

ORIGINAL RESEARCH: EMPIRICAL  
RESEARCH - QUALITATIVE

# Pandemic perspectives from the frontline—The nursing stories

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## Abstract

**Aim:** To describe the experiences of registered nurses working in a US healthcare system during the COVID-19 pandemic.

**Design:** This qualitative thematic analysis study is a secondary analysis of stories submitted by nurses to a repository established by the parent study.

**Methods:** Registered nurses working in various roles in a healthcare system submitted stories ( $N = 45$ ) to open-ended prompts via an online repository between June 2020 and February 2021. A team of three nurse scientists coded the stories using Dedoose software. Initial codes were then reviewed by the team to synthesize initial coding into themes. The COREQ checklist was used to ensure research reporting guidelines were met.

**Results:** Thematic analysis revealed three themes in a global theme of COVID-19 pandemic-related personal and professional evolution: (1) The art and science of pandemic nursing, (2) Persisting despite challenges; and (3) Learning as we went. Each of the three organizing themes were supported by basic themes.

**Conclusions:** Identified themes affirm some of nursing's long-standing core values, such as the central role of human connectedness in restoring health, but findings also reflect new evolutionary processes of moral identity formation that occurred among nurses and the nursing profession during the COVID-19 pandemic.

**Impact:** Findings from this study describe the processes by which nurses' moral identity evolved during a segment of the COVID-19 pandemic. Collectively, these evolutions represent important shifts in the nursing profession. Using findings from this study, nurse educators, nurse managers and healthcare administrators will be able to implement effective, sustainable policies and processes that meet the needs of both the community and the workforce.

**No Patient or Public Contribution:** This study was designed to capture the experiences of nurses employed by one healthcare organization. However, it was not conducted using input or suggestions from the public or the patient population served by the organization.

## KEYWORDS

COVID-19 pandemic, moral identity, nursing practice, nursing workforce, qualitative research

## 1 | INTRODUCTION

With the onset of the COVID-19 pandemic, a global spotlight was focused on healthcare workers and their response to a healthcare crisis, the likes of which has not been seen since the devastating flu pandemic of 1918 (Kolawole, 2010). The World Health Organization's (WHO) designation of 2020 as The Year of the Nurse (Yazdi, 2019) proved to be a prescient action; nowhere is this light more intently focused than on nursing. The successful evolution of the state of global healthcare involves identifying opportunities for transformation and growth inherent in any healthcare crisis. Consequently, documenting experiences of the COVID-19 pandemic is crucial for understanding the personal and professional experiences and changes occurring as a consequence of this pandemic. Quality nursing care is essential for effective healthcare (Catton & Iro, 2021), thus the experiences of nurses are vital to informing how to advance and adapt to an irrevocably changed healthcare landscape. Engaging the voices of the largest group of frontline workers allows us to capture and to preserve this unprecedented moment in history *as it unfolds*.

In 1850 Emerson (1903) once wrote, "All things are engaged in writing their history ..." Humans are a species for whom stories have historically helped us not only record but make sense of events influencing our development and advancement. As such, qualitative research with its emphasis on lived experiences is a tool widely used by nurse researchers to explore the effects of the current global pandemic on nursing and patient experiences as evidenced by the numerous publications devoted to this topic. We would argue that more is necessary. Hence, our study provides insight into the unique experiences of nurses involved in caring for communities across the nation; it is these stories that will allow both bearing witness and being witnessed, and that will ultimately allow healthcare entities to participate in making meaning of this upending, world-changing and ongoing event.

This study, involving associates from a national healthcare system, was initiated to first establish a repository for the stories of healthcare workers' personal and professional experiences of the pandemic. Then, the stories submitted to the repository by nurses were systematically analysed and synthesized into themes. The purpose of this study is to give a voice to nurses by describing the experiences and impact of the COVID-19 pandemic in nurses' own words. We found that the experiences of nurses during the pandemic were rich and diverse, but also contained some commonalities. These commonalities can be used to inform policies and practises to effectively support nurses and ensure their voices are heard as the pandemic continues, subsequently driving a more strategic and empowering transformation of the nursing profession.

## 2 | BACKGROUND

Nurses have experienced profound positive and negative effects of the current pandemic in both their personal and professional lives.

Many describe being changed physically, emotionally or spiritually (Foli et al., 2021; Moretti et al., 2021). The psychological trauma associated with witnessing the traumatic experiences of others while experiencing your own trauma is well documented (Schuster & Dwyer, 2020). In many ways, the COVID-19 pandemic has affirmed long-standing, virtuous characteristics attributed to the nursing profession; stories about nurses' heroism, selflessness, courage, faith, patriotism and compassion were, and still are, abundant in the news (Halberg et al., 2021; Ke et al., 2021).

However, as the pandemic persists, nurses are experiencing negative effects, too. As of May 2021, an estimated 115,000 healthcare workers have died from COVID-19, although reporting is scant and the exact number is unknown (WHO, 2021). Nurses who identify as racial and ethnic minorities have been disproportionately affected, with a higher death rate from COVID-19 (Qureshi et al., 2021). Many nurses who are COVID-19 survivors are experiencing enduring physical, cognitive and psychosocial symptoms for several months after the initial illness (Henneghan et al., 2022). The cognitive impact on executive function was greatest among the 28–33-year-old age group in one study by Henneghan et al. The mental health of nurses and their families has also been affected (Kellogg et al., 2021; Li et al., 2021; Nestor et al., 2021; Norman et al., 2021). The physical and mental effects are impacting workforce retention, resulting in nurses intending to leave their jobs and the profession in greater numbers than were reported pre-pandemic (Mirzaei et al., 2021; Nashwan et al., 2021).

Despite the depth of the impact, in the frenzy of healthcare systems to address the COVID-19 pandemic, it can be difficult to 'hear' or discern the collective voice of the nursing workforce. This is in part because nurse voices are underrepresented at the highest levels of leadership and often missing from the media, even though nurses make up the largest segment of the healthcare workforce (Mason et al., 2018). In 2018, only 4% of hospital boards of directors, the group of leaders responsible for organizational decision-making, included a nurse (Van Dyke et al., 2019). Globally, 60–74% of WHO member countries have a government-level chief nursing officer responsible for a national nursing strategy, but the United States is not one of those countries (WHO, 2015; WHO, 2020). One consequence of this absence is that there is not a designated person at the national level who is responsible for identifying the needs of the nursing workforce, and for ensuring that those needs are met. Yet at the local level, we witnessed numerous signs of courageous nursing leadership and advocacy, manifesting in both traditional and novel ways, and felt that their stories deserved to be told and their voices amplified.

Evidence is building about nurses' experiences during the COVID-19 pandemic, and the impact on both the individual, as well as the nursing profession. Robinson and Stinson (2021) studied the 'lived experiences' of 14 nurses working in a variety of units caring for COVID-19 patients across facilities in the United States (U.S.). One of three major themes that emerged from their study via semi-structured telephone interviews and verbatim transcription was 'the human connection.' Subthemes were identified and revealed the immeasurable disruptions in those human connections, and the struggles, compassion and resilience of the nurses to face those

challenges. There is qualitative evidence describing why nurses report to duty during a pandemic, the psychosocial impact of working during a pandemic and the implications of the hero narrative. Throughout the past year, several repositories of frontline healthcare worker stories have been created, but to the best of our knowledge, this is the first to report a systematic, qualitative synthesis of the stories submitted to an open-ended prompt by nurses at any level or role in a U.S. national healthcare system (American Hospital Association, 2021; Bennett et al., 2020; Loresto Jr et al., 2021; National Institutes of Health, 2020; Xu et al., 2021).

The impact of the pandemic on nursing and nurses is too complex and multifaceted to be captured solely by surveys and quantitative research. In her book, Bylander (2020) reminds us of the importance of using clinician experiences to “frame a new paradigm of care” (p. 76) that maximizes health equity. Historically, the stories of healthcare workers' experiences during a pandemic have not only provided insights into the political and social climate of the time but have also served to inform subsequent advancements in social justice as well as changes in healthcare policies and practises (Corless, et al., 2018; D'Antonio, 2019; Jones & Saines, 2019; Kolawole, 2010). For example, using archived stories and interviews, Jones and Saines (2019) made the compelling case that the hardwon inclusion of 18 Black nurses in the U.S. Army during the influenza pandemic of 1918–1919, was a catalyst for the advancement of civil rights in the Army Nurse Corps and the Red Cross.

### 3 | THE STUDY

#### 3.1 | Aims

The primary aim of this study was to gain an in-depth understanding of nurses' personal and professional experiences throughout the COVID-19 pandemic. Using audio and audiovisual recorded and written stories in response to question prompts, we aimed to capture the experiences of nurses through the participants' own words and voices. Hence, the research question guiding this study was: How are nurses working in any role of a national U.S. healthcare system experiencing the COVID-19 pandemic?

#### 3.2 | Design

This qualitative thematic analysis study is a secondary analysis of stories submitted by nurses to an Institutional Review Board (IRB) approved study repository established by the parent study.

#### 3.3 | Sample/participants

The parent study involved recruiting interdisciplinary healthcare workers who had been directly involved in one or more aspects of COVID-19 pandemic patient care, education or planning. Healthcare

workers were recruited from across multiple clinical settings throughout the U.S. Participants were required to identify their role in healthcare (e.g. nurse, physician, surgical technician, etc.). Those associates employed in non-clinical roles such as environmental services, food services or maintenance were also invited to submit stories.

#### 3.4 | Data collection

Repository stories examined in this study were collected prior to the availability of vaccines between June 2020 and February 2021 using audio, audiovisual and/or written methods. Advertised via posted informational fliers, a QR code was used to access a secure, internally facing web platform developed in REDCap, a web application in which surveys can be created, data captured and databases managed. The Pandemic Perspectives protocol contained instructions (including the directive to maintain HIPAA compliance), prompts and a link to upload recordings or written stories. Story prompts included questions like “Without including any identifying information, please discuss a patient experience you've had during this time that was significant to you” and “Think about your shifts at work right now. How are things different from work before COVID-19?”

In appreciation of the collaborative nature of healthcare, the option to record with a peer was made available as well. Clinicians were encouraged to share their story with another colleague in more of a conversational format. The data collection platform provided a checkbox to indicate a peer-to-peer recording. If checked, two consents and two demographic sections were opened for the peers to access and complete before being given the option to upload their written story or recording. Otherwise, participants were asked to complete one consent and demographic form. Demographics included age, self-identified sex (male, female, non-binary, transgender or other), self-identified race and ethnicity, tenure as a nurse at the organization, and professional role. See [Table 1](#).

#### 3.5 | Ethical considerations

This study received full approval from the IRB of the organization. All participants provided electronic informed consent.

#### 3.6 | Data analysis

Consistent with the analysis process outlined by Braun and Clarke (2006, 2019), an inductive thematic analysis was used to explore the personal and professional experiences of nurses during the COVID-19 pandemic. A six-step method of qualitative data analysis, the process is both a reflexive and a recursive one. At the time of our analysis, the repository included 45 stories from nurses, 43 of which were written submissions and two of which were audio recordings that were transcribed by the principal investigator. Data immersion occurred with extensive reading and documentation of preliminary

TABLE 1 Characteristics of nurse participants (N = 45)

Characteristic	Mean $\pm$ SD, or N (%)
Age (years)	42.9 $\pm$ 13.2
Tenure in Current Role (years)	12.1 $\pm$ 12.0
Race <sup>a</sup>	
American Indian or Alaska Native	2 (4.3%)
Asian	4 (8.7%)
Black or African American	1 (2.2%)
White	36 (78.3%)
Prefer not to say	2 (4.3%)
Ethnicity <sup>a</sup>	
Not Hispanic or Latino	40 (87.0%)
Hispanic or Latino	3 (6.5%)
Prefer Not to Say	2 (4.3%)
Sex <sup>a</sup>	
Females	42 (91.3%)
Males	3 (6.5%)
Role <sup>a</sup>	
Nurse	42 (91.3%)
Nurse executives or researchers	3 (6.5%)

<sup>a</sup>Self-identified.

patterns and potential codes. Additionally, the team met weekly to discuss all aspects of the analytic process. Meeting minutes were kept for reflexive review and as an essential part of the audit trail.

Using the Dedoose software program (2021), the research team identified relevant excerpts from the stories as codes of data. The stories were divided equally among individual team members for initial code determination. The use of Dedoose enabled the team to collectively review each code extracted by an individual team member, thus enhancing the credibility of the analysis process.

All potentially significant themes were then identified and included in a Google spreadsheet with relevant codes listed with each theme. Subsequently, thematic maps were created to assist us in visualizing the themes as independently significant while allowing us to consider ways they were connected or linked. Our culminating thematic map not only reflected the entire data set but also provided a visual representation of the answer to our research question. Both the spreadsheet and the maps are elements of the audit trail.

Furthermore, our analysis involved comprehensive discussions of each theme, how these themes were defined, the stories and excerpts that best represented these themes, and finally, the names for each theme. Personal insights were contributed by each team member as the data were repeatedly examined and as this process evolved to reinforce the integrity of our findings.

### 3.7 | Validity and reliability/Rigour

Unlike quantitative data analysis, qualitative analysis requires the researcher themselves to act as the mechanism for analysis as they

engage with the data (Norwell et al., 2017), thus making the establishment of rigour and trustworthiness imperative. Key trustworthiness criteria as identified by Whittemore et al. (2001) include credibility (participants' meanings are accurately interpreted and reflected), authenticity (a variety of voices are heard), criticality (the research is critically assessed) and integrity (the investigators are self-reflexive).

#### 3.7.1 | Credibility

Credibility was firmly established and enhanced in several ways, beginning with our team's rigorous and sustained engagement with the data. All nursing stories gathered in the indicated time frame were identified, uploaded to the Dedoose platform and read repeatedly throughout the data analysis process. Due to the volume of the data, after the initial reading by team members the stories were divided equally among us for preliminary code production. Codes were then systematically cross checked and validated by the entire team during weekly meetings. Our collaborative approach ultimately resulted in the generation of resonant and nuanced themes while reinforcing the credibility of the analysis process (Braun & Clarke, 2019; Norwell et al., 2017). Additionally, the use of the Dedoose software program allowed us to work efficiently with a significant amount of content, subsequently expediting an in-depth, rich and complex analysis.

The aforementioned weekly research team meetings were held throughout the entire analysis process during which we refined codes and themes, discussed evolving ideas and developed items such as the theme map that are integrated into our audit trail. Meeting minutes and personal notes were kept illustrating both the reflexive and the recursive nature of the team's process.

Finally, we were fortunate enough to present our preliminary findings to several groups of frontline and executive nurses. This external check essentially allowed us to assess resonance with and recognition of the experiences reflected in the findings. Responses tended to be very moving as nurses verified seeing themselves and/or their colleagues in the data.

#### 3.7.2 | Authenticity

Authenticity was realized in the very nature of the study itself. Establishing a national repository for an entire healthcare system allowed frontline nurses and those nurses in executive positions from multiple sites in many areas of the country to participate, thus ensuring that a variety of voices were heard.

#### 3.7.3 | Criticality

As discussed previously, criticality was achieved by the assessments done during our weekly team meetings, the nursing peer and leadership debriefings and the development of our audit trail. Notably,

the leadership debriefings included nurse research scientists whose feedback contributed to the critical appraisal of our research.

### 3.7.4 | Integrity

Self-reflexivity was practised by all team members as demonstrated by our manuscript notes, weekly meetings and thoughtful dialoguing. Likewise, personal self-reflective notes were recorded by the PI throughout the research process, including after every peer and leadership debriefing, frequently involving personal correspondence between the PI and those frontline nurses and nurse leaders who attended these debriefings.

## 4 | FINDINGS

In total, 45 registered nurses participated in this study. Sample characteristics are detailed in [Table 1](#). A majority identified as female (91.3%) and white (78.3%). Participants had a mean of  $12.1 \pm 12.0$  years of experience in their current role (range 2 months to 38 years), and the mean age was  $42.9 \pm 13.2$  years. Most stories were submitted by nurses working in Midwestern and Southern U.S. locations. Although additional gender identity options were made available for participants (e.g. non-binary and transgender), all participants identified as either 'male' or 'female'.

Data synthesis identified a global overarching theme with three organizing themes describing pandemic-related personal and professional evolutions in perspectives, nursing care and patient engagement, moral identity and values. Each organizing theme was further supported by basic themes. Basic themes reflect the grouping of similar concepts, phenomena and relevant topics. These basic themes were then connected and used to support the creation of organizing themes. Although the stories were as individual as the experiences of each professional nurse, they also revealed some common elements that spanned location, practice specialty, nurse characteristics and nursing roles. Hence, the thematic analysis process yielded themes that affirm values long-attributed to nurses and nursing, but they also described the occurrence of both an individual and collective evolution. These evolutionary experiences reflected transformations in thought, identity, coping mechanisms, perspective about the art and science of nursing, roles and clinical practice. This shift in how nurses viewed themselves was supported with the following organizational themes: "The Art and Science of Nursing During a Pandemic," "Persisting Despite Challenges," and "Learning as We Went." [Table 2](#) provides additional details about each of the themes.

### 4.1 | The art and science of nursing during a pandemic

It is common to hear nursing described as both an art and a science. The symbiotic nature of the relationship between the two

skill sets has emerged as the foundation of nursing practice; likewise, it often informs the meaning that nurses associate with their work (Peplau, 1988). This organizing theme was further organized into four basic themes: moral identity disruption, wholeness, meaning making of the patient experience and acknowledging the loss.

#### 4.1.1 | Moral identity disruption

As nursing core values such as autonomy and honesty (Chitty & Black, 2007) are learned and practised, they become integrated with personal and organizational values to create a nursing moral identity (Fowler, 2015). The unique, dynamic dimensions of nursing practice can profoundly affect nurses' construction of moral identity—both professionally and personally—in different ways. For example, when the sacrosanct mandate of "first do no harm" is perceived as compromised, moral injury may result (Williamson et al., 2020) leading to a disruption in moral identity. Moral identity disruption became evident when nurses described how their practice and the potential impact of their care had changed since the pandemic started. A frontline RN with 25 years' experience offered the following perspective:

*The main issue I have is that I am a very friendly, smile all the time at every one, and like to have physical contact (touch, hold or shake a hand, or give a hug, when appropriate) when someone is having a difficult time or given some life changing news. I like to sit near them, be interactive, and use a tender touch. The time period I went through nursing, touch was encouraged. Now that social distancing is the only way to be around people, I feel empathy and tenderness have been removed, to a certain degree. If a nurse doesn't get creative, the care given seems cold and distant. I look forward to the going back to the time of being "present" in all the sense of the word.*

The inability to provide care and interact with colleagues in ways that align with personal perceptions of nurses and nursing, was found to trigger feelings of uncertainty, conflict and disappointment.

*Being ostracised by others, especially other health care workers, because we were perceived as "unclean" was devastating on our psyche. We went from loving being nurses to questioning why we were in this profession. I have been a nurse for 34 years and have never experienced anything like this. Not with Ebola, not with H1N1, not with SARS. The mistrust of each other, the raging over mask mandates, the uncivility [sic] of people with each other.*

*(Frontline RN with 34 years of experience)*

TABLE 2 Pandemic perspectives: theme table

Global theme	Description	Supporting excerpts
The process of personal and professional evolution	These stories describe and document individual and collective transformations in clinical practice, roles, self-care, and professional perspectives and philosophies. Never static, these transformations are constant and evolutionary	'Before this pandemic I was a really busy person, always on the go. I tried to fit a lot into every day, but I find that I'm now a little more conscious of slowing down—number one, because I was forced to, but because I really enjoy it now, and just really living in the moment.' (#261 RN with 34 years of experience) 'So here is a post I sent to my team. "Reflection time: Look at where we started and look at where we are now. When 18 patients gave us anxiety beyond belief and now at 30+ patients, we are strong and undeterred. We are now consultants to another floor of nurses and even to some doctors. We have been creative, smart, brave, and could not be more proud [sic] of the floor and hospital I work at"'. (#82: RN with 13 years of experience)
Organizing theme		
The art and science of pandemic nursing	The pandemic impacted what it means to practice as a nurse by altering how the art and science of nursing are realized	'As a non-clinical RN, I was horrified to learn that I was being forced to return to "floor" work. I have not worked on the floor in over 10 years! Furthermore, who in their right mind would send inexperienced nurses to care for patients during a pandemic?? For 12 hours?? I was upset. I was angry. I was deathly afraid ... of contracting COVID or bringing the virus home to my family that included young children and elderly parents. I had to remind myself that I had participated in a medical mission trip in Kenya, so certainly I could do 3 shifts here! Keeping that in mind gave me the courage I needed to show up.' (#105, RN researcher with 7 years of experience)
Basic themes		
1. Moral identity Disruption	1. There are indications in the stories of moral identity disruption precipitated by the challenges of pandemic nursing. Moral identity disruption occurs when a nurse's ability to provide safe patient care is perceived as compromised	1. '[It] is now 6 months later & the fear is certainly under much better control, but it will never be gone as it seems we will be in this longterm state of caring for these patients until a vaccine is available. At times, it feels never ending & I am certain this has permanently changed how nursing care is provided.' (#319, RN with 36 years of experience)
2. Wholeness	2. Nurses expressed that an initial tendency toward self-preservation evolved into heightened holistic self-care efforts to preserve a sense of personal wholeness	2. 'Self-care is of the utmost importance. Rest and hydration is a must to keep all healthcare providers going. Reflection after your shift is a must- this self-reflection will enable us to continue forward. Knowing that by my mere rounding, the staff appreciation was enormous-time- giving of yourself in whatever way possible is a must'. (#376: RN executive with 35 years of experience)
3. Meaning-making of the Patient Experience	3. The perception of patients' experiences of pandemic care deeply impacted nurses on both a personal and professional level	3. 'I will never forget you. Your legacy, your smile, your funky hair, the way you cracked a joke when you could not even take in a deep breath. Your love for others and life and spreading joy. All of us were so hoping you would live. And you still do in a way, in our thoughts and spirits. A little piece of you lives on every time I can get a patient to smile or laugh despite their suffering. I think every nurse has their "one" patient who impacted them so deeply, they still can remember every detail of interaction even years later. You are my "one"'. (#263: RN with 1 year of experience)
4. Acknowledging the Loss	4. Grief was frequently expressed for the loss of patients on a scale never before experienced as well as the loss of long-established ways to provide safe and holistic nursing care	4. 'No [sic] more than ever I have had to comfort patients missing their family that cannot see them. Patients that have not spent a night away from their spouse in years. I have cried more with patients then I ever thought I would and FaceTimed with strangers I have never met just so they could see their loved ones'. (#377: RN with 3.5 years of experience)
Organizing theme		
Persisting despite challenges	A sense of determination to provide the best patient care possible, referred to by some as a calling, in spite of unprecedented challenges was pervasive throughout the stories	'As I grapple with upcoming rent, homeschooling my children, recovering from COVID, and returning to work to don reused PPE, I know that I am exactly where I need to be in this moment'. (#7: RN with 10 years of experience)

TABLE 2 (Continued)

Global theme	Description	Supporting excerpts
Basic themes		
1. Teamwork	1. The key factor contributing to nurses' determination to provide high-quality patient care was teamwork.	1. 'I started my residency in ... in the midst of the pandemic. It was with a sense of importance, excitement and fear as I entered my new role as a medical professional. With exceptional teamwork I have managed [sic] to work through some really rough shifts, where stress levels have been high and possible emergencies only one small step behind me'. (#426: RN with 4 months of experience)
2. Gratitude	2. The practice of gratitude was consistently cited as a means for diminishing the effects of uncertainty and stress experienced by nurses	2. 'I'm thankful and honoured to be in a profession where there are so many of my peers willing to risk their lives on the front lines'. (#431: RN with 19 years of experience)
3. Spirituality	3. Many RNs met the challenges presented by the pandemic by relying on their faith and spirituality	3. 'Without the medications and my therapy appointments and my faith in God, I would be a complete mess'. (#329: RN with 32 years of experience)
Organizing theme		
Learning as we went	The ever-changing nature of the care protocols for COVID-19 presented extraordinary challenges for both nurses and their healthcare organizations.	'I hate that I had to see the "Guess and Check" side of medicine where the physicians say, "I do not know, but let us try it and see what happens" in last attempts it is better than doing nothing'. (#104: RN with 3 years of experience)
Basic themes		
1. New Registered Nurse	1. New RNs expressed anxiety and grief over the disruption of a traditional orientation experience	1. 'I am a apart [sic] of...a nurse residency cohort. I had been on my own as a nurse on my floor for about a month before our unit became strictly COVID patients. I remember how we started with less than 10 patients with COVID. I also remember coming to work and suddenly being told I was taking care of COVID patients of my own...as a brand new nurse. I was completely taken off guard and unprepared. I was terrified. I held in tears as I got report from the day shift nurses'. (#374: RN with 8 months of experience)
2. Organizational Response	2. The organizational response to the myriad challenges presented by the pandemic directly affected nursing practice and nurses' ability to adjust to the shifting healthcare landscape	2. 'Even during the early HIV outbreak years...I wasn't afraid because we had all the PPE we needed & blood is visible; this virus is not. There was little known about Covid in the beginning & the scarce PPE & conservation measures to reuse PPE only increased the fear'. (#319: RN with 36 years of experience)

#### 4.1.2 | Wholeness

Appreciating the multifaceted nature of the nursing experience lends itself to the concept of 'wholeness'. In their attempt to remain physically, emotionally, mentally and socially 'whole', many nurses shared insights into how their initial focus on self-preservation evolved into self-care as they considered implications for the future state of self—both in and outside of the nursing profession.

*I lost my daily routine. I stopped reading, meditating, working out, and eating healthy. One day it hit me that I needed to get back to my routine, make the best of each day and focus less on not knowing what the next day would bring but be grateful for the moment. I started doing yoga, running, reaching out to old friends, reading, meditating, facetimeing my family and going to bed early regularly. Quickly my perspective on covid changed. Maybe this was the change I needed,*

*maybe this was the reminder that I needed to appreciate the small things and stop focusing on what the future will bring.*

*(Frontline RN with 3 years of experience)*

#### 4.1.3 | Meaning making of the patient experience

Participants routinely shared personal perspectives of patient experiences and how those experiences, having been shaped by evolving policies and procedures related to the pandemic, affected their practice, specifically their ability to fulfil roles they seemed to associate with the art and science of nursing. These experiences and range of interactions influenced perceptions of themselves and their care. A frontline nurse with 1 year of experience said, "A mask, gown, shield and gloves have put a damper on one of the most fundamental aspects of being human. A patient with long term [sic] HIV told me it was the 80's [sic] all over again. On the other side of the

shield, I wept." The idea of compassionate care would likely most closely align with the art of nursing. However, compassionate care should not only apply to how nurses care for people, but also how they care for themselves.

#### 4.1.4 | Acknowledging the loss

The notion of self-care being an aspect of the art of nursing was highlighted in the grief experiences shared by participants. Their grief experiences were shaped by both personal and collective experiences of pain and suffering. Most participants expressed a sense of profound loss associated with frequent deaths of patients, family members and friends, unmet expectations and abrupt changes in professional roles. A majority indicated that they had not experienced this level of loss during their professional careers, and in an effort to bear witness to these experiences, they acknowledged the suffering and pain of their patients, colleagues and themselves. It was this self-compassion and care that seemed to help these nurses overcome feelings of helplessness and hopelessness. As one frontline nurse said, "If death teaches us anything it'd be the importance of cherishing life and the people around us, to find joy in the small things and to not leave things unfinished. By doing so and by giving and receiving more love than I ever have before, I think I'll be able to recover and heal" (Frontline RN with less than 1 year of experience).

## 4.2 | Persisting despite challenges

Nurses described the process of persisting despite the potentially overwhelming emotional and logistical challenges created by the COVID-19 pandemic. Nurses in our sample described three basic tools that they relied on to fulfil their perceived duty to their patients: teamwork, gratitude and spirituality (Table 2). Strong emotions such as extraordinary fear, stress and anxiety, uncertainty, grief and loss, and feelings of isolation were mentioned to some degree by all participants. Nurses shared stories rife with fear of the unknown and of stress related to managing nursing practice, specifically long-held beliefs about the art and science of nursing, in completely new ways. A frontline nurse with 6 years' experience said, "There is no doubt that this has been the most difficult time in health care for my time [sic]. Stress, anxiety, fear... are all things that we have overcome to continue to deliver care to our patients."

### 4.2.1 | Teamwork

The theme 'persisting despite challenges' was reflected in the collective desire among nurses to continue 'showing up' both for their colleagues, as well as their patients and the community at large. Participants expressed a desire to provide the best care possible

despite the abundance of challenges associated with caring for a community reeling from the novel coronavirus. Participants identified that the key component in achieving this common goal of persistence was teamwork and support from their colleagues. Teamwork was deemed crucial in encouraging one another, sharing best practices and information, as well as creating workplace efficiencies. Teamwork appears to have helped associates remain committed to their work despite adversity.

*What will remain with me forever is the excellence of our nursing team, who each day give it their all to help those under their care. The positive attitude of our nurses and PCTs (patient care technicians) and entire team as they continue to meet the daily challenges presented to them on a daily and minute by minute basis.*

*(Non-frontline nurse with 35 years of experience)*

### 4.2.2 | Gratitude

The sustained commitment and sense of duty to continue working were also framed and grounded in gratitude. Even in the context of uncertainty and stressful experiences, participants consistently reported an intentional focus on gratitude as a means of fatigue and burnout mitigation. For a majority of participants, the appreciation for family, community and organizational support, connectedness to coworkers and positive patient outcomes helped foster feelings of mental well-being and counter anxiety in stressful work situations. A unit manager with 10 years' experience shared, "But the experience in general, very much life-changing and we're just grateful to be alive and proud of our care - I couldn't be more proud of the facility I work for because I trusted the people that took care of my husband, and I trust them to take care of everybody else as well." Another non-frontline nurse with 19 years of experience declared, "I am so grateful for such a fulfilling career as a nurse and all the wonderful people who support me at work daily."

### 4.2.3 | Spirituality

Many participants spoke about the importance of spirituality and religious faith in their ability to persevere through moments of uncertainty and distress. For them, a deliberate focus on faith and prayer was a strategy they often utilized to remain hopeful, as well as to renew or reinforce their sense of purpose. In reference to her team, a nurse with 5 years of experience as a manager and 17 as an RN asserted, "By the morning we were proud of the work we had done. We followed our Christian values and prayed for the community at the end of our shift." Many reported finding comfort and a sense of optimism associated with their religion. "My faith continues to comfort me as we wait for this pandemic to become [sic] under control," was stressed by a non-frontline RN (with 36 years of nursing experience) in the early stages of the pandemic.



### 4.3 | Learning as we went

The skilful adaptation to the progression of the COVID-19 pandemic is reflected in the theme of 'learning as we went', supported by two basic themes of the new registered nurse and the organizational response. This process was shaped and affected by the organizational response to resource allocation, perceived support (e.g. additional orientation time), as well as years of experience and tenure. It is imperative to frame this process of learning as one with both positive and negative repercussions. To be sure, these instances were sometimes considered opportunities for personal growth, but most participants expressed an overall sense of fear and exhaustion that were associated with constant change.

*We were unfamiliar with the virus, the incubation period, the extreme contagious nature of it and what to do about it. We were changing processes daily, sometimes hourly as we moved through the beginning phases. We really knew so little.*

*(5 years experience as a nurse manager, 17 as a nurse)*

#### 4.3.1 | New registered nurse

Embarking on a new career in nursing requires tenacity, courage, flexibility and dedication. Nursing can, at times, be overwhelming, yet satisfying. The adaptive nature of nursing practice in the context of the COVID-19 pandemic has been maximized. Newly licensed nurses experienced a profound challenge as they entered the nursing profession. They were challenged to transition into a new profession while simultaneously being expected quickly to: develop new skill sets; manage stress, anxiety and exhaustion; absorb and adhere to frequent policy and practice changes; and care for people with a complex, unknown condition.

*I am a part of a new nurse residency cohort. I had been on my own as a nurse on my floor for about a month before our unit became strictly COVID patients. I remember how we started with less than 10 patients with COVID. I also remember coming to work and suddenly being told I was taking care of COVID patients of my own ....[sic] as a brand new nurse. I was completely taken off guard and unprepared. I was terrified. I held in tears as I got report from the day-shift nurses.*

*(RN with less than 1 year experience)*

As the pandemic abated, many newly licensed frontline nurses reported feeling lost as they transitioned from practising on newly created COVID-19 units back into the specialty they were initially hired (e.g. postpartum).

*So when we went back to our "normal", I was still a baby nurse who had only been on my own for one month before*

*going into full on COVID. I had to relearn and adjust again. I am still adjusting. I deal with anxiety a lot and go to work overwhelmed most days. I try my best. I know COVID had an effect on us all. It definitely had an effect on me as a brand new nurse. I am proud I got to serve in this Pandemic, but no one can prepare you for it and the aftermath.*

*(Frontline nurse with less than 1 year experience)*

#### 4.3.2 | Organizational response

The COVID-19 pandemic created a multitude of challenges for healthcare entities. Nurses acknowledged that organizations were also 'learning as they went' while simultaneously doing what they believed was best for their workforce and community. This dynamic learning and adaptive process was apparent in resource utilization and allocation (e.g. personal protective equipment), as well as frequently changing policies and procedures (e.g. visitor guidelines). There was a consensus among participants that organizational leadership response to supply shortages, care complexities and uncertainties influenced their ability to adapt to these changes.

*Supplies that we took for granted in the context of "they are always there and always will be" now were gone, fit testing upon fit testing occurs as levels of supplies dwindle; gowns that we are used to, no longer exist. Re-using supplies and bundling of care for the safety of all now occurs ... creative staff with positive demeanors ... they smile and are proud to be here to continue the remarkable work they have always done, just now in a different way. I'm grateful for the support of our management team.*

*(Non-frontline nurse with 35 years of experience)*

## 5 | DISCUSSION

Our study highlights the various ways in which the COVID-19 pandemic impacted nurses through the overarching theme of the process of personal and professional evolution supported by three main themes: the art and science of nursing during a pandemic, persisting despite challenges and learning as we went. Although some aspects of the themes are reported in other studies—for example, the idea of learning as we went (LoGiudice & Bartos, 2021)—the personal and professional evolutionary process as revealed throughout the three main themes has not been previously described in the literature. The nurses in our study found themselves learning and evolving in real time, without specific frameworks for patient safety or self-care, or direct evidence to guide practice structure. This dynamic process of evolution was not only enlightening and challenging at times, but it was also devastating when personal safety and patient care delivery were perceived as compromised.

Because nursing schools are tasked with educating nurses to become proficient in caring for people in the most vulnerable moments

of their lives, nursing is undergirded by professional values and ethical principles that pervade all aspects of practice. These core values (e.g. altruism and integrity) and principles are a starting point for ethical behaviour and personal integrity (Chitty & Black, 2007). In other words, nurses use a combination of their personal and professional values and experiences to formulate what they believe to be the characteristics of a 'good nurse'. Discourse between moral identity and the professional duties and obligations of nurses is likely to arise when internal and external situations and factors occur that evoke uncertainty, fear and vulnerability. According to Schmidt (2011), (discourse) "requires agents who articulate and communicate their ideas in exchanges that may involve discussion, deliberation, negotiation, and contestation."

Along with strong core principles and values bolstered by effective discourse, it is important to consider the contextual factors that influence the moral identity of nurses. Peter et al. (2018) suggest that there tends to be a reciprocal relationship between the strength of nurses' moral identity and their feeling like the care they are providing is having a positive impact on the health and well-being of their patients and community. According to Chrisinger (2021, p. 10), "Trauma is trauma. Viewed through a less clinical and more philosophical lens, these sorts of trauma might best be described as events that split life into two. Before the event, there is wholeness. After the event, there is fracture. Where there was once some semblance of safety and security, dignity and peace, there is now fear and hopelessness, pain and grief." It is this process that healthcare entities and organizations must recognize, accept and adapt to create a workplace that supports the mental and emotional well-being of its staff in effective, sustainable ways.

Understandably, the pandemic evoked a gamut of emotions evident in our study, including pride, fear, anxiety, grief and gratitude—emotions that nurses describe having to manage both personally and professionally. Coping with extreme emotions and adapting to new, untested models of care and workflow while interacting with patients in the 'COVID reality' affected both the art and science of nursing. Therefore, evidence of moral identity disruption is apparent in many of the narratives submitted, particularly those submitted by newer RNs. However, even experienced RNs expressed grappling with changes in patient care that demanded compromise of established practice and professional values.

Our sample of nurses described the compounding effect of overcoming logistical challenges in the presence of strong psychosocial emotions. The complexity of addressing the logistical challenges for nursing practice created by the COVID-19 pandemic is consistent with findings from recent studies (Góes et al., 2020; Yuan et al., 2020). Themes like extraordinary fear (Góes et al., 2020), stress and anxiety (Chidiebere Okechukwu et al., 2020; González-Gil et al., 2021), uncertainty (González-Gil et al., 2021), grief and loss (Hofmeyer & Taylor, 2021; Nyatanga, 2020) and social isolation (Luo et al., 2020) are also consistent with previous work about healthcare workers during the pandemic. The nurses in our sample relied on teamwork, gratitude and spirituality to persist despite the potentially overwhelming circumstances. Even still, their stories contained beginning signs of moving beyond moral identity to moral identity disruption. This shift

further illustrates the need for healthcare entities to create opportunities to influence moral identity development in ways that leave nurses 'whole' and able to care for themselves and the community effectively. Future work should also investigate how the presence of moral identity disruption has evolved as the pandemic endures.

The last of the organizing themes, 'learning as we went', featured prominently in the nurses' stories in our sample. Our findings echo the work of LoGiudice and Bartos (2021) in which two of their five overall themes are: "Theme 1: What's the Protocol Today? Where, Oh Where, Is the Research?"; and "Theme 2: Family Ties Broken: How Nurses Bridge the Gap" (p. 19). Nurses in our study repeatedly described their frustrations with the lack of and changing evidence during the pandemic together with their ethical and moral distress in delivering quality, compassionate management for their patients and their significant others.

Furthermore, some degree of real-time adaptation was expected because of the novel nature of the virus. However, the prominence of this theme in our findings also reflects the need to increase two key roles in the hospital-based nursing workforce: nurse educators and nurse scientists. This theme lays bare the consequences of healthcare systems operating with increasingly limited nurse education departments (Mlambo et al., 2021). It also exposes how few nurse scientists are both working in hospital systems and actively conducting nursing care delivery and/or workforce research. For example, fewer than 1% of U.S. nurses have a doctoral degree, and of those only an estimated 3% with a research-focused doctoral training program work in a hospital as principal investigators in a nursing research-based role (National Institutes of Health, 2018; Nursing Management, 2017; U.S. Department of Health and Human Services, Health Resources and Services Administration, 2010).

## 5.1 | Implications for practice

As we emerge from the pandemic and look to the future, the nursing profession can take actions now to address the themes identified in our study. To support the pandemic-related disruptions in the art and science of nursing, organizations, leaders and colleagues can begin by acknowledging the extensive grief and loss in local (e.g. daily huddles) and national venues (e.g. system-wide initiatives). Grief can be complex and individualized, and as such a multi-faceted approach may be most useful (Wallace et al., 2020). For example, organizations could provide direct access to a mental health worker (Shore et al., 2016; Wallace et al., 2020) via a hospital code (e.g. 'Code Lavender') which could deploy a chaplain or other mental health support team member to an area of the hospital to provide listening sessions and comfort supplies for acute distress (e.g. items that attend to the five senses such as snacks or beverages; essential oil patches, compresses, diffusers, soothing sounds, weighted blankets, etc.).

Apart from an individualized approach, the work environment can be adjusted to support coping with grief and loss (Gibson, 2017; Wallace et al., 2020). These adjustments include being adequately staffed to allow for break time to disconnect from the traumatic

event; adequately preparing nurses for their response role via sufficient training and education; making nurses aware of local resources and services to refer patients and families for additional assistance; and having adequate supervision and peer support while facilitating patient care (Gibson, 2017; Wallace et al., 2020).

Leaders should look for evidence-based strategies to promote teamwork (Lacerenza et al., 2018; Rosen et al., 2018), gratitude (Aryankhesal et al., 2019; Melnyk et al., 2020), and spirituality (Crane & Ward, 2016). One way to do so is to re-evaluate the 'scope creep' that occurred early in the pandemic. Due to personal protective equipment preservation strategies, infection prevention strategies, and solutions to hospital-wide staffing shortages, nurses were asked to shoulder additional tasks that previously were shared among the multi-professional healthcare team (Centers for Disease Control and Prevention, 2020). Tasks such as cleaning and sanitizing patient rooms, delivering and removing patient trays, or phlebotomy can now be reassigned to their appropriate departments to relieve nurses of tasks that had not required skilled nursing care to complete.

Shortening or modifying new nurses' orientation periods was a necessary action for many hospitals during the pandemic, but this truncation has also contributed to increased turnover and burn-out among our newest colleagues (Turale & Nantsupawat, 2021). Organizations need a solution that will nurture early and essential professional development while also addressing increased staffing needs. One possible solution is for hospitals and nursing schools to work in partnership to conditionally hire pre-licensure students who are entering their capstone training hours. This strategy allows students to train as pre-licensed in the unit in which they will be working post-licensure, which will probably shorten orientation time for both the nurse and hospital post-licensure.

Three actions may minimize the theme of 'learning as we went' in future pandemics. First, direct national and local efforts to increase the number of research-focused, doctorally prepared nurses. Next, increase the number of nurse educators and nurse scientists working in hospital systems and involve them in leadership planning, strategizing and operational decision-making. Because of their integrated roles in the healthcare system, clinical nurse scientists are best positioned to expediently produce care-delivery and workforce evidence. Since they are familiar with the key stakeholders and the system's operations, clinical nurse scientists can operate efficiently and effectively to produce both retrospective and prospective research. Lastly, ensure that nurse scientists lead or support research-related efforts in hospital systems. By doing so, hospital systems can ensure the production of high-quality evidence to guide nursing care delivery and workforce decisions.

## 5.2 | Limitations

The recruitment methods utilized in this study led to a sample that was predominantly female and non-Hispanic white. As a result, some groups of nurses were underrepresented in our sample such

as people who identify as male and those who identify as racial and ethnic minorities. It is unknown how their stories may be similar to or different from those in our sample. To ensure a representative sample, future research should incorporate targeted recruitment strategies. This study design did not involve contacting participants to ask follow-up or probing questions, so findings are limited to the stories as-submitted. However, these stories capture nurse perspectives in their own words, the content of which was determined by the participant at the time of submission. As such, they represent what the nurse perceived to be the most important narrative to offer at that moment. Finally, the nurse experience has evolved over time. This cross-sectional collection of stories represents a snapshot of experiences at a particular moment in time, but it is unknown how these individuals' perspectives have evolved since their submissions. Future studies should examine the nurse experience through the arc of the pandemic.

## 6 | CONCLUSION

Nurses are agents of change. As such, they occupy a unique position in the creation of formative, historical reflections, policies and processes for navigating the current and future pandemics. The Pandemic Perspectives program is vital for facilitating our understanding of the effects of the COVID-19 pandemic on nurses' experiences, their practice and the experiences of their patients. Effective professional evolution—and, it can be argued, the evolution of healthcare—requires a re-evaluation of how healthcare organizations acknowledge that nursing and nurses have changed. The knowledge gained from this program can be used for such a re-evaluation and will enable us to inform policies, guide hospital management, anticipate long-term health needs to allocate resources accordingly, identify lasting innovations and provide evidence-based recommendations for management of future pandemics and other healthcare crises.

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## APPENDIX A

### Pandemic perspectives: Prompts

- Talk about your shifts at work right now. How are things different from work before COVID-19?
- What have you felt since the pandemic began? Think about your experiences mentally, emotionally and physically. What changes have you noticed?

- Have you noticed changes in any other areas of your life? Please talk a little bit about those changes.
- What has been the most difficult thing for you about the pandemic?
- Have you had any positive experiences?
- What have you learned about yourself that you did not already know?
- Has anything surprised you about working during this time?
- Think about things like keeping families connected, conserving use of PPE, supporting each other, connecting with patients or anything else that you and others have thought about or done.

What kinds of things have you or anyone you work with done to problem-solve during this time? What are people doing to deal with things that are challenges during this time? How have these ideas been used and how did they work out?

- Without including any identifying information, please discuss a patient experience you have had during this time that was significant to you.
- How has your journey informed how you'll move forward?
- What will remain with you forever?
- How will you recover and heal?
- Is there anything else you want to talk about?

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