



A Mixed-Methods Study of Nurse Managers' Managerial and Clinical Challenges in Mental Health Centers During the COVID-19 Pandemic

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Key words

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Abstract

Purpose: The worldwide outbreak of the COVID-19 pandemic has posed challenges for nurses. The aim of this study was to examine the managerial and clinical challenges of nurse managers in mental health centers during the current COVID-19 pandemic.

Design: A mixed-methods study based on an analysis of data obtained in focus groups with 25 nurse managers from two mental health centers in Israel.

Methods: The quantitative phase was conducted prior to the group sessions using a structured self-administered questionnaire that examined the nurse managers' (a) background data, (b) communication with the staff nurses, (c) perceptions of nurses' functioning, (d) perceptions of their own functioning, and (e) management as impacted by the pandemic. The qualitative phase included three sessions of focus groups in which the nurse managers discussed both their challenging and positive issues during the pandemic.

Findings: The most important challenges were related to the need to protect patients from infection and communicating with families and primary caregivers. Work policies and procedures were less well adapted to pandemic conditions; nevertheless, nurse managers felt a sense of purpose, duty, and pride in their work. Three themes emerged: (a) "management complexity" included the change from a familiar routine to a new reality, working in capsules, protecting against infection, functional confusion, and insights into future epidemics; (b) "challenging communication" included communication with patients through glass walls and communication with staff through screens and (c) "bright spots" referred to staff cohesion and the provision of respectful care.

Conclusions: Mental health nurse managers have experienced during the pandemic a change in their roles from being less managerial to focusing more on clinical work. Communication between nurse managers and staff nurses and between mental health patients and staff were the main challenges. Nurse managers favorably noted the uniformity and humanity of the staff, sense of cohesion, and shared responsibility.

Clinical Relevance: In the first wave of the pandemic, there was confusion as to the functional role of ward nurse managers, as the focus of their activities became more clinical and less managerial. During and after the pandemic, preventive interventions should be carried out in order to assist patients, staff nurses, and nurse managers in mental health centers.

The worldwide outbreak of the COVID-19 pandemic in early 2020 led to an unprecedented demand on health services in the community, nursing homes, hospitals, and mental health facilities (Maben & Bridges, 2020). Healthcare providers needed to adapt new approaches to providing quality care to patients. This was particularly important for nurses, who are at the forefront of the fight against the pandemic and who continue to experience shortages in resources for equipment usage, a lack of adequate personal protection, an increased use of technologies, and a heavy workload (Henderson, 2020). Nurse managers are facing the challenge of handling uncertainty in this crisis, setting up isolation wards, and having to cope with the sudden increase in the number of patients. This involves ensuring sufficient manpower, maintaining the quality of care, and motivating nurses to work during this demanding time (Wu et al., 2020).

Pandemics of infectious diseases, such as COVID-19, lead to psychological distress and mental illness symptoms among vulnerable populations, the public, and health workers themselves. Therefore, as COVID-19 continues to spread, the mental health discipline faces new challenges (Rajkumar, 2020). The majority of the current studies on the COVID-19 pandemic have examined the challenges of healthcare staff in general hospitals (Maben & Bridges, 2020; Mo et al., 2020). There have also been numerous studies on how mental health staff deal with the consequences of the current pandemic (Cheung, Fong, & Bressington, 2020). However, the new challenges of nurse managers in mental health centers during this outbreak have not been studied. For example, to reduce the risk for infection, outreach face-to-face visits in community mental health clinical services are being replaced by phone calls placed by mental health nurses, and hospital inpatient mental health departments are closed to visitors. Patients and their families communicate only through virtual networks, resulting in patients feeling a great sense of loneliness and abandonment. Additionally, newly hospitalized mental health patients are required to be in isolation for 14 days in special admission wards before being transferred to inpatient wards (Cheung et al., 2020).

In Israel, the first infection of COVID-19 was confirmed on February 21, 2020. Due to the increase in confirmed COVID-19 cases, from March 11, gatherings were limited to a maximum of 100 people. On March 12, educational institutions were closed. A lockdown was then imposed on the Jewish holiday of Passover beginning on March 17, and restrictions continued until mid-April (Keshet et al., 2020). A second

lockdown was later enforced during the Jewish New Year holiday from September 19 until October 11. At the time of writing, Israel is currently in its third lockdown (from December 2020).

The aim of the current study was to examine the experience of nurse managers, specifically their managerial and clinical challenges, in two mental health centers (MHCs) following the first wave of the COVID-19 pandemic in Israel. This was conducted via a self-administered questionnaire and through their participation in focus groups.

Methods

Study Procedure

This mixed-methods study was based on an analysis of data obtained in focus groups with ward nurse managers from two MHCs in Israel. All nurse managers in both MHCs were invited to participate in the focus groups. The aims of the focus groups were to identify key work-related challenges and issues during the COVID-19 pandemic; to share experiences of dealing with the first wave of the COVID-19 pandemic in Israel (February–May 2020); and to suggest further possible solutions and ways of coping with the challenges. Nursing directors addressed the rationale and purpose of the focus groups at nursing management meetings approximately 2 weeks before the focus groups commenced. It was emphasized that participation in the groups was on a voluntary basis.

Quantitative Phase. Prior to the focus group sessions, a structured self-administered questionnaire was completed by the study participants. The questionnaire was constructed by the authors and examined the nurse managers' (a) background data, (b) ways of communicating with ward staff nurses during the pandemic and how well they worked in capsules (smaller working teams to reduce the risk for infection), (c) perceptions of how well the ward nurses were functioning, (d) perceptions of their own functioning, and (e) management as impacted by this new challenging situation. Five senior nursing supervisors who manage nursing divisions in these MHCs validated this tool. They were asked to examine whether the items of the questionnaire address the content and challenges of nursing management during the COVID-19 pandemic. The items that had full consensus were included in the final version of the questionnaire.

Qualitative Phase. The focus groups included three weekly sessions, each lasting 90 min. The groups were held during a morning shift. The focus group sessions

were delivered online using the Zoom platform and were guided by two of the authors. Of the 31 nurse managers working in these two MHCs, 25 participated in the study (77%). As shown in Table 1, 40% of the mental health nurse managers worked in capsule formation (groups). Only 28% of the participants worked only morning shifts, which indicates a change in the work pattern (i.e., a transition to evening–night shifts) that is not typical for nurse managers.

Twenty-five nurse managers attended the first focus group session. To ensure an in-depth and fruitful discussion, the group was split into two subgroups that were then approached separately for the second and third sessions. At the beginning of the sessions, a recorded explanation and further anonymous content analysis was provided. The sessions were recorded using the Zoom application, and the recordings were transcribed and then deleted.

The three focus group sessions included the following components. In the first session, after self-presentation, coordination of expectations, and setting the group discussion rules, participants were asked to present one challenging issue and one positive issue while working during the pandemic. All participants were given a few minutes to present their experience. Eighteen challenging issues were raised during the discussion (Table 2). At the end of the session, the facilitators promised to summarize all the presented issues and to ask for their feedback. Then, all the participants received a list of the issues and were asked to rate each issue on (a) their importance and (b) the possible applicability of a solution to the problem. Each issue was rated on a 5-point scale from 1 (*not at all*) to 5 (*to a very large extent*). The aim of the ratings was to identify the most important and most applicable issues that will serve as a basis for preparing the hospital wards for the next waves of the pandemic. Prior to the second session, all the

participants' responses were received. The 10 most highly rated or ranked issues (see Table 2) were distributed by internal e-mail to the participants 2 days prior to the second session. Prior to the second session, the nurse managers were asked to examine whether the issues represent the main problems, to suggest additional issues that have not yet been discussed, and to consider possible solutions. The second and third sessions, in which the participants were divided into two subgroups according to their MHC, addressed these top 10 issues. A summary of the findings and suggestions for improvement were forwarded to hospital management. The information presented in the focus group then underwent qualitative analysis.

Data Analysis

Because the sample size was 25 mental health nurse managers, quantitative data analysis was limited to descriptive statistics. Descriptive analysis was used to determine the distribution of the items and variables. The qualitative methodology was performed using constant comparative analysis, by ascertaining content fields that were repeated in the participants' responses. Similar content was then divided into themes and the themes categorized (Glaser & Strauss, 1967). Validation of the trustworthiness of the findings was ensured by a peer debriefing process. Namely, the findings were presented by one of the researchers who is specialized in qualitative research methods to the other researchers of this study. A discussion on the findings was held until mutual consent concerning the identified themes and categories was reached (Lincoln & Guba, 1985).

Results

Quantitative Findings

Table 2 represents the results of the discussion from the first focus group session. The most important challenges the nurse managers reported were related to the clinical impact of the pandemic, such as a need to protect patients from infection (M score = 4.55, SD = 0.62); communication with families and primary caregivers (M score = 4.50, SD = 0.60); and the impaired communication between patients and their family and relatives (M score = 4.36, SD = 0.95). It appears that the managerial aspects of ward and staff management, which are a direct responsibility of nurse managers, were rated as less important than the clinical aspects of care. Therefore, the needs of the patients preceded the needs of the staff and the managers themselves.

Table 1. Participants' Background Characteristics ($N = 25$)

Variable	Category	n (%)
Mental health center (MHC)	First MHC	12 (48)
	Second MHC	13 (52)
Ward	Closed	13 (52)
	Open	8 (32)
	Other	4 (16)
Working in capsules	Yes	10 (40)
	No	15 (60)
Working morning shifts	2 shifts	4 (16)
	3 shifts	8 (32)
	4 shifts	5 (20)
	5 shifts	7 (28)
	Missing	1 (4)

Table 2. Participants' Ratings of Issues That Were Raised in the First Group Session (N = 25)

No.	Issue/challenge	Importance M (SD)	Applicability M (SD)
1	Protecting patients at risk from the COVID-19 infection	4.55 (0.66)	3.93 (1.18)
2	Impaired contact with families and primary caregivers	4.50 (0.60)	3.67 (1.24)
3	Impaired communication between patients and their family and relatives	4.36 (0.95)	3.45 (1.36)
4	Impaired quality of therapeutic contact with patients who are in an isolation room for fear of infection	4.23 (1.16)	3.91 (0.83)
5	Integrating male and female patients in the Corona Unit for isolation due to the difficulty in maintaining their safety	4.18 (0.87)	3.00 (1.49)
6	Shortage of personal protective equipment	4.12 (1.33)	4.19 (1.12)
7	Difficulty in maintaining the continuum of care	4.08 (1.14)	3.39 (0.99)
8	Weakening of working relationships with a multiprofessional team	4.00 (1.16)	3.62 (1.12)
9	Difficulty guiding, supporting, and listening to the nurses	3.82 (1.56)	3.76 (1.34)
10	Difficulty in ensuring and controlling the quality of nursing care	3.79 (1.32)	3.72 (1.20)
11	Neglecting managerial aspects and over-focusing on clinical aspects of patient care	3.68 (1.29)	3.86 (1.20)
12	The need to compromise on standards and principles due to imposed restrictions	3.66 (1.20)	3.57 (1.07)
13	Difficulty communicating and transferring messages to the ward nurses	3.62 (1.43)	3.94 (1.13)
14	Distancing from patients	3.52 (1.31)	3.28 (1.15)
15	Working in 12-hr shifts	3.27 (1.44)	3.53 (1.13)
16	Workload due to multiple admissions to an isolation unit for diagnosis of COVID-19	3.16 (1.70)	3.30 (1.57)
17	Training and teaching nursing students	3.11 (1.32)	2.57 (1.22)
18	Difficulty arranging work schedule	2.95 (1.55)	3.18 (1.47)

Note Participants' ratings are on a scale from 1 (*not at all*) to 5 (*very much*). The first 10 items were the most challenging issues ranked by the participants.

Tables 3 and 4 show the distribution of the answers to the research questionnaire that was completed by the participants prior to the focus groups. Table 3 represents the responses of nurse managers on items related to their personal functioning as managers and to the professional functioning of the ward nurses compared to prepandemic times. Responses concerning the nurses' professional functioning on the ward showed both negative and positive consequences of working during the pandemic. Examples of the former were that nurse managers reported that work policies and procedures were less adapted for the pandemic period (M score = 2.52, SD = 1.33); advanced work and project execution were decreased (M score = 2.51, SD = 1.05); and working relationships with a multidisciplinary team were weakened (M score = 3.08, SD = 1.41). However, the nurses felt a sense of purpose, duty, and pride (M score = 4.54, SD = 0.66), and were more disciplined compared to regular prepandemic times (M score = 3.54, SD = 1.14). On a personal level, nurse managers felt burned out and overwhelmed by their new tasks and duties (M score = 3.54, SD = 1.32) but demonstrated high satisfaction with their managerial performance (M score = 3.92, SD = 0.72).

As shown in Table 4, the most common way to communicate, collect information, and transfer managerial messages to the ward nurses during this period of social distancing and working in capsules was via WhatsApp groups (M score = 3.58, SD = 0.58). Therefore, this social networking application was applied as a way to manage the nursing staff and as a solution to this new situation, where there is a loss of direct managerial control due to the inability to have face-to-face time. Interestingly, using Zoom calls and sessions did not gain momentum as a well-used platform, either at the personal level (M score = 1.28, SD = 0.74) or professional level (M score = 1.52, SD = 0.87), despite being available in the MHCs.

Qualitative Findings

Three themes and nine categories emerged from the focus group sessions. The first letter of the participant's first name appears in parentheses next to each citation.

First Theme: Management Complexity

From a familiar routine to a new reality. The nurses stated that their routine job completely changed

Table 3. Professional Functioning on the Ward (Nursing Staff) and Personal (Nurse Manager) Levels as Compared With Prepandemic Times (N = 25)

Professional functioning on the ward level	M	SD
Staff nurses are more disciplined	3.54	1.14
Staff nurses are more burned out and fatigued	2.83	1.34
All tasks are performed and fully completed	3.50	1.14
Departmental projects continue as usual	2.17	1.05
Working relationships with multiprofessional team are weakened	3.08	1.41
There is a greater disciplinary laxity at work	3.92	1.25
Ward policies and procedures are tailored to the pandemic period	2.52	1.33
Working in capsules contributes to the team working	4.18	.59
Nurses feel a sense of purpose, duty, and pride	4.54	.66
Professional functioning on the personal level		
I feel a greater responsibility	3.14	1.46
I am satisfied with my performance as a manager	3.92	.72
I feel burned out and overwhelmed by new tasks and duties	3.46	1.32
Preparing the work schedule and other arrangements is easier while working in permanent capsules	2.92	1.38

Note Items were scored on a scale from 1 (*not at all*) to 5 (*very much*).

with the COVID-19 pandemic. Departments were closed, and no outside visits were permitted, as the following quotations illustrate: "Everything we know has changed" (Y); "Our department is usually open to volunteers and visitors but in a short time we have become a fortified place, completely closed. Patients are accustomed to receiving visits, food from home or home visits. It all stopped abruptly" (S); "We have restarted the department and now think differently about how to proceed" (D).

Working in capsules. In order to reduce risk for exposure and infection, nurses in Israel worked in capsules (capsule formations), that is, in permanent groups of nurses who always work the same shift and schedule. Working in capsules ensured functional continuity of the ward, since when a nurse tested positive for COVID-19, only nurses working in her or his capsule needed self-isolation. One nurse noted that she worked as usual and came to the ward every day to see the staff: "I decided that I would not work in any capsule since I

Table 4. Nurse Managers' Communication With Nursing Staff Under the Restrictions of Working in Capsules: Distribution of Responses (N = 25)

Tools and means of communication	M	SD
Individual WhatsApp conversation	2.88	1.05
Ward WhatsApp group	3.58	.58
Initiated face-to-face conversation	2.96	.91
Telephone conversation	2.96	.91
Transferring information through other staff members (chain)	2.86	1.08
E-mail	2.33	.92
Individual Zoom call	1.28	.74
Group Zoom call	1.52	.87

Note Items were scored on a scale from 1 (never) to 4 (several times a day). WhatsApp = WhatsApp Messenger messaging application; Zoom = application for video communications.

work every morning and so meet everybody each time" (Y). However, most of the nurses worked in capsules and consequently experienced difficulty in management, as one of them shared: "We worked in 12-hr capsules, so my control was complicated. It was difficult to guide the team, say what was expected, convey messages, feel what the atmosphere was like, how they felt and how they coped" (A). Determining the staff capsules (smaller working teams) raised issues the nurse managers had to deal with:

It was complex to determine the capsules. We had to check who gets along, who prefers nights or mornings. The complexity of the capsules is determining the pros vs. the cons. The main plus was working only 3 days a week and the minus was being less with the staff (L).

Protection against infection. Possible exposure to the virus raised fears of infection and requests for adequate protection, as two nurses stated: "I felt a sense of uncertainty and insecurity due to possible exposure to Corona, and above all, a lack of protection" (A); "There was a lack of protective equipment but later we got many masks and gloves" (R).

Functional confusion. The nurse managers reported a change in their professional roles, as they actually functioned as ordinary nurses rather than managers: "I became one of the nurses in the capsule and managed with a 'remote control'" (I); "There was no management involved, I worked as an ordinary nurse and I also had to be in charge with a comprehensive vision" (L).

Insights into future epidemics. The nurses expressed a sense of loneliness in their management. They attributed this to a lack of guidance from hospital

administrations with the sudden onset of the pandemic, as one of them said:

This time it came as a boom, but next time the management team of the hospital and the epidemiological nurse must distribute roles accurately with any epidemic that may break out. We should have procedures in place and a fair division of roles. (H)

Second Theme: Challenging Communication

Communication with patients through glass walls. Communication with patients was either through transparent walls or via cameras, as two nurses explained:

We cared for the patients and we went beyond the glass walls but avoided going in as much as we could in order not to get infected. We entered protected once every shift to give the patients food, medication, and help with showers, or when we observed through the glass wall a commotion. (R)

We saw everything through cameras so actually we did not see the patients themselves, (L)

Communication with the staff through screens. Similarly, communication with the team was through software and phones, with limited personal encounters: "I could not meet all my nurses. The communication was only by WhatsApp or phone. There were teams I did not get to see at all" (K); "The communication was mostly remote. The interpersonal communication in the department became very limited since we worked in other shifts" (A). This led to nurse managers finding it difficult to manage their staff, as one of them said: "The hardest thing for me was managing the team I hadn't met in all this time. Advice, guidance, and support was all through WhatsApp messages" (R).

Third Theme: Bright Spots

Staff cohesion. Within the chaos, there were also positive aspects. The nurse managers favorably noted the uniformity of the staff, sense of cohesion, and shared responsibility: "The unification of the team within the department and the support we had for each other helped us" (R); "The entire staff shared responsibility. Everyone's

commitment was full" (D).

Humanity and quality care. Another positive aspect noted by the nurses was the close relationships with the patients that developed as a result of the situation: "No entry was permitted onto the ward by any other person, be it family members or lawyers, so a very special bond was created with the patients. When no one comes in, it creates something unique at home" (Y); "Even though we closed the ward, without noticing, we became the patients' family showing empathy and warmth. Something happened, which does not happen every day" (A).

Discussion

The current study found that during the first wave of the COVID-19 pandemic in Israel, nurse managers in MHCs faced managerial and clinical challenges. They experienced a reversal of their roles; instead of focusing on management, they dedicated their time to clinical issues and mainly worked as staff nurses. The study's findings further indicated that communication between the nurse managers and the staff, as well as between the mental health patients and the staff, were the main challenges. Communication with patients' families and primary caregivers was online, and the treatment and care of patients was mostly through transparent walls and via cameras. The nurse managers similarly talked with the ward nurses mainly via WhatsApp and phones due to limited personal encounters, which caused them to find it difficult to manage their staff as they had in prepandemic times. This challenge of insufficient and less effective communication during the COVID-19 pandemic therefore plays a central role in nurse managers' ability to balance their support for their nursing staff with their provision of quality care to their patients. To maintain this balance, nurse managers need to adhere to the moral duty of transparent communication by telling the truth and being authentic, reliable, and humane (Prestia, 2020).

The possible exposure to the virus raised fears of infection and requests for adequate protection. Indeed, a main challenge as reported by the nurse managers was the need to protect the staff nurses, the patients, and themselves from infection. This is supported by a previous report from a director of a nursing department in a general hospital located in Shanghai. The director observed that improving nurses' preparedness in infection control and the suitable use of protective equipment are essential to combat COVID-19 (Zhang, 2020). It should be emphasized that working in MHCs involves caring for mentally ill patients who are particularly

vulnerable to the psychosocial effects of pandemics. These patients are at an increased risk for being emotionally distressed due to emotional isolation, a sense of insecurity, and stigma. In addition, healthcare workers are vulnerable to emotional distress in the current COVID-19 pandemic, especially in light of their higher risk for being exposed to the virus, their long working hours, and the lack of personal protective equipment (PPE; Pfefferbaum & North, 2020). The nurse managers in our study further attributed their emotional distress to a lack of guidance from hospital administrations after the sudden onset of the pandemic. Zhang (2020) stated that although there is no uniform management model for nurse managers in such pandemics, established protocols for preventing and controlling pandemics can assist in successfully managing the situation.

The focus group sessions also raised some positive responses from the nurse managers following the COVID-19 pandemic. Although the nurse managers felt burned out and overwhelmed by their new tasks and duties, they demonstrated a high satisfaction with their managerial performance. Indeed, they felt a sense of purpose, duty, and pride. They also favorably noted the uniformity of the staff, sense of cohesion, and shared responsibility. Moreover, close relationships with the patients were created as a result of the situation. In fact, the benefits resulting from nurses coping and adapting to changes brought about by the pandemic was mentioned by Bambi, Iozzo, and Lucchini (2020), who pointed out positive consequences such as an increase in nurses' competence, knowledge, skills, and resilience. Mental health nurses with their improved professionalism are therefore in the position to lead access to mental health care through telepsychiatry interventions, while supporting their colleagues and each other (Kameg, 2020).

Limitations

The present study focused on nurse managers working specifically in mental health departments and may not be generalized to other hospital departments. Therefore, nurse managers' managerial and clinical challenges resulting from the COVID-19 pandemic should also be examined in general hospital wards. In addition, there is a possible geographical limitation related to the fact that the study was conducted only in Israel. The nurse managers' coping with COVID-19 pandemic challenges in other countries may be different. Furthermore, this study did not examine the challenges from the patients' perspective and experiences. It would therefore be beneficial for future studies to examine the aspects of coping with the pandemic from the perspective of hospitalized mental health patients.

Clinical Implications

During and after the pandemic, preventive interventions should be carried out to assist patients, staff nurses, and nurse managers in MHCs, including psychoeducation and professional psychosocial support (Pfefferbaum & North, 2020). Such interventions can include 24-hr help with a psychotherapist for nurses who experience anxiety, stress, or insomnia, as was provided for nurses in a hospital in the Guangdong Province in China during the present COVID-19 epidemic (Huang, Lin, Tang, Yu, & Zhou, 2020). Implementation of key measures should include maintaining a level of "zero nurse infections" during the present pandemic by establishing protocols to reduce the risk for nurses getting infected through interactions with COVID-19 patients. Moreover, there should be management of a reasonable nursing shift schedule and infection control system that provides real-time monitoring of healthcare staff use of PPE. Indeed, consistent personal meetings of nurse managers with their staff nurses should be scheduled to assist them in applying work procedures during the pandemic, in ensuring the proper usage of PPE, and in reducing workplace stress (Huang et al., 2020).

Conclusions

The current study shows that in the first wave of the COVID-19 pandemic in Israel the nurse managers of MHCs were confused as to their functional role as the focus of their activities became more clinical and less managerial. This change in focus may in turn have impaired the functioning of the psychiatric wards and led to an impairment in the quality of nursing care for psychiatric inpatients. In times of crisis and epidemics, mental health nurses can and should lead access to mental health care, and support their peers and each other.

Acknowledgment

Ethical approval for this study were obtained from the Helsinki Ethics Boards of the Beer-Yaakov Ness-Tzyona and Eitanim Kfar Shaul MHCs, where the study was conducted. Approval numbers are #661-20 and #9-20, respectively.

Clinical Resources

- Coronavirus and psychiatric hospitals: 'Staff are scared, patients are scared.' <https://www.bbc.com/news/av/health-52943524>
- We can't forget about psychiatric hospitals during the COVID-19 outbreak. <https://www.healthline.com/health/mental-health/psychiatric-hospitals-during-covid-19>

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