ARTICLE

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The lived experience of frontline nurses: COVID-19 in rural America

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Abstract

Aim: This multisite study describes the lived experience of registered nurses (RNs) caring for coronavirus (COVID-19) patients during the pandemic in rural America.

Design: A qualitative phenomenological design was used.

Methods: From January to June 2021, using the purposeful sampling method, 19 frontline nurses were interviewed regarding their experience caring for seriously ill COVID-19 patients in three Upper Midwest tertiary care hospitals. Three doctoral prepared nurses transcribed and analyzed verbatim interviews with data interpreted separately and conjointly. Approved qualitative methods specific to transcendental phenomenology were used.

Results: This phenomenological study identified four themes describing the lived experience: (1) feeling of being overwhelmed, (2) feeling of role frustration related to chaos in the care environment, (3) feeling of abandonment by leaders, families, and communities, and (4) progressing from perseverance to resilience.

Implications for Practice: Significant implications include ensuring frontline RNs are in communication with leaders, and are involved in tactical planning. Leaders can provide a stabilizing presence, build resilience, confidence, and security. Recommendations for additional research are provided.

Conclusion: Nurses in intensive care and COVID-19 designated medical units had experiences similar to high population United States and international cities. Their shared experience included high volumes of critically ill patients in hospitals frenzied by rapid change, uncertainty, and capacity strain. Differences in the experience of rural nurses included close social connection to patients, families, and community members. This rural connectedness had both positive and negative effects.

KEYWORDS
COVID-19, frontline nurses, lived experience, qualitative, rural healthcare

1 | INTRODUCTION

The coronavirus (COVID-19) pandemic has defied the capabilities of prevailing healthcare and public health science. It impacted all socioeconomic classes and left global feelings of fear, despair, and apprehension.[1] With no known cure or vaccinations available early on, a great deal depended on healthcare professionals, including nurses, to set aside their own personal fears and step forward to the frontlines to care for critically ill patients diagnosed with COVID-19. Being at the forefront day after day, month after month, it was important to capture, as Munhall[2] emphasized, the essence of this lived experience to better understand the opportunities and challenges rural frontline registered nurses (RNs) face when providing care to COVID-19 patients.

2 | BACKGROUND

The significance and novelty of this study is the largely unknown impact of the COVID-19 pandemic on RNs on the frontlines at rural hospitals. The context surrounding the experiences of these nurses during the early stage and through the surge of the pandemic in the rural Upper Midwest is essential background for this study. The study hospitals are located in two of the least densely populated states deep in America's interior.[3] These states have a combined population of just over 1.5 million with approximately 10 people per square mile.[3]

The severe acute respiratory syndrome (SARS) virus responsible for COVID-19 was introduced to the world in late 2019, originating in Wuhan, China. In early 2020, the World Health Organization (WHO) announced the COVID-19 pandemic as an "International Public Health Emergency of International Concern."[4] Similar to prior infectious epidemics,[5] public information messaging in early 2020 was inconsistent and ineffective, frequently lacking consensus. By the spring of 2020 the human threat level was high, the virus was spreading rapidly and had arrived in rural America. Although expecting delayed and muted impact, rural hospitals faced capacity strain similar to that reported elsewhere,[6] including COVID-19 patient volumes that overwhelmed bed capacity, staffing, and resources. In anticipation of the delayed surge in COVID-19 cases, hospital systems in the Upper Midwest scrambled to rapidly adjust and adapt to an influx of seriously ill COVID-19 patients. Immediate changes were required in workflows, education, staffing, and care delivery processes. In rural America, hospital staffing and workflows are uniquely dependent on a limited pool of available professional staff. Small rural hospitals are less adept and equipped to provide intensive care delivery, let alone respond to larger volumes of seriously ill patients whose care needs are largely unknown.

Prior studies compared the impact of epidemic viral outbreaks, including SARS, COVID-19, Middle East respiratory syndrome (MERS), and the current pandemic.[5,7] Common to all were the pervasive psychological effects on clinicians working to manage the novel and intense care needs. Staff in contact with affected patients had greater levels of both acute or posttraumatic stress and psychological distress. The meta-synthesis conducted by Billings et al.[5] explored 40 qualitative studies related to healthcare workers' experiences. From these studies emerged concerns and fears about personal and family physical health and safety related to highly transmissible viruses.

Since the beginning of the current pandemic, studies with various designs and methods have been published.[8–18] Thirteen early studies originated from China, the outbreak epicenter.[8,9,11–14,18] Similar to reports of prior epidemics, these studies described uncertainty, psychological and emotional stress, concern about physical safety, inadequate personal protective supplies and equipment, and the pervasive need for constant communication with information sources and workplace leaders. More recent studies[10,17–20] echo earlier studies regarding posttraumatic and psychological stress, and fear of acquiring or spreading infection due to prolonged patient contact while covering for other health disciplines. Recent studies also describe nurses' experience of moral distress and personal trauma while caring for dying patients,[21–23] need for mental health support and use of maladaptive coping mechanisms, such as substance use and alcohol.[24] However, others describe perseverance and development of resilience in the workplace[10,17,25] from teamwork, collegial support, and leader involvement.[19,26]

In summary, both quantitative and qualitative published studies have focused on provider mental health outcomes, levels of stress, emotional response, coping patterns, and the need for mental health resources and work-life support. However, there remains a gap in the knowledge and reports about the impact of this novel virus on RNs in sparsely populated rural America. The aim of this study was to describe the lived experience of RNs caring for COVID-19 patients during the pandemic in rural regional hospital intensive care and COVID-19 designated medical units. Study emphasis was on the experience of bedside caring, working in a rapidly changing environment, and balancing work and home life. It was anticipated the study outcomes would better prepare practicing nurses as well as nurse managers and staff development educators for future pandemics or similar situations. The following research questions were explored: (1) What is the lived experience of RNs caring for seriously ill patients with COVID-19 during a novel pandemic? (2) How does the lived experience of frontline RNs inform knowledge and preparation in future similar events?

3 | METHODS

Design

A qualitative phenomenological study was conducted to investigate the lived experiences of frontline nurses working in the intensive care and COVID-19 designated medical units of three tertiary hospitals in a healthcare system in two rural states in the Upper Midwest.

Participants and recruitment

Participants ($n = 19$) were recruited for the study through the purposeful sampling method. The inclusion criteria were (1)

consenting RNs of any age, gender, race or ethnic group; (2) employed at least 6 months at the respective hospital; and (3) cared for at least three different COVID-19 patients in intensive care or COVID-19 designated medical units. RNs excluded were travelers, advanced practice, agency/contract, and individuals on leave of absence. The sample size was determined by data saturation, at the point where no new topics from interviewees' experiences were generated.

Eligible participants were notified of the study via email from nurse interviewers. The participants' experiences caring for COVID-19 patients occurred during the period of time between the onset of the pandemic in the Upper Midwest and the time of study recruitment, approximately April 2020 to January 2021.

Ethical considerations

This study was reviewed and approved by the Institutional Review Board of the healthcare system (Exempt: Category 2i). Core principles of research ethics were followed throughout the study to ensure the safety and confidentiality of the participants. Numbers were assigned to each interviewee; names were not used. Informed consent was obtained before the interview.

Data collection

Nineteen audiotaped face-to-face interviews were conducted in private locations by five trained study team members representing three rural hospitals. The team members used approved interview techniques and a common set of semistructured questions:

- What was it like for you to care for seriously ill hospital patients with COVID-19?
- What was it like in the hospital work environment as it rapidly adjusted to a crisis?
- What was it like to comingle your personal life at home with the experience at work?

The interviews took place between January and June 2021. Before the interviews, nurse interviewers received education regarding qualitative research with a phenomenological approach, participant recruitment, consent procedure, and interview process with probing questions. The training sessions included time for mentoring and simulated interview role play to assure consistency in techniques used for interviews.

The length of interviews ranged between 19 and 69 min, with an average time of 43.4 minutes. The interview guide was designed based on relevant literature. At the onset of the interview, participants completed a demographic questionnaire including age, marital status, educational background, and years of nursing experience. The participants were also informed about the option to answer only the questions of their choosing and the ability to withdraw from the study at any point in the process. Due to the sensitive nature of the participants' experiences, they were also provided information to access mental health support resources if needed.

Data analysis

Descriptive statistics using percentages, means, and standard deviations were used to describe the demographic data of the participants. Verbatim interviews were transcribed by a secure online transcription service (rev.com).[27] Following transcription completion, interviewers reviewed their specific transcription and rated its accuracy on a scale of 1−5 with 5 being the most accurate. All 19 interview transcriptions were given ratings of 4 or 5 with the average being 4.4.

Following the interviewer's review, three experienced, doctoral prepared nurse analysts interpreted the interview data separately and conjointly. Data were analyzed through approved qualitative methods specific to transcendental phenomenology as described by Creswell and Poth,[28] Moustakas,[29] and Giorgio.[30] The credibility of data was assured by each analyst reading each interview transcription multiple times to gain an understanding of that nurse's lived experience, highlighting significant statements/quotes describing the experience and coding the statements into themes.[28–30] After completing the separate reviews, the analysts convened to discuss their findings. The analysts then reduced the data to significant quotes and developed textural and structural descriptions to convey an overall essence of the experience.[28,29] To enhance the trustworthiness of the data, group meetings with the interview team ensured lived experiences of study participants were properly captured. Consensus of themes, subthemes, and frontline nurses' quotes was achieved by the research team. During this entire process the research team bracketed bias and assumptions to assure the lived experience of the study participants was authentic.

4 | RESULTS

Fourteen female and five male nurses with an average age of 28.6 and 4.7 years of nursing experience enrolled in this study. The majority of the RNs were in their 20s, single, and all but one nurse worked more than 20 shifts caring for COVID-19 patients. During the COVID-19 surge, 10 RNs worked in intensive care and nine in COVID-19 designated medical units in the three hospitals located in two rural states. Refer to Table 1 for specific sample demographics.

From the multiple lenses of individual experiences of the frontline RNs, four themes emerged. They included *feeling of being overwhelmed*, *feeling* of *role frustration related to chaos in the care environment*, *feeling of abandonment by leaders, families, and communities* and *progressing from perseverance to resilience*.

Theme 1: Feeling of being overwhelmed

TABLE 1 Participant characteristics ($n = 19$)

Characteristic	Count	%
Age		
Mean (SD)	28.6 (7.29)	
Median	26	
Range	23–49	
Age < 30 years	14	73.7
Age 30–39 years	3	15.8
Age ≧ 40 years	2	10.5
Gender		
Female	14	73.7
Male	5	26.3
Education level		
AD	2	10.5
Baccalaureate degree in nursing	17	89.5
Family/home life		
Marital status		
Single/widow	11	57.9
Married	8	42.1
Children at home		
No	14	73.7
Yes	5	26.3
Relatives/family in skilled nursing facilities		
Yes	6	31.6
Nursing career		
Years of experience		
Mean (SD)	4.7 (5.14)	
Median	3	
Range	0.75–23	
Home unit		
Observation	2	10.5
ICU	10	52.6
Medical/surgical/pulmonary	7	36.9
Years at current unit		
Mean (SD)	3 (1.88)	
Median	2.5	

Definition: Overwhelmed means to affect deeply in mind or emotion; to present with an excessive amount; to engulf; to defeat completely and decisively.[31]

When asked how it felt to be caring for seriously ill COVID-19 patients, study participants expressed a *feeling of being overwhelmed* during the COVID-19 pandemic. The participants were deeply impacted in every facet of their being and endured an excessive amount of uncertainty in the clinical practice environment that was coupled with physical and emotional exhaustion. The uncertainty in patient care stemmed from the novel intensity and complexity of care. "In my four years of working as a nurse, these COVID patients are sicker than anyone I've taken care of in my entire life. They're on ventilator settings I never would have dreamed [and an] amount of sedation and paralytics I never have thought [was possible]…"

There were also so many unknowns in the disease process and outcomes of care. Unlike other patients that nurses were experienced caring for, COVID-19 patients didn't respond to the same treatments and often had poor outcomes. A participant reported, "It was overwhelming. The needs of these patients, it was completely overwhelming where you're just like, No matter what you do they are still going down."

Their overwhelming experiences, when repeated over time, led to physical and emotional exhaustion. Many participants described the anxiety and sense of stress that they experienced which had a significant impact on them professionally. "At the end of shift, I would have nothing, drained emotionally, and mentally and physically, and have to come back and do it again. The toughest part was not knowing if there was going to be relief…" The sense of being overwhelmed also permeated their personal lives. One participant described the experience, "…by August is where I felt like, 'Wow, this is bad.' End of September, October, November were horrible. They were just horrible. I mean, it was a strain on me physically, mentally, emotionally, and my marriage."

The high volume of death contributed to the nurses' feelings of being overwhelmed and intensified the emotional exhaustion that nurses were experiencing. Never before had these nurses experienced such a significant number of deaths while caring for patients at the end-of-life. "I think, that I know of, pretty much every patient that I took care of passed away…it was again, super discouraging and overwhelming to just constantly be, I don't know, just ineffective."

In all of the interviews, nurses reported not having visitors or family present at the bedside during the beginning of the pandemic or throughout the surge. Unfortunately, there were not enough staff to go around and patients ended up dying alone. As a result of these experiences, nurses were constantly being drained of emotional energy and were not finding an adequate resource to replenish themselves. "Me and the charge nurse cried in the room together, and then you move on and go home, and come back the next day. We kind of just got numb to death for a while. Then you had to put them in a body bag, and you had to wipe down the body bag. It's the worst feeling…" These frontline nurses were overwhelmed by the patient volume, novel intensity, and complexity of care as well as the mortality rate to the point they became physically and mentally exhausted.

Theme 2: Feeling of role frustration related to chaos in the care environment

Definition: Frustration means to prevent from accomplishing a purpose, or fulfill a desire, to cause feelings of discouragement and bafflement.[31]

In their rich descriptions, study participants described *feeling role frustration related to chaos in the care environment*. Hospitals responded quickly to capacity strain and necessary rapid changes in the work environment. The nurses described a frenzied practice environment with rapid changes in protocols, relocation of supplies, and unfamiliarity with equipment. "Every day was an unknown. Our protocols were changing every single day… We're going to do this now, now we're going to do this. You could never keep up…."

Early in the pandemic, nurses performed tasks outside of their scope of practice, filling in for other disciplines and departments to reduce staff exposure. Alone in the patient room, nurses even cleaned and mopped floors. "When we first started COVID, nurses were the only ones who went into the rooms, and I mean the *only* ones. We learned to do breathing treatments, we drew labs, therapies did not go into the rooms… Doctors really weren't even going into the rooms at that point. We were doing everything via iPads."

Frontline staff were often involuntarily assigned to COVID-19 units, often without adequate preparation. Limited resources including lack of time, staff, and orientation contributed to the chaos. Upskilling for higher level of care and extremely ill patients was minimal for frontline bedside staff. "That was a really big adjustment, just taking care of the sicker patients and having to really trust your skills and knowing who to call when you need to call…. Our nurses had never seen non-rebreathers. High flow up to 60 liters, we've never seen that. BiPAP was not a thing that we saw…and all of a sudden, all of your patients were on these…I mean, you have to grow, you have to learn. I think I learned a lot on my own."

There was frustration due to lack of central monitoring for detection of rapidly changing patient condition and precipitous deterioration. "We were asking for central monitoring systems so we could see our patients… A lot of times there were three doors between you and the patient. Patients fell, patients' oxygen alarms were dinging and we didn't know." "You're only 10 more feet away behind those two closed doors, but it felt like a million miles because you're not right there. And you can't see and hear what you're used to seeing and hearing."

Infection control protocols, constant and burdensome, added to role frustration by altering workflows and relationships in unexpected ways. Protocols limited human touch and contact between care providers and patients and prevented family from visiting. "They are essentially alone. Then we come in with all of our garb on and that's the only face they see…" Skin to skin contact ended.

Role frustration in rural hospitals, with critical space and staffing concerns, was a special challenge. The usual RN role in lower acuity units was transformed by the need for higher levels of care with nontraditional spaces and observation areas quickly adapted for COVID isolation. In the midst of unfamiliarity and rapid adaption of both geography and workflows, nurses often felt unable to meet a standard of safe care for their patients.

Within the chaos of the pandemic work environment, nurses universally experienced role disillusionment and denial of professional purpose. The end results of care were often contrary to the usual goals of nursing for hospitalized inpatients, that of recovery or a peaceful death. "For us in nursing, the frustration is that you did not get into nursing [to] see people die…"

Theme 3: Feeling of abandonment by leaders, families, and communities

Definition: Abandonment means to withdraw one's support or help from, especially in spite of duty, allegiance or responsibility; to give up by leaving; feeling of being left behind or discarded.[31]

During the interviews, participants described a *feeling of abandonment by leaders in their work settings, their own families, and communities*. Some of the frontline nurses expressed a lack of support and a sense of losing something that had provided support or strength to them before the pandemic. In the work setting, some nurses shared their experience of having managers/leaders they depended on for support and guidance suddenly being replaced by individuals who were not visible and provided inconsistent messaging. One nurse explained it this way: "It just felt like we were forgotten about in the COVID world where no one wanted to come and see us. We didn't have a manager to bring our issues to. So we just felt like left out and fending for ourselves." Some nurses experienced a lack of communication or information from day to day and had the perception of "lack of voice," often feeling no one was listening to them; in other words, they had a feeling of being left behind or discarded.

In *their own families*, some nurses felt isolated by the lack of understanding of their intimate experience with suffering and death related to COVID-19. They described situations in which some family members had different beliefs such as "well, they have to just write COVID on the death certificate. They just want to make it look like the numbers are bad." Often nurses reported they just stopped talking about their experiences to some family members and stated "Eventually I just can't talk to some family about it anymore." However, others reported having support of family members who were in healthcare and understood what the nurses were currently experiencing.

In *their communities*, nurses felt abandoned by disbelief about the disease, its consequences, and avoidance of necessary precautions to reduce the spread. They worked long hours every day with the goal of saving lives only to experience more deaths in 1 day than they ever had before the pandemic. Then they would listen to the news or go on social media to see the public's wavering support. Early in the pandemic they felt supported by the public (e.g., Nurses are Heroes signs) and then as one participant stated, "having that feeling sort of ripped away when the public was saying this wasn't real or it was getting better." Some nurses questioned whether or not the American public still thought of the nursing profession as the most trusted profession. Additionally, those nurses residing or regularly visiting family members in rural communities expressed genuine

concern about the views and practices of their families and neighbors. "I'm from a super small town. So there's a lot of people that are pretty conservative and just don't feel like they want to be restricted." "Nobody in the grocery store was wearing masks, not even the employees."

These experiences demonstrate how many of these frontline nurses had a feeling of being abandoned by their leaders in their work setting. They also felt abandoned by their own families, many who had different beliefs that caused dissonance in their relationships. The nurses experienced feelings of abandonment and a lack of support from their communities, including small towns. It is in this rural environment where they felt a lack of support and a view of not wanting to be restricted by for example, wearing masks.

Theme 4: Progressing from perseverance to resilience

Operational definitions: *Perseverance is a steady persistence or ability of individuals to keep doing "something" despite obstacles in the way.*[31] *Resilience is a process where individuals display positive adaptation despite experiences of significant adversity or trauma.*[25]

Statements by some frontline nurses revealed progression from perseverance to resilience which transpired over many months of caring for COVID-19 patients. A perseverance example provided by one nurse was "We just step up. That's what we do as nurses is just get by and make sure our patients are taken care of, no matter how we feel." Another nurse vocalized, "I was motivated to do what I could when I came to work." These statements are indicative of nurses being steadfast and persistent in their efforts to ensure patients were cared for in spite of the obstacles encountered.

At the end of the COVID-19 surge, some study participants offered statements substantiating their move from perseverance to a feeling of becoming more comfortable with this horrific situation. One participant stated, "We had somebody in the 50s on their oxygen the other day, and nobody panicked. Originally, they would have called a rapid alert but now we can handle this. We've done it before."

There was additional evidence some frontline nurses initially displayed perseverance and then over time demonstrated resilience. These frontline nurses experienced adversity and tragedy on a daily basis, often alone at the bedside and practicing outside or on the fringe of their scope of practice. They learned new knowledge and skills in the moment. However, many nurses described how they were able to "figure it out" and provided examples of being innovative. They were interdependent, relying on their unit team, and later in the surge, on traveling RNs from around the country. By exchanging knowledge and experience as well as combining intuition with critical thinking skills, they innovated and discovered necessary workrounds.

If the nurses had the support of those around them, either in the work or home setting or both, resilience was somewhat easier to attain. Nurses expressed the importance of teamwork and having supportive unit supervisors and clinical leaders at the bedside. One nurse stated, "Having someone there to help you or advocate for you was probably the best thing." Nurses not having that support and teamwork were less able to move forward.

In their personal life, nurses who had family members or friends who were nurses could connect over the "shared experience" and were supportive to one another. They described it as "having an outlet" with someone they could trust. "Traveler nurses" not only assisted the core group in caring for the surge of COVID-19 patients, but also brought information from other hospitals across the country.

Even though the group did cite examples that indicated perseverance and with some nurses, progression to resiliency, it was apparent during the interviews their lived experience was still "very raw" in their minds and hearts. Many had tears in their eyes as they relived what they had been through the last year. The majority of them had not been part of any debriefing or professional counseling sessions to assist in coping and moving forward.

In an effort to assist the nurses, interviewers used techniques such as stopping and continuing the interview when the nurse was ready as well as encouraging the nurse to seek mental health counseling. In reading the interview transcriptions, it was apparent the interviewers were quickly able to establish a rapport with each nurse; thus, creating an environment where the nurse felt comfortable in sharing their story.

5 | DISCUSSION

Although studies of nursing experiences with COVID-19 have been widely reported, experiences in rural America are lacking. About 60 million people or one in five Americans, live in areas categorized as rural in the United States,[32] yet there are few reports on the experiences of frontline nurses who practice in rural hospitals in small towns and cities.

The experiences of 19 rural frontline RNs in three different Upper Midwest hospitals in two very sparsely populated adjacent states are described. Overarching themes emerging from this phenomenological study include the feeling of being overwhelmed, feeling of role frustration related to chaos in the care environment, feeling of abandonment by leaders, families, and communities, and progressing from perseverance to resilience.

Similar to other studies,[5,7,19,21,33] the first theme of feeling overwhelmed was experienced by rural nurses who cared for patients with fulminate respiratory failure, unlike anything they had seen before. Rural America also experienced the pandemic as described by Beckman,[22] "healthcare under siege, battling unprecedented COVID-19 volumes, and acuity that was capricious…" (p. E3). In a study of 10,000 nurses who cared for COVID-19 patients, the American Nurses Association (ANA) reported that 50% described themselves as emotionally overwhelmed.[34]

The second theme, feeling of role frustration related to chaos in the care environment, was also similar to other studies.[19,21,33,35,36] Rural nurses experienced role frustration related to rapid changes in protocols and practices within a chaotic workplace where it was difficult to accomplish purpose, maintain standards of practice, and

align professional values. Conflicting, ambiguous, and confusing iterations of practice guidelines contributed to role stress, further compounded by unreliable "evidence" from media and public reports. Role stress and frustration mounted as rural nurses adapted to structural issues such as lack of negative pressure rooms or an inadequate oxygen supply. They coped with lack of physical resources through innovation and "workarounds," awaiting physical transformation of nontraditional spaces into functional clinical areas.

As in other reports,[19,21] isolation protocols added to workplace and professional role disruption, causing care delays and interfering with usual end-of-life comfort measures and human skin-to-skin connection. The "no visitor" policy had a unique impact on rural frontline nurses. Lack of visitors and family at a small community hospital would leave proxy nurses, who knew the patient and family, alone at the bedside, often experiencing sorrow and moral distress.

Central to theme three, the feeling of abandonment by leaders, families, and communities, was lack of social connection and support. Support from nursing and hospital leadership was personal, as well as professional, to rural frontline nurses in the workplace. Staff within smaller hospitals tend to be familiar and even close knit. Anonymity is rare in most rural settings. Yet, consistent with a survey of nurses that described leadership as "absent" during the pandemic,[37] some rural nurses in this study perceived similar abandonment by their leaders. Giving voice to real time frontline RN experiences, and being heard by leaders, was critically important in this study, and others.[21,22,33,35,36] Rural nurses wanted their leaders to listen and respect their frontline observations, and to include them in daily decisions. As reflected in other COVID-19 studies,[22,34–36] a stable management environment where leaders "come alongside," are present, inclusive, round and communicate builds frontline resilience, confidence, and security. Conversely, a work environment characterized by turnover, poor communication, rare presence, and dismissive incivility, left nurses feeling frustrated, alone, insecure, and abandoned.

The theme of feeling of abandonment also emerged from perceived lack of support from families and communities. Social support, connectedness, and belonging are part of local rural heritage. Like other studies,[19] in the midst of this crisis, social support often shifted from family and friends to other nurses and healthcare professionals, at work or in the community, who shared the lived experience. As cited elsewhere,[19,36,38] rural nurses even felt varying degrees of ostracism, even in their own homes and close-knit communities. From home and community came expressions of political bias, rural stoicism, and local disbelief in the pandemic in rural America—"not here"…"not us."

A finding unique to this study was the interconnectedness of the nurses with their patients, families, and communities due to the rural nature of their hospitals. These nurses often cared for patients they had a personal connection to outside of the work environment. This interconnectedness heightened the dichotomy experienced by the nurses when they would find themselves caring for patients that had been opposed to masking and vaccinations, and were even in disbelief that they were admitted with a COVID-19 infection.

Acerbic misinformation on social media contributed to "cyber-incivility" experienced by rural nurses and common during the pandemic. According to a multistate mixed methods study, 43% of nurses experienced cyber-incivility during the early phase of COVID-19 pandemic.[37] In this study, rural nurses described a sense of professional and personal hurt and insult from social media.

Despite the many months of caring for COVID-19 patients, study participants revealed some progression from perseverance to resilience, the fourth and final theme. This finding is similar to a mixed-methods study of 43 nurses working during the COVID-19 pandemic who demonstrated medium resilience on the Brief Resilience Coping Scale.[39] LoGiudice and Bartos[39] reported some nurses demonstrated high resiliency in spite of all that was happening around them, which aligns with the findings of this study. On the other hand, the fear and anxiety caused by constantly changing protocols and being unable to provide optimal patient care influenced feelings of low resilience.[39]

The lived experience of feeling overwhelmed, having role frustration, and feeling abandoned by leaders, family, and their communities required the nurses to persevere through these circumstances that were beyond their control. Beckman[22] described the COVID-19 pandemic as a "major disruption in nursing, nursing practice and personal well-being" (p. E5). Contributing factors mimic the basic level of Maslow's hierarch of needs: physiological (survival), safety, and love and belonging.[22] Rural nurses in this study experienced parallel needs both personally and professionally. Safety and a sense of belonging were core at work, at home, and in the community. Intense emotional connections layered the frontline experience at the bedside. Yet in the midst of a tragic pandemic, rural frontline nurses were able to persevere and develop even greater resiliency. Their professionalism and commitment propelled them through exhaustion and witness of inconceivable suffering and death.

6 | FRONTLINE NURSES' RECOMMENDATIONS FOR FUTURE PANDEMIC/SIMILAR EVENT PREPARATION

While at the frontlines throughout the COVID-19 pandemic, study participants became valuable resources for what worked and what did not. Based on their experience, they had future pandemic/similar event preparation advice for leadership, staff development educators, and nurse colleagues (refer to Box 1).

These were universal recommendations from the interviewees. Involving frontline nurses in the pandemic/similar event planning process, providing clear communication, offering mental health services in the work setting, conducting education, and providing support for coworkers are essential. Additionally, revisions to curricula in higher education could give nurses a stronger foundation to enhance their response to future pandemic/similar events. These recommendations would contribute to the perseverance and resilience of frontline nurses, and to overall organizational performance.

BOX 1. Frontline nurses' recommendations for future similar event preparation

Leadership:

- *Involve frontline nurses from the beginning and throughout.*
  - Invite frontline nurses to the table as critical stakeholders.
  - Listen to opinions on workability of ideas to create solutions.
  - Plan for equitable rotation of frontline nurses.
- *Communication is critical.*
  - Continual communication. Keep stakeholders in the loop every day.
  - Listen.
  - Build on stakeholder feedback.
- *Provide mental health services.*
  - Ensure outreach and easy accessibility at the work site.
  - Normalize debriefing sessions at regular intervals and after critical events.
  - Provide professional mental health counselors, early and consistently throughout the ordeal.

Staff Development Educators:

- Prioritize education for frontline nurses on COVID-19 units.
- Maintain presence of a staff development educator or training supervisor.
- Upskill nonfrontline nurses *after* training the frontlines.

Nurse Colleagues:

- Support coworker well-being.
- Be "present" for one another.

7 | STRENGTHS AND LIMITATIONS

A study strength was the ability to explore and uncover the lived experience of 19 rural frontline nurses in the specific areas of bedside caring, work environment, and balancing work and home life. Qualified interviewers conducting in-depth, semistructured interviews and the nurses' willingness to share their stories generated a wealth of information. Even though there was study team consensus around the integrity of data collection and analysis methods, complete bracketing of personal beliefs and opinions was subject to compromise from witnessing the pandemic in real-time.

8 | IMPLICATIONS FOR PRACTICE

Frontline nurses in this study perceived an overwhelming, chaotic, and frustrating work environment coupled by a feeling of abandonment by leadership. Findings of this study revealed what happens when a lack of preparation and tactical planning influences the ability of frontline nurses to safely perform their roles. Additionally, this study confirms that the nurses did not have a platform for their voice to be heard; frontline nurses have issued a call for action to leadership. However, for leadership to effectively respond, individual healthcare systems and national nursing leadership organizations should collectively address the importance of providing the proper education and resources for all current and future nurse leaders to ensure they are adequately prepared for their role in a dynamic, changing environment. To accomplish this, frontline nurses must be present to participate in the tactical planning.

Even though one in five Americans live in rural areas,[32] the literature reporting experiences of frontline nurses has been scarce. It is believed this study is one of the first to capture the insights of frontline nurses living in sparsely populated states. Future research is needed to determine if frontline nurses in other rural states have similar perceptions. Findings of this study offer opportunities for investigating effective and innovative communication methods for future emergency preparedness in an effort to decrease the degree of chaos, confusion, and frustration of frontline staff. Additional research could focus on how specific leadership programs may impact the work environment to build nurse resilience, confidence, and security. As reported in this study, provision of mental health services during an emergent event is extremely important. Future research could also identify specific interventions that can be implemented during pandemic or similar emergency events to strengthen mental health well-being.

9 | CONCLUSION

The experience of frontline nurses in rural America is overlooked in recent COVID-19-related literature. Interviews of rural nurses revealed experiences similar to high population United States and international cities. Their shared experiences included high volumes of critically ill patients, rapid change, uncertainty, and capacity strain. Rural nurses were overwhelmed by the high volume of critically ill patients, frustrated by their inability to accomplish their universal professional purpose of assisting patients to recovery or a peaceful death, and felt abandoned in their work setting as well as by their own families and community. Despite these experiences, rural nurses demonstrating perseverance were more likely to overcome adversity and experience personal and professional resilience. Differences in the experience of rural nurses included close, social connection to patients, families, and community members. This rural connectedness had positive and negative effects on professional, personal, family, and community support and cohesiveness.

What is learned from frontline rural nurses during the COVID-19 pandemic will support bedside nurses, nursing management, and staff development educators. Consistent with Gordon et al.[19] future pandemic/similar event planning and preparations must directly involve frontline nurses who are living the experience. Nurses need better communication, real-time education at the frontlines, supportive coworkers, and accessible mental health services.

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Data AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, (KRR) upon reasonable request.

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REFERENCES

1. Robinson KR. Comparing the Spanish flu and COVID-19 pandemics: lessons to carry forward.*Nurs Forum*. 2020;56:1-8. doi:10.1111/nuf.12534
2. Munhall PL. *Nursing Research: A Qualitative Perspective*. 5th ed. Jones & Bartlett Learning; 2012.
3. Chaffin J. *"It's finally got to rural America:" coronavirus surges in the Dakotas. Financial Times*. 2020. Accessed July 6, 2021. https://www.ft.com/content/82311cae-7775-4359-9c47-c13ea1e4bee7
4. World Health Organization, Emergency Committee. Statement on the second meeting of the International Health Regulations (2005). Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV). 2020. Accessed June 24, 2020. www.who.int/news-room/detail/23-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus
5. Billings J, Ching BCF, Gkofa V, Greene T, Bloomfield M. Healthcare workers' experiences of working on the frontline and views about support during COVID-19 and comparable pandemics: a rapid review and meta-synthesis. *medrxiv*. 2020. doi:10.1101/2020.06.21.20136705
6. Anesi GL, Lynch Y, Evans L. A conceptual and adaptable approach to hospital preparedness for acute surge events due to emerging infectious diseases. *Crit Care Explor*. 2020;2(4):e0110. doi:10.1097/CCE.0000000000000110
7. Kisely S, Warren N, McMahon L, Dalais C, Henry I, Siskind D. Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis. *BMJ*. 2020;369:m1642. doi:10.1136/bmj.m1642
8. Liu Q, Luo D, Haase JE, et al. The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study. *Lancet Global Health*. 2020;8:e790-e798. doi:10.1016/52214-109X(20)302204-7
9. Sun N, Wei L, Shi S, et al. A qualitative study on the psychological experience of caregivers of COVID-19 patients. *Am J Infect Control*. 2020;48:592-598. doi:10.1016/j.ajic.2020.03.018
10. Schroeder K, Nordul AA, Travers J, et al. Nursing perspectives on care delivery during the early stages of the COVID-19 pandemic: a qualitative study. *Int J Nurs Stud Adv*. 2020;2:100006. doi:10.1016/j.ijnsa.2020.100006
11. Yin X, Zeng L. A study on the psychological needs of nurses caring for patients with coronavirus disease 2019 from the perspective of the existence, relatedness, and growth theory. *Int J Nurs Sci*. 2020;7(2):157-160. doi:10.1016/j.ijnss.2020.04.002
12. Liu CY, Yang YZ, Zhang XM, et al. The prevalence and influencing factors in anxiety in medical workers fighting COVID-19 in China: a cross-sectional survey. *Epidemiol and Infect*. 2020;148:e98. doi:10.1017/S0950268820001107
13. Mo Y, Deng L, Zhang L, et al. Work stress among Chinese nurses to support Wuhan in fighting against COVID-19 epidemic. *J Nurs Manag*. 2020;28(5):1002-1009. doi:10.1111/jonm.13014
14. Lai J, Ma S, Wang Y, et al. Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Netw Open*. 2020;3(3):e203976. doi:10.1001/jamanetworkopen.2020.3976
15. Feng MC, Wu HC, Lin HT, et al. Exploring the stress, psychological distress, and stress-relief strategies of Taiwan nursing staffs facing the global outbreak of COVID. *Hu Li Za Zhi*. 2020;67(3):64-74. doi:10.6224/JN.202006_67(3).09
16. Sterling MR, Tseng E, Poon A, et al. Experiences of home health care workers in New York City during the coronavirus disease 2019 pandemic: a qualitative analysis. *JAMA Intern Med*. 2020;180(11):1453-1459. doi:10.1001/jamainternmed.2020.3930
17. Tan BYQ, Chew NWS, Lee GKH, et al. Psychological impact of the COVID-19 pandemic on health care workers in Singapore. *Ann Intern Med*. 2020;173(4):317-320. doi:10.7326/M20-1083
18. Zhu Z, Xu S, Wang H, et al. COVID-19 in Wuhan: immediate psychological impact on 5,062 health workers. *medrxiv*. 2020. doi:10.1101/2020.02.20.20025338
19. Gordon JM, Magbee T, Yoder LH. The experiences of critical care nurses caring for patients with COVID-19 during the 2020 pandemic: a qualitative study. *Appl Nurs Res*. 2021;59:151418. doi:10.1016/j.apnr.2021.151418
20. Rucker F, Hardstedt M, Rucker SC. From chaos to control—experiences of healthcare workers during the early phase of the COVID-19 pandemic: a focus group study. *BMC Health Serv Res*. 2021;21:1219. doi:10.1186/s12913-021-07248-9
21. Kellogg MB, Schierberl Scherr AE, Ayotte BJ. "All of this was awful:" exploring the experience of nurses caring for patients with COVID-19 in the United States. *Nurs Forum*. 2021;56:1-9. doi:10.1111/nuf.12633
22. Beckman BP. COVID-19: never seen anything like this ever! *J Nurse Adm*. 2020;50(6):E3-E7. doi:10.1097/NNA0000000000000900
23. Rushton CH, Caldwell M, Kurtz M. Moral distress: a catalyst in building moral resilience. *Am J Nurs*. 2016;116(7):40-49. doi:10.1097/01.NAJ.0000484933.40476.5b
24. Foli KJ, Forster A, Cheng C, et al. Voices from the COVID-19 frontline: nurses' trauma and coping.*J Adv Nurs*. 2021;77(9):3853-3866. doi:10.1111/jan14988
25. Luthar SS, Cicchetti D. The construct of resilience: implications for interventions and social policies. *Dev Psychopathol*. 2000;12(4):857-885.
26. Torkelson E, Holm K, Bäckström M, Schad E. Factors contributing to the perpetration of workplace incivility: the importance of organizational aspects and experiencing incivility from others. *Work Stress*. 2016;30(2):115-131. doi:10.1080/02678373.2016.1175524
27. Rev Transcription. Accessed December 15, 2020. https://www.rev.com/transcription
28. Creswell JW, Poth CN. *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. 4th ed.Sage Publications; 2018.
29. Moustakas C. *Phenomenological Research Methods*. Sage Publications;; 1994.
30. Giorigo A. *The Descriptive Phenomenological Method in Psychology: A Modified Husserlian Approach*. Duquesne University Press; 2009.
31. *American Heritage Dictionary of the English Language*. 5th ed. Houghton Mifflin Harcourt; 2020.
32. United States Census Bureau. What is rural America? 2017. Accessed January 15, 2022. https://www.census.gov/library/stories/2017/08/rural-america.html

33. Chegini Z, Arab-Zozani M, Rajabi MR, et al. Experiences of critical care nurses fighting against COVID-19: a qualitative phenomenological study. *Nurs Forum*. 2021;56(3): 571-578.
34. American Nurses Association. NEW pulse on the nation's nurses survey series: half of frontline nurses emotionally overwhelmed by COVID-19. July 15, 2020. https://www.nursingworld.org/news/news-releases/2020/new-pulse-on-the-nations-nurses-sur
35. Markey K, Ventura CAA, Donnell CO, Doody O. Cultivating ethical leadership in the recovery of COVID-19. *J Nurs Manag*. 2021;29: 351-355. doi:10.1111/jonm.13191
36. Schroeder K, Norful AA, Travers J, Aliyu S. Nursing perspectives on care delivery during the early stages of the COVID-19 pandemic: a qualitative study. *Int J Nurs Stud Adv*. 2020;2:100006. doi:10.1016/j.ijnsa.2020.100006
37. El Ghaziri M, Johnson S, Purpora C, Simons S, Taylor R. Registered nurses' experiences with incivility during the early phase of COVID-19 pandemic: results of a multi-state survey. *Workplace Health & Saf*. 2021;70:148-160. doi:10.1177/21650799211024867
38. Kackin O, Ciydem E, Aci OS, Kutlu FY. Experiences and psychosocial problems of nurses caring for patients diagnosed with COVID-19 in Turkey: a qualitative study. *Int J Soc Psychiatry*. 2021;67(2):158-167. doi:10.1177/0020764020942788
39. LoGiudice JA, Bartos S. Experiences of nurses during the COVID-19 pandemic: a mixed-methods study.*AACN Adv Crit Care*. 2021;32(1): 14-25. doi:10.4037/aacnacc2021816

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