# "I Called us the Sacrificial Lambs": Experiences of Nurses Working in Border City Hospitals During the First Wave of the COVID-19 Pandemic

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## Abstract

**Background:** The first wave of the COVID-19 pandemic had a significant impact on the personal and professional lives of frontline nurses.

**Purpose:** The purpose of this descriptive phenomenological study was to explore the experiences of Canadian Registered Nurses (RNs) working in Ontario or United States hospitals during the first wave of the COVID-19 pandemic.

**Methods:** Semi-structured interviews were conducted with 36 RNs living in Ontario and employed either at an Ontario or United States hospital. Three main themes were identified across both healthcare contexts.

**Results:** 1) The *Initial Response* to the pandemic included a rapid onset of chaos and confusion, with significant changes in structure and patient care, often exacerbated by hospital management. Ethical concerns arose (e.g., redeployment, allocation of resources) and participants described negative emotional reactions. 2) Nurses described *Managing the Pandemic* by finding new ways to nurse and enhanced teamwork/camaraderie; they reported both struggle and resiliency while trying to maintain work and home life balance. Community responses were met with both appreciation and stigma. 3) Participants said they were *Looking Forward* to a "new normal", taking pride in patient improvements, accomplishments, and silver linings, with tempered optimism about the future. Many expressed a reaffirmation of their identities as nurses. Differences between participants working in the US and those working in Ontario were noted in several areas (e.g., initial levels of chaos, ethical concerns, community stigma).

**Conclusions:** The COVID-19 pandemic has been very difficult for nursing as a profession. Close attention to post-pandemic issues is warranted.

The first wave of the COVID-19 pandemic put an unprecedented strain on healthcare systems worldwide and caused devastating effects on the mental health and wellbeing of healthcare workers, especially nurses (Pappa et al., 2020). The severity of patient illness and the high volume of patient deaths caused ethical dilemmas and moral challenges related to patient care (Kackin et al., 2020). A lack of personal protective equipment (PPE) and chaotic response on behalf of hospital organizations contributed to high stress levels (Halcomb et al., 2020; Kackin et al., 2020; Tan et al., 2020). Constant close contact with infected patients caused healthcare workers to fear for their own health and safety and that of their families (Crowe et al., 2020; Halcomb et al., 2020; Kackin et al., 2020; Lapum et al., 2021a; Liu et al., 2020; Sheng et al., 2020). These problems associated with the COVID-19 pandemic resulted in increased symptoms of depression, anxiety, stress, and other traumatic symptoms among healthcare workers (Crowe et al., 2020; Gao et al., 2020; Havaei et al., 2021; Kackin et al., 2020; Liu et al., 2020; Sheng et al., 2020; Tan et al., 2020), as well as changes in eating habits, sleep disruptions, and alcohol/substance abuse (Galehdar et al., 2020; Sheng et al., 2020). In many healthcare settings,

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nurses had already been reporting high levels of understaffing and burnout prior to the advent of the COVID-19 pandemic, which worsened these pre-existing issues (Bourgeault, 2021; Lasater et al., 2021).

Qualitative studies with nurses during the COVID-19 pandemic have identified a variety of stressors in this population. Nurses reported that a decrease in work shifts led to financial hardship and job insecurities (Halcomb et al., 2020). For many, adjusting to a new working environment, new and rapidly changing protocols (e.g., changes in patient codes, patient care practices) and wearing cumbersome PPE for excessive periods of time contributed to exhaustion and burnout (Liu et al., 2020; Sheng et al., 2020). Nurses described distress at failing to meet their own pre-pandemic standards for patient care (Gao et al., 2020; Halcomb et al., 2020; Kackin et al., 2020; Sheng et al., 2020; Tan et al., 2020). Those who were redeployed to units for which they did not have the appropriate training or experience described elevated stress and tension that affected work performance (Liu et al., 2020).

Pandemic intensity, as well as nursing and management practices, have varied significantly across Canada (Detsky & Bogoch, 2020), with Ontario having one of the highest case counts in the first wave of infections (Government of Canada, 2021). Likewise, pandemic intensity and healthcare practices vary significantly between Canada and the US, which is consistent with significant pre-pandemic differences between the two healthcare systems (Villeneuve & Betker, 2020). Unlike many US states, Ontario's nursing workforce is mostly unionized (Canadian Federation of Nursing Unions, 2021); however, this coupled with ongoing cuts to the Ontario healthcare system (Ontario Hospital Association, 2019) has given rise to a lack of entry-level full-time nursing positions (Freeman et al., 2012) and pay concerns for RNs (Macnab, 2021). As a result, many RNs who live in border cities seek employment in the US (Freeman et al., 2012); in Southwest Ontario, it is estimated that 20% of RNs living in cross-border counties work full or part-time in the US (Hall et al., 2009).

During the first wave of the COVID-19 pandemic, nurses who held positions on both sides of the border were forced to choose between working exclusively in Canada or the US (Coletta, 2020). Cross-border nurses have also faced significant challenges due to political pressure and conflict caused by differing responses to, and intensity of, the pandemic (Fraser, 2020) as some US border cities were early emerging "hot spots" in the first wave of the pandemic.

The purpose of this qualitative study was to capture the lived experiences of Canadian RNs working in hospital settings in either Ontario or the US during the first wave of the COVID-19 pandemic (i.e., March-June 2020). Given the proportion of Canadian RNs who commute to the US for work, our secondary goal was to capture the specific challenges caused by the pandemic related to different healthcare systems, different hospital management practices, and different epidemic intensities, while holding constant the challenges related to home living situations.

## Methods and procedures

### Participants

We recruited RNs living in Ontario, Canada, and working in acute care hospital settings in either Ontario or the US for interviews in May and June of 2020. In the city where interviews were conducted, many nurses commute across the Canada/US border daily and have held permanent jobs in American hospitals for many years while residing in Ontario.

### Procedure

All research protocols were cleared by the researchers' university-based Research Ethics Board (REB# 36968). A recruitment advertisement was circulated through several local nursing listservs (e.g., professional groups, alumni lists for the local university, sessional instructors for the local university). Word-of-mouth and snowball sampling (Johnson, 2014) were also used to recruit additional nurses. Several nurses volunteered to share recruitment details with friends and family who were nurses; others posted study details in private Facebook groups (e.g., for Canadian nurses working in the US) or in their breakrooms at work.

Interested participants contacted us by email or by phone to express their willingness to participate. They were then sent the informed consent form to complete, along with a calendar invitation to set up an interview time. Participants emailed their completed and signed consent forms to a research assistant prior to their interview. Inclusion criteria were the following: 1) current licensure as an RN and 2) current employment in an Ontario or US hospital. Exclusion criteria included: 1) non-RN nursing licensure (e.g., licensed practical nurse, nurse practitioner) and 2) employment in a setting other than a hospital (e.g., long-term care home, family practice).

Interview questions were structured around three principal domains: general experiences working in hospital settings during the COVID-19 pandemic (e.g., "Tell us about your experiences so far working during this pandemic"), identified stressors (e.g., family health concerns, finances, moral injury), and coping strategies, including follow-up questions where indicated. All interviews were conducted virtually via the Microsoft Teams (MS) platform and in pairs (i.e., one nursing faculty, one psychology faculty), with questions alternating between the two interviewers. Nurses were compensated with a $50.00 Amazon e-gift card. Interviews

ranged from 60 to 120 min with an average of 90 min. Transcripts auto-generated by MS Teams were reviewed, corrected, and de-identified by research assistants. All potentially identifying information was removed (e.g., names of people/hospitals) and each interview was assigned a unique identifier code. De-identified transcripts were reviewed a second time by members of the interview team for quality control.

## Qualitative analyses

The epistemological and ontological framework through which our findings were analyzed was descriptive phenomenology, an ideal approach for use with qualitative data when the goal is to produce descriptions of previously-unexplored phenomena (Giorgi & Giorgi, 2003; Langdridge, 2007; Polkinghorne, 1994). This framework was particularly suitable given how little was known about the COVID-19 pandemic in the spring of 2020 and about its potential impact on healthcare workers. The purpose of such an approach is not to generalize findings to other individuals outside the sample but to better understand the richness of a phenomenon from different subjective realities (Camic et al., 2003).

Our analysis methodology followed Braun and Clarke's (2006, 2013, 2020) *reflexive thematic analysis* (RTA) procedures, which is compatible for use with different ontological and epistemological frameworks. RTA is a method of systematically identifying, organizing, and interpreting patterns of meaning across a corpus of data, guided by research questions and theoretical underpinnings.

Braun and Clarke's phased approach requires familiarization with the data; generating initial codes; searching for themes based on clusters of similar codes; reviewing, revising, and labeling themes; and then describing the themes and their interconnections to "tell an overall story about the data" (Braun & Clarke, 2006, p. 65). Our analytical team comprised two psychology professors with expertise in qualitative analyses, one graduate student, and one undergraduate student. Each analyst read and coded a set of transcripts, noting emergent impressions, observations, interpretations, and reactions. Line-by-line coding was completed, and each code represented an active and specific meaning unit. Analysts then met at biweekly intervals to discuss thoughts, codes, and themes, as well as to reflect critically on the analytical process (Lincoln & Guba, 1985). This iterative process continued until a set of agreed-upon themes were identified by all team members. All meetings were documented, and notes were circulated for further reflection. Each research team member also kept audit trails of how codes were generated and clustered to aid in discussions and interpretations.

## Results

A sample of 36 RNs living in Ontario, Canada, and working in acute care hospital settings in either Ontario ($n = 20$) or the US ($n = 16$) completed interviews. Female ($n = 31$) and male ($n = 5$) nurses ranged in age from 23 to 58 years ($M = 38.06$, $SD = 10.56$), with 1.5 to 36 years ($M = 12.52$, $SD = 9.14$) of experience in the profession. The following units were represented among nurses: medical/surgical, cardiac care, rehab, and ER ($n = 5$); ICU (i.e., adult, neonatal, stepdown and surgical) ($n = 19$); COVID-specific units and field hospitals ($n = 3$); surgery, day surgery, and recovery ($n = 3$); other (e.g., float, oncology, vascular access) ($n =$ ); and labor and delivery ($n = 2$). While most nurses were not redeployed ($n = 24$), several were restationed to a new unit, a COVID-designated unit, or to a community field hospital ($n = 12$).

We identified three themes encompassing participants' experiences during the first wave of the COVID-19 pandemic: (1) *Initial response*, (2) *Managing the pandemic*, and (3) *Looking forward*. Each major theme also encapsulated numerous subthemes, as reported in Table 1. Our analysis also highlights similarities and differences in working experiences between nurses employed in the US vs. those employed in Ontario and offers insight into the unique dimensions of a cross-border workforce during such a precarious time.

### Major theme 1: initial response

Theme one captured the initial response when the pandemic descended on hospitals in Ontario and the US. Canadian

**Table 1.** Nurses Experiences During COVID Pandemic Themes and Subthemes.

| Themes | Subthemes |
|---|---|
| Initial response | Chaos and confusion, rapidity of onset |
| | Rapid changes in structure and patient care |
| | Initial emotional impacts |
| | Management and organizational response |
| | Ethical concerns |
| Managing the pandemic | Changing work relationships and dynamics |
| | New ways to nurse – advocacy and leadership |
| | Life is upside down/significant disruptions |
| | Struggle and resiliency |
| | Community response – stigma and appreciation |
| Looking forward | Changes and reaffirmation of the nursing identity |
| | Balance of anxiety and hope – tempered optimism |
| | Improvements, accomplishments, and silver linings |
| | The "new normal" |

participants working in both US and Ontario hospitals described working within a *rapid onset of chaos, confusion*, with hurried *changes to patient care*, an *overload of information*, all the while attempting to deal with the *emotional impact* of the situation, differing *management and organizational responses* and evolving *ethical concerns*. However, these early impacts differed in intensity between Canadian and US hospital systems and had correspondingly different effects on nurses working in those two systems.

*Rapid onset of chaos and confusion.* US hospitals were not prepared for the rapid influx of COVID patients and were quickly stretched beyond their limits. One Ontario RN working in the US recounted, "We woke up one day and the hospital exploded with a bunch of coronavirus patients. Others recounted, "Our hospital was in surge" and described shortages of key equipment (e.g., PPE, ventilators). RNs working in the US recalled having "to be on your toes all the time…like there isn't enough of me to go around" and expressed significant difficulty "keeping their heads above water" emphasizing "chaos" as the best descriptor of this initial phase of COVID-19.

In contrast, RNs working in Ontario reported a lower level of epidemic intensity, which allowed more time for units to prepare. One Ontario RN recalled, while awaiting a potential influx of COVID patients:

> They [hospital management] made a lot of changes to our units, like tenting, negative pressures rooms, tried to secure PPE, to get as ready as possible. They also made the [field location] to bring the COVID patients to so we could not overwhelm our hospital and separate the residents.

Participants working on both sides of the border reported comparable experiences with rapidly-changing protocols and an onslaught of conflicting information. Many reported that procedures changed hourly, and it was, in the words of one Ontario RN, "impossible to handle the volume of information that was being shared". Guidelines from hospitals and government entities were often contradictory, making it difficult determine proper care procedures. Emails were also excessive, and rarely streamlined, which caused confusion, chaos, and mistrust of management and hospital administrators. An Ontario RN describing the opening of the field hospital said: "Nobody knew how it was staffed. Nobody knew what kind of patients they were taking in."

All participants reported that inadequate PPE caused significant stress. Most reported having to reuse PPE beyond recommended use, and many nurses, particularly those working in the US, brought their own make-shift PPE to work (e.g., raincoats from the dollar store), spent hours searching for equipment, and reported feeling unsafe and unprepared. One RN working in the US explained, "As nurses, the threat of dealing with infectious, transmissible,

and potentially deadly disease is not new. What was new was the idea that we would not be protected".

*Rapid changes in structure and patient care.* Nurses working on both sides of the border were required to effectively navigate rapid changes in structure and patient care; while Ontario nurses working in the US navigated these changes amidst chaotic work conditions. RNs working in Ontario experienced similar expedited changes, but in a more coordinated fashion. "Before this pandemic, we really never proned [placing a patient face down in their bed] anybody, and so that was a whole new experience, especially being newer to the ICU, we were proning everybody," reported one Ontario RN. One nurse working in the US compared their ward to a "MASH camp"; while another working in Ontario described their first month of changing algorithms, critical care team responses, physical construction, PPE requirements as "horrendous".

Safely donning and doffing PPE was a time-consuming struggle, leaving less time for interacting with patients at the bedside and managing basic care. It also led to additional responsibilities for nurses (e.g., housekeeping, blood draws) as changes led to staffing restrictions. Clustering care was a new and mandatory reality, particularly for Ontario nurses working in the US, as echoed by one nurse:

> You're just so distant from your patient and it is one of the hardest things…I'm always, always in my patients' rooms and I know my patients in and out and even to this day, I think it's still one of the hardest things with still working a COVID unit.

Restricted family visitation required nurses in both Ontario and the US to use video chat systems (e.g., FaceTime) to facilitate communication with family members. Many participants reported it was heartbreaking to see patients suffering and dying alone without family.

> Her mother had to stand outside with her hand on the plexiglass, looking in, watching her daughter take her last breath, and we were all just at the nurse's station just crying because we just felt so horrible that we were able to go in and be that person while she was dying holding the hand but her own mother couldn't go in. (Ontario RN)

### Initial emotional impacts

All participants reported feelings of fear, anxiety, and panic coupled with feelings of being devalued during the early stages of the pandemic. Concerns about exposure to COVID and getting sick themselves or passing the virus to family members were ubiquitous. One Ontario RN working in the US nurse explained, "There's no PPEs, but you're literally going into a room where you know it's a positive

COVID patient and they're actively coughing or actively giving breathing treatments."

Many Ontario nurses working in the US bore witness to traumatic loss of life with attendant feelings of helplessness. High morbidity rates, rapid patient deterioration, and shortages of life-saving equipment led to high patient death rates. An RN working in the US described bringing bodies to a refrigerated truck in the parking lot because there was no room in the morgue:

> I worked trauma and so we just stopped intubating patients. And so often, I would bring patients back to the ED to die in the hallway, so I would sit with them and hold them as they died. It happened multiple times where 2–3 min, I put a non-rebreather on them and they would be cuddling me and, I remember I had a [patient] who is like delirious, aspiration pneumonia, I put a non-rebreather on her, I carried her. She must have been 80 pounds soaking wet. I just sat in the stretcher with her and cuddled her until she died.

In addition to fear and anxiety, nurses reported feeling "disposable" to their employers; this was particularly evident from accounts of participants working in the US. They experienced job furloughs, cuts to their pension, and unclear guidelines regarding access to sick leave and COVID tests. Inequitable allocation of duties between nurses and other care providers was also reported. One RN working in the US stated, "The doctors never went in the room, ever, ever. We were the ones that were, you know, I called us the sacrificial lambs".

*Management and organizational response.* In these early days of the pandemic, nurses emphasized the need for clear, transparent, honest communication from management teams, and stressed the importance of managers being available and present for staff. One Ontario RN explained that having management present, "makes people feel like respected, understood and valued. … and it prevents a lot of those ethical dilemmas, and it allows you time to do things in a way that protects you from getting sick."

Frustration and mistrust toward absent US hospital managers and administrators was evident. Again, this sub-theme was documented primarily in transcripts of Ontario nurses working in the US, who expressed greater dissatisfaction with management, particularly in terms of resource allocation and PPE distribution. "None of them were walking into those rooms, experiencing what we were experiencing," said one Ontario participant working in the US. Hospital policies and procedures were described as political or fear-driven, rather than evidence-based. On some occasions, RNs reacted with disbelief when provided with clearly inaccurate information (for example, being asked to share N95 masks amongst one another). Nurses on both

sides of the border reported questioning the honesty and integrity of their leaders for the first time in their careers and feeling disturbed to find themselves in that position.

*Ethical concerns.* Ethical concerns arose from a variety of sources in the initial phase of the pandemic and were more pronounced for nurses working in the US than for nurses working in Ontario. Some nurses reported being redeployed to high-demand areas to manage the first surge of the pandemic without adequate preparation and training. One participant working in the US described how she was redeployed out of her comfort zone:

> Morally, I questioned like, oh my gosh, we have these people that need higher level care, they need critical care nurses. I'm not, I'm not even trained in critical care, so it's not like I was just without equipment, I'm also without training when people are falling that sick.

The reuse of PPE in the US and disparity of who received specific types of PPE also created moral concerns. Many felt that reusing PPE created unsafe working conditions and patient care, while others reported unfairness in distribution of PPE among units and healthcare workers. Anger and frustration were evident:

> That experience of seeing physicians walking around with respirators on and… I, the nurse, have, nothing! I was very angry, very frustrated and I'm literally going in the room, and I have to touch the patient. I'm the one putting the mask on, I'm the one putting the IVs in, I'm the one putting the Foleys in….The physicians can stand there, they don't even have to pull a stethoscope out 'cause all you need is that chest X-ray really to look….The disparity of who gets what, very upsetting, very upsetting. (Ontario RN working in the US)

The allocation of scarce care resources became a critical ethical issue as, without adequate medical resources, nurses and other medical staff had to decide who would benefit most from ICU beds, ventilators, and extracorporeal membrane oxygenation (ECMO); forced do not resuscitate/do not intubate (DNR/DNI) code changes became a reality. Reactions to the death toll were intense among participants. "The patients just didn't receive that like support and dignity that they should receive [when they were dying] and that was kind of the worst of the worst experiences," said one Ontario RN working in the US. Another participant described a nightmarish visual:

> And to know that people are piled [participant crying] in, in, in a truck trailer like, like animals, like garbage, that needs to not be sheltered like they have it at the hospital….the public needs to know that.

## Major theme 2: managing the pandemic

After the initial chaos and confusion, the second major theme encompassed what participants did to manage the pandemic. Many on both sides of the border reported *changing work relationships*, finding new ways to nurse, feeling like *life was upside down* and having to deal with changes in family dynamics and their social lives, *struggles encountered and self-work to become more resilient*, and finally feeling *stigma or being bolstered by their communities*.

*Changing work relationships and dynamics.* A strong sense of commitment and camaraderie emerged among nurses and their colleagues. Many participants reported that they never worked so well as a team. "I feel closer to my coworkers probably than I ever have," said an Ontario nurse. Support from coworkers made the pandemic bearable, whether this was in person, via phone, or in a group chat: "The staff members in the [hospital] ICU are just an amazing group, and I don't think, if it wasn't for them, I think this would have had a lot more impact on a lot of people." (Ontario RN)

Support from management was particularly appreciated, whether this involved providing updates from administrators or advocating for the needs requested by staff:

> My manager specifically was very open about what the plan was going to be….they were very open and just allowed us any questions that we had or any concerns that we had. They made themselves available 24/7. (Ontario RN)

While nurses certainly appreciated support from friends and family, many said that only other nurses could understand their situation. One nurse working in Ontario said, "People that are outside of healthcare, they just don't really understand it the same way", a sentiment echoed by a nurse working in the US: "I feel like anyone who's not a nurse doesn't really get it."

*New ways to nurse – advocacy and leadership.* Participants, having weathered the initial crisis, gradually adapted to their new work situation and practices. Many began to advocate for greater safety and protection, both for their patients and for themselves. Nurses championed for patients to receive the medical care they needed (e.g., tests, procedures) and advocated for visitation from family. The importance of protecting and advocating for themselves was also emphasized, "It was your responsibility to advocate for yourself. So, it was just on your own time, protecting yourself, putting the equipment on without rushing." (Ontario RN working in the US)

Nurses shared the costs of this new approach: time spent advocating for patients took time away from the bedside. "It sucks, like this is not how I want to nurse, but I have to nurse that way to protect myself, to protect my other patient, and to kind of protect my family as well."

(Ontario RN working in the US). Another explained, "All those little things that make nursing so special, I have not done since this began." (Ontario RN working in the US).

*Life Was upside down/significant disruptions.* Changes in social dynamics, living situations, and financial stress were almost universal among participants. The phrase "life is upside down" described disruption in their lives, and how time-consuming the transition from work to home became. Many nurses described removing all their clothing in their garages, showering, donning clean clothing, and wiping any surface they touched before entering their homes. Family members took on the responsibility for errands and grocery shopping so nurses could avoid potentially exposing others to COVID-19.

Social isolation was a big stressor. Those who became sick with COVID confined themselves to one room, venturing out to use the washroom, and had family leave food at the door. A few nurses relocated to a hotel, apartment, RV, or other locations to protect their families. The imposed isolation and not being able to touch, hug, or kiss family members was emotionally difficult. One Ontario RN described an interaction with his toddler: "He's like, 'Hug daddy, hug?' And it's like, 'No sorry buddy, you can't touch daddy.' And he's like, 'Okay, no touch daddy, no touch daddy.' And it's like, 'Ugh!!'"

While some reported taking on mandated overtime, others endured financial stress. Hours were reduced, shifts were canceled, and US nurses were furloughed. "Our hours are very sporadic, like our schedule is almost on a day-to-day basis now, where you can just kind of call you in or cancel you if they don't need you," reported one Ontario RN working in the US. In some cases, partners and family members lost their jobs due to the economic downturn. Others reported that spouses were told not to return to work because they were married to a nurse and there was a perception of increased risk exposure, which often led to feelings of guilt among participants.

*Struggle and resiliency.* In the face of exceptional challenges, nurses exhibited resiliency and dedication to patient care, but many described struggling, both emotionally and physically. Symptoms reported included low mood, anxiety, hypervigilance, nightmares, fear, anger, sleep disturbances, changes in appetite, guilt, loneliness, burnout, physical exhaustion, and impairments in concentration. An Ontario nurse described their journey over time, "I started two months ago….all gung ho and chipper and let's get this COVID… and let's do it and now I'm completely defeated and like exhausted all the time and very—it's affecting my mental health big time." Many participants were tearful and/or cried during the interview process. One Ontario RN working in the US said, "I'm not coping [laughs] and I, I don't know why I'm laughing about it." Another explained the difficulty:

When you work in ICU and in that environment a lot, you tend to, um, distance yourself a lot emotionally from it and you don't really feel it over time, like, you feel the pain and empathy and the sadness, but you don't feel that hard emotion that you do in the beginning of your career. But I feel like everyone has been feeling that hard emotion because this is a whole new process for us (Ontario RN working in the US)

A few participants became sick with COVID and were still experiencing fatigue post- recovery. Multiple nurses described being physically drained, lacking concentration, and sleep disturbances.

Despite their struggles, many shared positive coping strategies and demonstrated resiliency; popular approaches included exercise (e.g., walking, running yoga), time with pets, gardening, reading, listening to music, prayer/meditation and watching TV/movies. Nurses said that they received important emotional support from partners, family members and friends, which was key. Although not explicitly labeled as such, many participants deliberately appeared to adopt positive thinking styles, saying to the interviewers, "at least I have a job" or "at least my family is not sick." (Ontario RNs). A few shared maladaptive coping strategies, often accompanied by acknowledgements that these strategies were less-than-ideal or feelings of guilt. Some reported increased consumption of alcohol (e.g., drinking more days per week, increased consumption) or other substances (e.g., marijuana).

*Community response – stigma and appreciation.* Participants described a polarized response from their communities towards healthcare professionals that encompassed both experiences of appreciation and social stigma. Support and appreciation came in many forms, including applause, parades, free meals, a "hero lives here" signage, and priority lines at community businesses (e.g., grocery stores). RNs working in Ontario expressed appreciation for donations of PPE and food from the community: "It wasn't easy what we were doing, but people understood that and that was good to be a part of." Some expressed the hope that this recognition and appreciation would persist post-pandemic.

However, RNs working across the border reported feeling rejected, ostracized, and "othered" by their communities. One RN working in the US said, "my neighbour said multiple times when I was out with my child walking, 'you're not supposed to be leaving your house, you work in [US city], you shouldn't be outside'". Other nurses noticed hurtful social media comments about nurses working on the US side of the border and felt unfairly blamed as carriers of disease. Others were turned away from banks or refused medical treatments (e.g., X-rays). One nurse working in the US summarized the experiences of many: "A lot of nurses feel ostracized, like the reason why our local COVID rate is high is because of us." Many RNs working in the US removed

signs identifying them as healthcare workers from their cars to prevent vandalism. One person described their hurt:

I think just the news and stuff that we see and just reading some of the comments underneath from fellow [city residents] and how they feel about us has been very hurtful. Uhm, you know, a lot of them are just saying, you know, 'Just live in [US city]!' not thinking the fact that we have family here, that you know we would want to do it, and quite frankly, working in [US city] was not my first choice, I work there because I've got a full-time job.

## Major theme 3: looking forward

The final major theme captured participants' adaptation to their circumstances and their thoughts about the future (as of May/June 2020). Most *reaffirmed their identities as nurses* but had actively reflected on the question. They expressed *tempered optimism* but were concerned about a likely second wave. Many noted *improvements and accomplishments* as the pandemic progressed and worked at remaining positive. Nurses shared *silver linings* they had seen so far and discussed the potential for a *new normal*.

*Changes and reaffirmation of the nursing identity.* The crisis brought on by the pandemic led to re-evaluation of participants' professional identities but, for most, reaffirmation of the nursing identity as well. Most participants reported a strong sense of passion, professional fulfillment, and commitment: "I've always loved being a nurse. Truthfully like it's not something that I've ever regretted….I'm in the right career. I don't doubt that for one minute." (Ontario RN) Another explained, "I feel stronger now than I did before. Like tested, you know." One nurse, however, expressed frustration at colleagues who had taken leave or quit:

I thought, you're a nurse, like, this is what we signed up for. How can you, like, turn your back now on all these people that need us when we knew that a pandemic or some sort of something like this was gonna come in our lifetime of our career. So, I kind of struggled with that a little bit. But, you know, everybody makes their own decisions, and they made that decision for a reason, so I shouldn't really be judgmental about it, but I just couldn't help but feel that initial anger (Ontario RN)

Some participants struggled with ambivalence. "I love being a nurse but… I never signed up for a pandemic," said one Ontario nurse while another working in the US explained, "I didn't sign up for not having myself protected." Another described a conflict in values: "I already felt guilty or potentially exposing my family and I think as a nurse, I would feel even guiltier quitting at a time when we are needed the most." Some reported feeling pressured to leave

their jobs by family members but reiterated their commitment to their patients and their coworkers.

A few nurses found themselves reassessing their careers and priorities, especially those who felt they had been treated poorly by employers. While many did not plan to change their careers, some thought about changing units or hospitals, or going back to school to improve their credentials. Many viewed nursing as a very stable, valuable career but objected to being treated as 'disposable' by administrators.

*Tempered optimism.* As infection rates began to decline, all nurses reported feeling hopeful; however, their hopes were tempered by anxiety in advance of a predicted second wave of infections. Participants expressed concerns about the government's plans for reopening businesses, loosening restrictions, and reopening the Canada/US border. Some nurses observed that pandemic fatigue was resulting in coworkers becoming less vigilant and cautious about PPE usage. "It's an evolving situation, but you can only deal with the day in front of you," said one Ontario nurse.

Many nurses expressed concern about a future mental health crisis, both for themselves and for their colleagues, acknowledging that healthcare workers experienced significant stress during the crisis. Participants working in the US described the trauma of watching patients die due to limited life-saving resources available: "I can imagine just a lot of PTSD in the future from this". They also pointed out that the pandemic added disruption, burn-out, and complexity for new nurses:

> I think we're going to lose a lot of new nurses….I would be working with a nurse…who had just graduated six months ago and they're caring for an ECMO patient. And I'm like how the heck are they like, it's just ridiculous and so I would take over that patient for them. But at the same time, like you can only put so much stress, especially on a new nurse.

*Improvements, accomplishments and silver linings.* As time passed, nurses began to see improvements and positive outcomes from their efforts and the policy changes brought in by management. Patients who had been in hospital for weeks or months and had been near death were able to come off ventilators and walk out of the hospital. Several nurses said that seeing such patients discharged were the best moments of the pandemic to date.

> First COVID patients that came in, he was finally released like a few weeks ago and doing well, and it was – honestly, we thought he was gonna pass away. [His] heart stopped like several times and…it's like a miracle. [laughs] We were just like … there is hope, I guess is what it kinda gave us. (RN working on Ontario).

Several US participants said that their hospitals had instituted a policy of playing a certain song when COVID patients were discharged, which provided them with a burst of energy and optimism after hearing codes the rest of the day.

Nurses described the work that they and other healthcare workers had done as "an overwhelmingly wonderful testament to humankind". Many expressed a newfound appreciation for their coworkers and described their teams as stronger and more unified than ever because of what they had overcome.

> We've never worked so well as a team together. There's a very strong support between the staff right now. And we talked about it at the start of this, that really, if we were going to survive a situation where we were in a surge….we would have to adapt more of a team mentality and instead of it being like, well that's your patient, it's like no, this is this is our job, this is our responsibility (Ontario RN).

*The New normal.* Although the number of new COVID cases gradually decreased, the need for diligent infection control remained. When asked "What will it be like to return to normal?", many expressed doubts that there would be a return to pre-pandemic normalcy. Although nurses expressed a wish to resume regular duties, go back to their own units, and visit with family and friends, most felt that the pandemic would be lengthy. Some felt that COVID-19 would fundamentally change the landscape of infection control in hospitals. They explained that the general public now had greater awareness around infections, hygiene and hoped that healthcare systems would be more responsive and prepared for future crises. Nurses hoped that the lessons learned from COVID might inform and facilitate more effective preparation and responses to future infectious emergencies.

Several expressed the hope that this crisis would precipitate greater funding to healthcare systems after decades of cuts in Ontario. "We need more staffing, a safe patient to nurse ratio, changes to polices to make sure we're properly equipped and proper resources," said one Ontario participant. Another stated, "Hopefully things don't go back to the normal of what they were before, and hopefully… we just go back to like some sort of better safety" (Ontario RN)

## Discussion

Thematic analysis of the interviews illuminated three major themes across interviews, with some notable differences between nurses working in the US and those working in Ontario. Nurses on both sides of the border described the initial response to the pandemic and influx of COVID-19 patients into hospitals as chaotic. They scrambled to find new ways to nurse and shared difficulties coping with redeployment to unfamiliar units, as healthcare workers did in other global hotspots (e.g., Liu et al., 2020; Sheng et al., 2020). They described problems with initial management and

organizational responses, especially related to resource management and distribution (e.g., PPE). Participants expressed ethical concerns related to resource allocation and management of severely-ill patients, a concern also identified in other studies (e.g., Halcomb et al., 2020; Lapum et al., 2021a; Liu et al., 2020; Sheng et al., 2020). The initial impacts of these issues on the nurses included fear, anxiety, hopelessness, stigma, and panic (e.g., Havaei et al., 2021; Galehdar et al., 2020; Gao et al., 2020; Halcomb et al., 2020; Kackin et al., 2020; Liu et al., 2020; Sheng et al., 2020; Tan et al., 2020), with many describing a sense of feeling devalued (i.e., "sacrificial lambs"). Inequities in availability of PPE (Lapum et al., 2021a), in pay increases, and in job responsibilities were highlighted by many nurses.

As the pandemic continued, many participants described ongoing struggles with physical and mental health alongside continuing efforts to engage in self-care, support one another, and build resiliency. The use of coping strategies and focusing on small improvements were common strategies reported by nurses in other investigations as well (e.g., Liu et al., 2020). Participants reported conflicting and upsetting experiences of receiving both stigma and appreciation from their communities.

Nurses expressed frustration about not being able to provide care to the level they felt was adequate, a concern echoed worldwide (e.g., Gao et al., 2020; Halcomb et al., 2020; Kackin et al., 2020; Lavoie-Tremblay et al., 2021; Sheng et al., 2020; Tan et al., 2020). However, participants continued to work toward finding new ways to nurse and discovered new roles related to advocacy and leadership. Similar to findings by Lapum et al. (2021b) they described improvements in work relationships and dynamics and often a closer sense of connection to their teams than pre-pandemic. Outside of the job, they weathered significant disruptions of day-to-day living (e.g., social dynamics, financial issues), a common experience for healthcare workers around the world (e.g., Crowe et al., 2021; Halcomb et al., 2020).

Looking forward at the end of the first wave of COVID-19 infections (May/June 2020), the participants described changes to their experience of the job but fundamental reaffirmation of their nursing identities. They identified feelings of tempered optimism: fears about the inevitable second wave of infections but also feelings of hopefulness and resilience (Liu et al., 2020). They shared improvements, accomplishments, and silver linings from their experiences to date. When asked about what it would feel like to "get back to normal", most said that there would be no return to the previous sense of normal but rather there would be a "new normal", both for their jobs and our reality.

Notable differences emerged in the accounts of Canadian nurses working in the US compared to nurses working in Ontario; many were related to the initial response to the pandemic. Nurses working in the US often described significantly-higher levels of chaos and confusion, having become overwhelmed in a short space of time with COVID-19 patients, which led to insufficient PPE. In contrast, nurses working in Ontario reported having sufficient PPE throughout the first wave along with time to run practice codes in anticipation of COVID-19 admissions. Nurses working in US hospitals also described greater frustration toward management response, particularly related to shift assignments and financial hardships (e.g., employer contributions to their pensions were stopped). They were also more likely to highlight ethical issues (e.g., forced code changes in patients, inappropriate reuse/sharing of PPE), increased job responsibilities, and conflict with healthcare team members outside of nursing. The combination of these stressors exacerbated their emotional response to the pandemic, and they reported more trauma-specific symptoms (e.g., nightmares). However, the mitigating impact of management practices associated with different hospital systems in the US was also clear; whereas some nurses working in the US expressed gratefulness and appreciation for what their employers had done to assist them (some noting that managers had gone out of their way to ensure that supports were available to Canadian employees), others felt that hospital policies had exacerbated their stress. In contrast, most nurses working in Canada, despite also feeling overwhelmed, said that they received adequate support by managers and senior hospital administrators, similar to findings of Bookey-Bassett et al. (2020). Lastly, nurses working in the US reported that they were incorrectly regarded as sources of infection to the Canadian community, resulting in restricted access to needed services and hurtful comments from the public, friends, and family. Nurses working in Ontario highlighted fewer conflicting experiences of community stigma.

Numerous participants reported being uncomfortable with the evolving 'nurse as a hero' narrative. Many stated that although they appreciated the attention and recognition for their work, the label felt inappropriate as their focus was on performing their jobs to the best of their abilities. Nurses may have reported feeling disheartened by hero rhetoric as this language suggests the possession of magical skills or superhuman characteristics (e.g., Einboden, 2020; Stokes-Parish et al., 2020). Participants emphasized their humanity and, like the general population, were not exempt from the emotional impacts and life disruptions of COVID-19.

The heightened anger, concerns, fears, and feelings of stigma raised by Ontario nurses working in the US were compelling findings and speak to how two communities, separated by only a few kilometers, can be impacted at such drastically different levels in a pandemic depending on infection intensity, management practices, and pre-existing differences in healthcare systems. Nurses' pandemic-related stress levels may be influenced by the combination of local infection severity, the local availability of resources, and support from their employing organization. Globally, nurses who live in one community but work in another may be at risk

for significantly different work experiences, and therefore different levels of distress and dysfunction, compared to nurses who live and work in one community.

### Implications of findings

Recommendations and implications for frontline leaders in hospital management made in this study were reported in an earlier publication (Ralph et al., 2021). These included the need for transparent and visible leadership, management of information to avoid overload and confusion, improvements to the healthcare supply chain, human resource issues, clear communication of policies, consideration of equity, and provision of psychological support.

The SARS pandemic that devastated Toronto in 2005 prompted a wave of early retirements and job changes (Shiao et al., 2007); the full impact of the COVID-19 pandemic on nurses is unknown, but is likely to be significantly worse due to the intensity, scope, and duration of the disease. A formal reconciliation process by hospital management and healthcare ministries may be required to recognize and acknowledge errors and mismanagement and to offer apologies and restitution, where possible. Nurses interviewed in May and June of 2020 described themselves as "sacrificial lambs"; as we write these words now following an entire year of COVID-19 in North America and following a devastating third wave of infections, it seems likely that nurses possibly are more given to seeing themselves as "sacrificial lambs." Reconciliation may be especially important in communities where nurses were simultaneously lionized and stigmatized, which may have fundamentally impacted relationships and feelings of community in nurses' own neighborhoods.

### Limitations and future directions

Like most qualitative investigations, the results of this study represent a snapshot of experiences at one point in time for a particular group of individuals. The generalizability of these findings relative to other nurses working in other healthcare settings and/or in other cities is unclear. Though widespread applicability of findings is not the goal of phenomenologically-oriented studies (Moustakas, 1994; Polkinghorne, 1994), some findings may still prove true and useful. It is also likely that participants' responses and coping strategies could be expected to change as the pandemic itself evolved and depending also on local response and infection rates. Nurses' reactions to future waves of COVID-19 infections might depend on the quality of the mitigation strategies deployed by hospital management as well as by their state, provincial, or federal governments. However, aspects of participants' experiences may be represented elsewhere and as such, may be useful in developing appropriate and timely interventions for nurses working in other hospitals. Further investigations should continue to evaluate how RNs are coping and adjusting to the ongoing pandemic now in its third year and throughout vaccine deployment on both sides of the border. Ongoing analysis of the experiences of other healthcare workers, similar to work done in the first wave by Ménard et al. (2022) (e.g., physicians, allied health professionals, non-medical hospital staff), to gather quantitative data on stress and coping may also be warranted. Lastly, continued work should be done to evaluate the ongoing effect of the known Canadian (Bourgeault, 2021) and global nursing shortage (Nebehay, 2021) on healthcare in both countries .

## Conclusion

A total of 36 Registered Nurses (RNs) were interviewed who lived in Ontario and worked in either the US or Ontario. Three major themes were identified: 1) *The initial response*, 2) *Managing the pandemic*, and 3) *Looking forward*. In the first days and weeks of the pandemic, nurses described scenes of chaos and confusion, rapid changes, and confusing responses from management resulting in ethical concerns and feelings of fear and panic. As the first wave evolved, nurses talked about finding new ways to nurse and to manage changing work relationships, while also coping with disruptions to their home life and an ambivalent response from the community; despite their struggles at work and at home, most conveyed a sense of grace and resiliency. Looking forward to the end of the pandemic, nurses talked about developing a sense of tempered optimism, focusing on improvements, accomplishments, and silver linings, and feeling a reaffirmation of their commitment to nursing, while slowly moving towards the "new normal". Differences emerged in the experiences of nurses working on either side of the border, primarily related to the intensity of the first wave of COVID-19 in the US.

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