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Examining effective communication in nursing practice during COVID-19: A large-scale qualitative study

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Abstract

Aim: The aim of this study was to conduct a primary examination of the qualitative communication experiences of nurses during the first wave of the COVID-19 pandemic in the United States.

Background: Ambiguity in ever-evolving knowledge on how to provide care during COVID-19. Remaining safe has created a sense of urgency, which has in turn created the need for organizations to quickly alter their operational plans and protocols to support measures that increase capacity and establish a culture of safe care and clear communication. However, no known study has described communication in nursing practice during COVID-19.

Methods: Utilizing qualitative descriptive methodology, semi-structured interviews were conducted with 100 nurse participants from May to September 2020 and recorded for thematic analysis. The consolidated criteria for reporting qualitative studies (COREQ), a 32-item checklist, were used to ensure detailed and comprehensive reporting of this qualitative study protocol.

Findings: Study participants shared descriptions of how effective communication positively impacted patient care and nursing practice experiences during the first wave of the COVID-19 pandemic. The thematic network analyses identified the importance of effective communication across three levels: (1) organizational leadership, (2) unit leadership and (3) nurse-to-nurse communication. Within this structure, three organizing themes, essential to effective communication, were described including (a) presence, (b) education and (c) emotional support.

Conclusion: Examining existing crisis communication policies and procedures across healthcare organizations is imperative to maintain highly relevant, innovative, and data-driven policies and strategies that are fundamental to preserving quality patient care and supporting optimal nursing practice.

Implications for Nursing Policy and Health Policy: Effective communication is critical to support nurses through extended periods of crisis. COVID-19 represents a unique

contemporary challenge to the nursing workforce given the high stress and prolonged strain it has created for both human and healthcare supply resources. There is value in nurses' presence at local, unit level and organizational leadership levels to convey critical information that directly informs leadership decision-making during unprecedented emergencies such as the COVID-19 pandemic.

INTRODUCTION

The coronavirus disease 2019 (COVID-19) global pandemic has created a sense of volatility and uncertainty in communication across the healthcare arena (Eldridge et al., 2020). Ambiguity in ever-evolving knowledge on how to provide care during COVID-19 while remaining safe has created a sense of urgency, which has in turn created the need for organizations to quickly alter their operational plans and protocols to support measures that increase capacity and establish a culture of safe care and clear communication. Successful navigation during any crisis requires communication that is timely in its dissemination, purposeful in its planning and clear in its directives (Edmonson et al., 2016; Eldridge et al., 2020). Effective communication is a priority and is vital to the performance of healthcare teams (Edmonson et al., 2016).

Nurses are noted in the healthcare workforce as the majority of providers for patient care (AACN, 2019); therefore, nurses' voices should be relied upon to promote communication in patient care that focuses on safety and optimizing clinical outcomes while decreasing uncertainty and distress. Research to date notes that enhanced communication is linked to decreased stress, burnout and fatigue among nurses (Knupp et al., 2018). However, no known study has described communication in nursing practice during COVID-19. Therefore, the purpose of this study was to conduct a primary examination of the qualitative communication experiences of nurses during the first wave of the COVID-19 pandemic in the United States.

METHODS

Study design

This qualitative descriptive study was conducted utilizing methodological design principles in which interviews with study participants were conducted to interpret their lived experiences in nursing practice during the first wave of COVID-19 (Polit & Beck, 2020). Semi-structured one-on-one interviews were conducted by nurse researchers with 100 nurse participants from May to September 2020 and recorded utilizing two digital voice recorders with subsequent verbatim transcription for thematic analysis. COREQ guidelines were followed in the description of the study design, analysis and presentation of findings (Tong et al., 2007).

This study was theory-generating in its design with subsequent analysis grounded in thematic analysis of interview content and development of a conceptual framework. Research team members trained in qualitative methodology examined nurses' experiences during the first wave of the COVID-19 pandemic by conducting semi-structured one-on-one interviews with nurses across the United States from May 2020 to September 2020. The consolidated criteria for reporting qualitative studies (COREQ), a 32-item checklist, were used to ensure detailed and comprehensive reporting of the 100 interviews with nurses. Consideration to ensure validity and rigour were exemplified in this study's 'design consideration, data generation, analytic procedures, and presentation' of finding as evident in the utilization of a self-conscious theory-generating design, purposive sampling techniques, the standardization of the data collection process and the thorough triangulation of data in the analysis (Cypress, 2017).

Ethical considerations

All data collection processes, procedures and formal documentation received proper approval from DePaul University Institutional Review Board located in Chicago, Illinois, USA, Research Protocol #SS041620NUR. All participants completed the study protocol voluntarily and received a gift card for 50 US dollars to an online retailer for their participation. All interviews were completed one-on-one via telephone at the participant's convenience. Participants were matched with interviewers from similar nursing background as well as racial and ethnic background as much as possible to build trust and rapport. The information sheet was read, and verbal consent was obtained from each participant before beginning the formal interview. All participants were ensured of the confidentiality of information shared during the interview. All participants were told they may skip any questions or end the interview at any time with no consequences and were given the information for the DePaul University's Institutional Review Board should they have any concerns they would like to report.

Characteristics of the research team

The principal investigator, an experienced PhD-prepared qualitative public health nursing scientist with formal training from the University of Washington, a globally recognized nursing research institution, was responsible for building the research study team, which at completion included 14 PhD-prepared nurse scientists and DNP-prepared advanced practice nurses from specialities including emergency department, acute care and nursing education settings. All doctorally prepared research team members served in nursing education roles at the time of data collection and were professional contacts of the study principal investigator. The 100 interviews were conducted by 9 doctorally prepared research study team members, each trained in group and one-on-one training sessions by the study principal investigator. In addition, the study team included 10 graduate student research assistants who aided in participant recruitment, data cleaning and data analysis. In sum, the research team was comprised of 23 females and one male. The research team met regularly from May 2020 forward to discuss study progress and the principal investigator debriefed with the research team members conducting interviews in weekly meetings during the study's data collection phase.

Study participants

Prospective study participants were recruited utilizing various approaches, including convenience sampling, purposive sampling and distribution of a digital recruitment flyer through social media platforms. Additionally, snowball sampling was utilized asking study participants, at the end of each completed interview, to recruit colleagues who may be interested in participation. Prospective study participants were told that the study was titled 'an examination of nursing practice during COVID-19' and that the reason for conducting the study was to 'learn more about the experiences of nurses practicing during COVID-19' to understand how the pandemic was impacting the 'nursing profession' and the health of communities. The principal investigator determined the study eligibility criteria for participants based upon the following inclusion criteria: nurses, including all levels of education and areas of practice, who self-identify as having provided nursing care during COVID-19 and can complete the study protocol in English. Exclusion criteria included nurses unwilling to complete the screening or that do not consent to be audio-recorded. To obtain a broad understanding of nurses' experiences providing care during COVID-19, the extensive research study team aided in participant recruitment and data collection, with the effort exerted to obtain participants from traditionally underrepresented groups in nursing research. Prospective participants were asked to complete a screening tool that assessed their demographic characteristics and nursing practice background before the interview was scheduled. This tool enabled the team to recruit a diverse sample of study participants. The study team received over 300 email inquiries from prospective study participants for the 100 interviews funded. With regard to non-participation, the study did not have any participants who refused to participate in the interview after reading the information sheet; however, there were prospective participants who emailed the study team but did not move forward with scheduling an interview.

Data collection and instrument

The interview guide was primarily developed by the principal investigator. The interview guide's content validity was performed by co-investigator (CS), a DNP-prepared emergency department nurse practitioner with 20 years' experience working the front line in one of the country's largest academic medical centres. The interview guide was subsequently reviewed and approved by all research team members across practice disciplines. The interview guide was intentionally developed to be broad and inclusive for utilization across nursing specialities and roles. The interview guide is presented in Figure 1.

Study participants were interviewed by research team members with whom they did not have established relationships as much as possible. All participants were interviewed by research team members with whom they do not practice clinically and all interview matches were checked for conflicts of interest or close established relationships at the time of scheduling and rescheduled with a different research team member when necessary. The data collection took place via telephone in participants' homes. The interviews included the interviewer and interviewee, in addition to the principal investigator during training interviews or a graduate research assistant for education purposes. The research team interviewer began the telephone call by introducing themselves by their first name, identifying themselves as a nurse, and reading the information sheet verbatim. Each interview lasted from 20 to 45 min, dependent upon the study participant's length of responses. Field notes were not formally made during the interviews. No repeat interviews were carried out, and transcripts were not returned to participants for comments. Two identical audio recordings of each interview, captured with a digital recorder, were uploaded to a secure cloud-based web application for storage. Data saturation was discussed in the research team meetings with saturation occurring by completion of the data collection period in September 2020.

Data analysis

Quantitative analysis of study participant characteristics was tabulated and analysed by the principal investigator and study coordinator (TNP) utilizing Microsoft excel and SPSS 26 statistical software. Happyscribe cloud-based software was utilized for the automatic transcription of the audio recordings. Then, each audio recording was verified by hand

1) *Tell us about your experience beginning with when you first learned of COVID-19... (take us back to that time...)*

2) *How did you prepared yourself to work with COVID-19 patients (mentally, emotionally, physically)?*

3) *How did the nursing leadership in your department prepare you to work with COVID-19 patients?*

4) *How did your institution prepare you to work with COVID-19 patients?*

5) *Tell us about PPE use during COVID-19...*

   a. *Has this changed over time? If so, how?*

6) *How do you feel taking care of COVID-19 patients?*

7) *How are you coping?*

   a. *Has this changed over time? If so, how?*

8) *What support are you receiving from your department?...*

   a. *Institution?*

   b. *Community?*

9) *How has working with COVID-19 patients changed your nursing perspective?*

10) *What implications does the COVID-19 pandemic have for nursing practice?*

11) *What implications does the COVID-19 pandemic have for nursing education?*

   (Prelicensure and/or Graduate-level as appropriate for interviewee)

12) *What implications does the COVID-19 pandemic have for nursing policy?*

   a. *Within healthcare institutions?*

   b. *With regard to national leadership?*

13) *Finally, what further comments related to COVID-19 and nursing would you like to share with us?*

FIGURE 1 Nursing During COVID-19 Semi-Structured Interview Guide

by trained graduate student research assistants for accuracy. The qualitative interview data were analysed using thematic content network analyses first by hand by 10 of the study team members including seven doctorally prepared nurses and three masters student research assistants, reviewing the first 20 transcripts as a full team. Once the thematic network was approved and discussed by the team, formal coding was completed utilizing Dedoose's web-based software platform for qualitative analysis by the three student research assistants under the guidance of the principal investigator and second author. Themes were derived from the data. There were no diverse cases departing from the major thematic findings. Study participants did not provide feedback on the findings; however, the themes identified demonstrated good face validity when presented and discussed among the full research team of 24. Participants' quotations are presented anonymously to illustrate the themes derived from the study data. For this study, codes related to effective communication were synthesized into distinct themes.

FINDINGS

The study participants ($n = 100$) had a mean age of 37.9 years, with a range of 38, a minimum of 24 and a maximum of 62. The majority of study participants identified as female, 84, while 14 identified as male, and two identified as trans/non-binary. The study sample racial composition included 57% reporting as White, 20% as Black, 14% as Asian, 7% as multi-racial and 2% as American Indian. With regard to ethnicity, 20% of our study sample identified as Hispanic or Latinx. In total, only 37% of our sample identified as both White and non-Hispanic, yielding a study sample composition in which the majority of nurses interviewed, 63% identified as a member of an underrepresented racial/ethnic group. A more detailed summary of the participants' characteristics can be found in Table 1.

Overall, our semi-structured interviews with nurses across the US revealed overarching shared descriptions of how effective communication positively impacted patient care and nursing practice experiences during the first wave of the COVID-19 pandemic. Based on the interview data, we define effective communication as expressions that positively impact nurses' psychosocial well-being. Within this context of effective communication, thematic network analyses enabled our team to identify the importance of effective communication across three levels: (1) organizational leadership, (2) unit leadership and (3) nurse-to-nurse communication. Within this structure, three critical organizing themes present at these three

TABLE 1 Demographic characteristics of study sample (n = 100)

Age	
Mean	37.9
Range	38
Min, Max	24, 62
Gender	
Female	84
Male	14
Trans/Non-Binary	2
Race	
White	57
Black	20
Asian	14
Multiracial	7
American Indian	2
Ethnicity	
Hispanic	20
Non-Hispanic	80
Education	
Diploma	1
Licenced Practical Nurse	2
Associate's Degree	4
Bachelor's Degree	41
Master's Degree	42
DNP	9
PhD	1
Years of Nursing Experience	
Mean	11.04
Range	41
Min, Max	<1, 42
Employment	
Academic Medical Center	36
Multi-Center Hospital System	17
Independent Community Hospital	16
Outpatient/Community-Based	23
Federal Hospital System	5
Preferred Not to Report	3
Speciality	
Emergency Department	19
Intensive Care Unit	13
Medical/Surgical Nursing	13
Labour and Delivery	22
Outpatient/Community	14
Anaesthesia	2
Leadership	7
Multiple Specialties	10

aforementioned levels led to positive patient care and nursing practice experiences. These three organizing themes, essential to effective communication, include (a) presence, (b) education and (c) emotional support, presented in Figure 2. These three organizing themes' illustrative quotes are detailed in Table 2.

Organizational leadership

Effective communication was necessary at the organizational leadership level during the first wave of the COVID-19 pandemic. For this study, organizational leadership is defined as individuals and departments whose operations impact the entire healthcare organization's structure and function. Effective communication at the organizational leadership level is embodied by the three organizing themes of (a) organizational leadership presence, (b) organizational leadership education and (c) organizational leadership emotional support.

Organizational leadership: Presence

Study participants reported the importance of the presence of organizational leadership during the first wave of the COVID-19 pandemic. One nurse interviewed described feeling 'tons of support' from organizational leadership such as CNOs through their visibility daily. Study participants described feeling an increased level of presence from their organizational leadership through the development of command centres, where they could see key stakeholders from throughout the organization planning as a group. One nurse manager interviewed recalled, 'I remember driving in at 3:00 in the morning once and my regional CNO giving me a call saying, "Are you okay? I'm headed in with you. I know you're coming in."' Nurses interviewed spoke of the importance of presence at the highest levels of leadership, with one participant stating,

> When you have a good CEO…when you have a good leader that embraces and engages with its members, it is then that you get a sense of "we" right. [Our CEO] is very inclusive of my information, my expertise, my knowledge at the table. So it's not like I'm by myself or she's by herself. And there's other nurses at the table. There were many of these roundtable discussions. It's very powerful… I have talked to other people, and you'll hear a lot of "they" and consequently… a lot of dissatisfaction. "They" do this and "they" do that. But when you say 'we,' it changes this whole perspective.

Organizational leadership: Education

Nurse participants interviewed described effective communication in the ongoing education surrounding COVID-19 offered by the organizational leadership within their institutions. As one participant recalled,
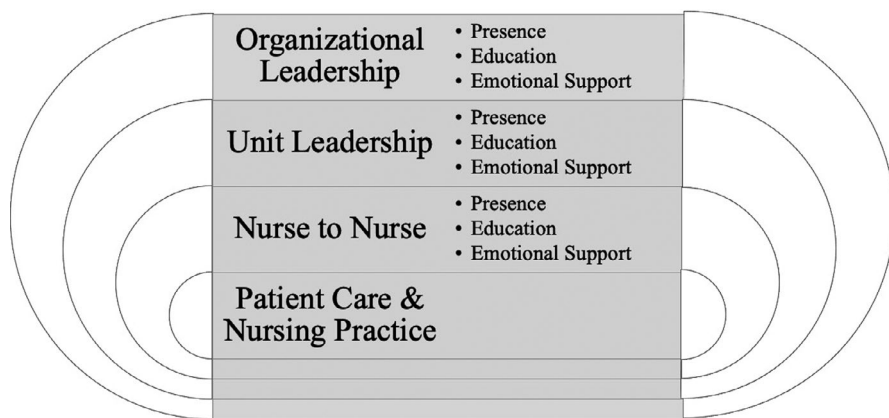
FIGURE 2 Effective Communication During COVID-19 Conceptual Framework

It was… all hands on deck and educating [through] daily huddles after my command center call with the hospital. I would relay that information to my triage nurse and my clinical staff, to my physician team. The guidelines changed almost daily because we were learning as we went, we have a daily huddle board. That whole huddle board became a COVID board. So, as things came from nurse education and the command center and infectious disease, I would make sure I educated all my staff but also posted all of that on the COVID board.

Nurses interviewed also described the importance of effective organizational leadership communication through online platform utilization, including developing COVID websites to enable staff to educate themselves and stay up to date on corporate communication that would impact their job function. Given the evolving nature of information during the beginning of the COVID-19 pandemic, ongoing education offered by organizational leadership was imperative, as one participant shared, 'there [were] a lot of things that were written… in theory that we had to kind of rewrite on the fly [through] daily meetings with the leadership'. Effective communication through organizational leadership's ongoing commitment to education for employees allowed nurses and allied health professionals to rewrite pandemic care plans in a timely fashion.

Organizational leadership: Emotional support

Study participants described the importance of organizational leadership, offering emotional support as a means of effective communication during the first wave of the COVID-19 pandemic. Emotional support at the organizational level included 'wellness teams', as described by one participant, who offered both physical and emotional nourishment to nurses by rounding 24 h a day. Another participant noted creation of safe environments within her work facility, a 'zen den' where nurses can 'process [their] feelings', in addition to ongoing resiliency and spiritual care

programming. Furthermore, nurses spoke of the importance of formal Employee Assistance Programmes with behavioural health services financially covered by their institutions and proper financial support for quarantined nurses. As one nurse recalled, '[For] staff [who have] had symptoms, [we have] financial support if they had to be quarantined. We have 14 days of pay… so that they [don't] lose income'. Both formal and informal structured that reinforced emotional support for nurses during the first wave of COVID-19 was perceived as effective communication from organizational leadership.

Unit leadership

Effective communication was imperative at the unit leadership level during the first wave of the COVID-19 pandemic. For this study, unit leadership is defined as individuals and groups whose operations impact structure and function at the unit level. Effective communication at the unit level is embodied by the three organizing themes of (a) unit leadership presence, (b) unit leadership education and (c) unit leadership emotional support. See Table 2 for more detail.

Unit leadership: Presence

Study participants described the usefulness of unit leadership presence as a form of effective communication during the first wave of the COVID-19 pandemic. Descriptions of unit leadership presence included leadership participating in making daily rounds, holding daily huddles, checking in daily by e-mail and being physically present on the floor, particularly in an emergency, critical care, and COVID-19 units across all shifts including weekends with both managers and executive directors in attendance. The frequency of unit leadership presence was crucial in describing effective unit leadership communication during the COVID-19 crisis, with daily presence received positively, including one unit nurse who reported it helped them to feel 'supported'. As one nurse leader interviewed shared with us, 'We [were] getting together with groups of staff [and asking] what… can we do better to help with the next surge?' another participant

TABLE 2 Key themes and illustrative quotes

Organizational Leadership Organizing Themes and Illustrative Quotes

Organizational Leadership: Presence

'We actually set up a command center… So we were proactively meeting… including our CEO, CMO, all of our major key stakeholders throughout the organization… to get everyone all at one place and com[e] up with plans for what we [were] going to do when we see our first patient'.

'I would say tons [of support]. Our CNO, she's our senior vice president of operations [was] very visible every day'.

'I remember driving in at 3:00 in the morning once and my regional CNO giving me a call and saying, are you OK? I'm headed in with you. I know you're coming in'.

'When you have a good CEO…when you have a good leader that embraces and engages with its members, it's then that you get a sense of 'we' right. [Our CEO] is very inclusive of my information, my expertise, my knowledge at the table. So it's not like I'm by myself or she's by herself. And there's other nurses at the table. There were many of these roundtable discussions. it's very powerful… I've talked to other people, and you'll hear a lot of 'they' and consequently… a lot of dissatisfaction. 'They' do this and 'they' do that. But when you say 'we,' it changes this whole perspective'.

Organizational Leadership: Education

'Infectious disease doctors… really took the lead at our institution with providing great…educational opportunities. And then we have a disaster management team and fellowship at our institution… work[ing] to plan for a massive influx of patients and preparing alternate treatment sites. There [were] many things that were written… in theory, we had to kind of rewrite on the fly… So we started with daily meetings with the leadership, some of the lead advanced practice providers, and our emergency department. Thus, I sat in on those daily meetings so [that] we could pretty much start rewriting our whole pandemic plan'.

'It was… all hands on deck and educating [through] daily huddles after my command center call with the hospital. I would relay that information to my triage nurse and my clinical staff, to my physician team. And, in the beginning, the guidelines changed almost daily because we were learning as we went, we have a daily huddle board. That whole huddle board became a COVID board. So, as things came from nurse education and the command center and infectious disease, I would make sure I educated all my staff but also posted all of that on the COVID board'.

'They built a COVID website, wherefrom home, you [could] just put in your ID number and you [could] see everything, [including] corporate communication. And then I also started e-mailing my staff at home [to keep them updated]. I [did not] want them to show up and not know what [was] going on… enhancing communication so it [was] more accessible to them. It made a difference'.

Organizational Leadership: Emotional Support

'We created a wellness team [of nursing liaisons] that [go] around twenty-four hours a day, giving away food, snacks, but also just talking. Our nursing liaisons have a good relationship with our nurses, [and we've] added our psychiatrist or psychologist on the rounds also'.

TABLE 2 (Continued)

'[We] have what's called a 'zen den,' and it's supposed to be a room [where] you can sit and reflect. So on your lunch hour, a nurse can sit down and just think or process [their] feelings'.

'We have many resources for folks to tap into…our Employee Assistance Program…our social workers and our nurse practitioners from psychiatry rounding and checking [in]… I, for one, have felt the entire time that I had emotional support and physical support from my colleagues'.

'[We have a] resiliency program…during the lunch hour twice a week and…outdoor blessing ceremon[ies] once a week'.

'We have a mission and spiritual care chaplains that have been very helpful to many of the staff. We have behavioral health services that have stepped up and offered individual and group counseling. [For] staff [who have] had symptoms, [we have] financial support if they had to be quarantined. We have 14 days of pay… so that they [don't] lose income'.

Unit Leadership Organizing Themes and Illustrative Quotes

Unit Leadership: Presence

'Well… nursing leadership would come and make rounds [and] check-in with us with daily e-mails. The union comes around to ask if we have questions [at] every shift… then [asks] if we have a certain problem or [if] we're worried about [anything]'.

'So I just needed to make sure that they were feeling supported. I was here with them doing [the] pushing, moving patients, [and] doing all of the [care] with the patients as well, just because I know that they needed that'.

'[We have] started daily call[s] with the managers… and went through all the changes so they could talk [with] their staff. We do Huddle's every day… We also started rounding on all shifts [including] the weekends, [with] the managers [and] the executive directors. We started rounding with the staff to try to start answering their questions… We are getting together with groups of the staff [and asking] what… can we do better to help you guys out with the next surge? And one of them said they loved the rounding by leadership'.

'I just really wanted to get out there and try to communicate with them and let them know what a great job they were doing and how much I appreciated it'.

Unit Leadership: Education

'[Most] of our training really was on the spot. It was… what the physicians were… telling us… We… learned day by day, kind of, [as] everything changed… So things we did a week ago, sometimes were like different. We would learn labs that we would need to check [and] certain drugs for first-line treatment. We started learning about the clotting issues, and then people being initially on heparin, and it just kept evolving'.

'[I] think we learned a lot [of] the information that we were getting from our operations team and the department management… the administrative people were… getting a lot of information from… the World Health Organization or Centers for Disease Control to help provide guidelines. Things [were] very fluid and changing almost by the minute [and] by the hour during our shift'.

Our attending [physicians] were good about running mock patient [scenarios]… for transfer[ing] [patients] to the operating room… Our managers [were] really good about updating all of us on what's [happening with]… any policy changes or new recommendations we would be practicing on the unit.

(Continues)

(Continues)

T A B L E 2 (Continued)

Unit Leadership: Emotional Support

'[We have] been doing… debriefings and… we [have done] a remembrance… [for] the patients that we [have] lost. We actually wrote cards to our patients' families who passed [away] too. That… obviously hurt but helped with… closure. A lot of us have a lot of anxiety'.

'[We] advocated for [debriefings]…. [from] our management [because] we were really burnt out and a lot of people weren't doing well on the unit as far as nurses processing everything that ha[s] happened. So they ended up… [having] a psychiatric liaison that we could we can consult for certain patients or families for support and then the chaplain service'.

'They were actually sending out a lot of resources… there was a [unit] doctor that would send out daily updates with COVID. [He] would also include some wellbeing resources and these 'feel good' articles that were [included]in [the] e-mails. That was nice to see'.

Nurse to Nurse Organizing Themes and Illustrative Quotes

Nurse to Nurse: Presence

'[Working] nights… we're such a tight-knit group. If you go in the hallway and… someone is there, it's like, "Hey, can you talk? You ok? You need anything?"'

'The two ICU nurses had to come [to our floor to] take care of [patients] because [the] ICU's [were full]. The [ICU nurses] have broken the walls… There is such collaboration between the two units now, and honestly, it is so refreshing to see'.

'I'm really lucky. Like I said, I've been there for 20 years. I have some really, really good friends, and we all are very supportive of each other…. back in the beginning, especially when we were really nervous about things…we would talk and text. We'd e-mail. We talked with each other about how we felt about different things… And a lot of these ladies, especially that I work with… they're not just your co-workers. They've become my really good friends. So coping and support for me has been really good'.

'It was unnerving just because the protocols were changing not only day to day, but sometimes from night shift to day shift and sometimes from hour to hour. So that was stressful. I think using our charge nurses was a great resource, just talking to them, asking them questions, and then just leaning on each other'.

'I work in a very close unit. I think that everyone really worked together well as a team. We really tried hard to make sure that everyone got a break [and] was able to step off the unit and take a few minutes yourself, which I know can be really hard to do, especially in the ICU'.

'I work with a bunch of awesome nurses. We [have] good camaraderie, good teamwork, things like that. So we all kind of just leaned on each other [said], 'hey, we'll see you tomorrow.' Make sure no one's calling off…that kind of thing'.

Nurse to Nurse: Education

'I asked [experienced COVID–19 nurses] for their advice. They said… limit as much contact as possible, cluster your care and ask for help. I asked them because they had gone [to the COVID ICU] more often…so by the time it was my turn to go, I wanted to ask them… What can I expect?'

'[An experienced nurse] would help me. I definitely learned so much… I graduated and I was thrown into this crazy world…. But because of that, I have learned at high speed'.

(Continues)

T A B L E 2 (Continued)

'If you are in that specialty, you will love that specialty. I think we should be open to having other nurses come into our specialty and teach us what they know, and we can teach them back what we. Cross-training'.

'We're all cross-training. They're combining us, the PACU nurses, with the preop nurses and the ambulatory surgical staff. Everyone's cross-training. People who didn't have ICU experience before are being sent over to the ICUs to shadow. We're basically all being prepared to be able to perform any of the roles that fall under our giant umbrella'.

'[As nurses], we're able to communicate with each other very easily and share our experiences and keep each other posted about changes and protocols that are happening. You know, we just talk to each other and make sure that we're… staying informed'.

Nurse to Nurse: Emotional Support

'After work, I would just give [a fellow nurse] a call and [say] 'this' happened today. How was your day at work? That was a big help because no one else could really listen or fully understand what was going on inside the hospital. So they were a big part of me… coping. It's nice to have someone understand what you're going through'.

'The emotional support I did get was with my co-workers because no one else… Family and friends… they knew about… how harmful and severe COVID was, but only your fellow nurses and co-workers knew exactly what you were going through. So, at lunch break, talking about what someone [was] struggling with or what can be done better. Or after a shift, calling a nurse friend that is also going through that same situation. I think talking with other fellow nurses is what helped me the most'.

'Leaning on the support of my…group of nurses… We get along very well. So…venting to them at times or…looking to each other for support. If we had a problem, we could band together and… have the courage to bring it up to [a] manager or provider'.

'We… have had the support of… nurses coming together. I think it's something that [will] make us stronger after the pandemic'.

'I have some amazing colleagues… through my [nursing association name] that I really lean on. So I definitely use [my] outlets whenever I need that. Whether it be shed a tear, or… to vent… because I'm upset… I have those people to call when I just need somebody to tell me, "it's going to be OK."'

'All [the nursing] professors that I used to have in school, peers, colleagues that reach out to me every once in a while. They're praying for me and for everybody. So just love and support. And I'm very thankful'.

noted, 'I just really wanted to…communicate with them and let them know what a great job they are doing and how much I appreciate it'.

Unit leadership: Education

Unit leadership providing education for nurses was described by many study participants as a form of effective communication during COVID-19. Providing formal education to nurses on laboratories, medications for first-line treatment, clotting issues and running mock patient

scenarios were among the effective communication strategies employed by unit leadership. Evolution and adaptation for several unit training and education throughout the first wave of COVID-19 also proved vital. Education as effective communication in unit leadership is exemplified in one participant's response as follows,

> [I] think we learned a lot [of] the information that we were getting from our operations team and the department management… the administrative people were… getting a lot of information from… the World Health Organization or Centers for Disease Control to help provide guidelines. Things [were] very fluid and changing almost by the minute [and] by the hour during our shift.

Unit leadership: Emotional support

Unit leadership demonstrating emotional support for nurses was a well-described theme surrounding effective communication during the first wave of the COVID-19 pandemic. Unit leadership helping its staff members process the emotional challenges of working in healthcare during COVID-19 was essential. One study participant noted, '[We] advocated for [debriefings] …. [from] our management [because] we were really burnt out and a lot of people weren't doing well on the unit as far as nurses processing everything that ha[s] happened'. Another participant shared, '[We have] been doing… debriefings and… we [have done] a remembrance… [for] the patients that we [have] lost. We actually wrote cards to our patients' families who passed [away] too. That… obviously hurt but helped with… closure. A lot of us have much anxiety'. Emotional support, even in the form of digital updates from unit leadership including 'feel good articles' and 'wellbeing resources', were perceived as helpful communication by two nurses interviewed.

Nurse to nurse

In addition to organizational leadership and unit leadership communication, effective communication also impactful in nurse-to-nurse relationships during the first wave of the COVID-19 pandemic. For this study, nurse-to-nurse communication is defined as communication between individuals or groups where they function in similar roles, whether within the same unit or different practice areas, and demonstrate mutual trust and validation. Effective communication at the nurse-to-nurse level is embodied by the three organizing themes of (a) nurse-to-nurse presence, (b) nurse-to-nurse education and (c) nurse-to-nurse emotional support. See Table 2 for more detail.

Nurse to nurse: Presence

Nurse-to-nurse presence was a well-described compelling communication theme among our study sample of 100 US nurses. Study participants described the importance of feeling other nurses' emotional and physical presence during the first wave of the COVID-19 pandemic. The closeness of nurses within departments was mentioned with frequency describing camaraderie, teamwork and emotional support among seasoned nurse colleagues. These sentiments were also shared between nurses changing shifts to talk about the stress of everchanging COVID nursing care. In addition, nurses articulated greater collaboration between departments, as one participant noted,

> The two ICU nurses had to come [to our floor to] take care of [patients] because [the] ICU's [were full]. The [ICU nurses] have broken the walls… There is such collaboration between the two units now, and honestly, it is so refreshing to see.

Nurse to nurse: Education

Education among nurses was a well-described effective communication theme during the first wave of COVID-19. Many novice nurses interviewed in our study sample described how they leaned on seasoned nurses' guidance for educational support, such as one shared,

> I asked [experienced COVID-19 nurses] for their advice. They said… limit as much contact as possible, cluster your care and ask for help. I asked them because they had gone [to the COVID ICU] more often…so by the time it was my turn to go, I wanted to ask them… What can I expect?

Another new graduate nurse expressed that as novices, they were 'thrown into [a] crazy world', but were learning 'at high speed' due to the mentorship by experienced nurse colleagues. In addition to nurse education being effective communication for new nurses, it also proved effective for seasoned nurses as practice guidelines shifted and cross-training among nurses became necessary. One participant described that,

> We're all cross-training. They're combining us, the PACU nurses, with the preop nurses and the ambulatory surgical staff. Everyone's cross-training. People who didn't have ICU experience before are being sent over to the ICUs to shadow. We're basically all being prepared to be able to perform any of the roles that fall under our giant umbrella.

Nurse to nurse: Emotional support

The effective communication theme of the nurse-to-nurse emotional support was well-described by study participants. Nurses described the role the emotional support of peers played in their ability to feel supported during the first wave of COVID-19, as one participant stated, 'it's nice to have someone understand what you're going through' as fellow nurses working in patient care settings during the pandemic. Another nurse interviewee shared,

> Family and friends… they knew about… how harmful and severe COVID was, but only your fellow nurses and co-workers knew exactly what you were going through. So, at lunch break, talking about what someone [was] struggling with or what can be done better. Or after a shift, calling a nurse friend that is also going through that same situation. I think talking with other fellow nurses is what helped me the most.

Emotional support at the nurse-to-nurse level also allowed nurses to advocate for themselves as a collective group. One participant shared that, 'If we had a problem, we could band together and have the courage to bring it up to [a] manager or provider'. Nurse-to-nurse emotional support during COVID-19 was, as one participant noted, about 'nurses coming together… something that [will] make us stronger after the pandemic'.

DISCUSSION

This study describes that nurses value reliable communication from organizational leaders, unit leaders, and nurse colleagues in the forms of presence, education and emotional support during the first wave of the COVID-19 pandemic. These findings reinforce the findings of previous researchers who note that during times of crisis, the non-technical skill of communication, the foundation of thoughts and actions, is critical for resilience in healthcare workers (Paquin et al., 2018).

In times of crisis, effective communication is a crucial fundamental leadership skill (Eldridge et al., 2020). It requires an understanding of psychological and emotional barriers to promote trust and credibility (Eldridge et al., 2020; Tseng et al., 2005). Similar to prior investigations on the SARS outbreak, this study findings highlight the importance of the dissemination of accurate and timely information delivered efficiently and consistently from organizational and nursing leadership to mitigate anxiety and fear (Liu & Liehr, 2009; Wong et al., 2020). This study also reinforces previous findings that describe how effective communication can set the foundation for best practices between leadership and providers by fostering transparency and trust (Hsu et al., 2017).

This study also described nurses valuing presence as a form of communication in relationships with other clinical nurses and among unit and organizational leaders. Presence is the condition of being either physically or felt to be present, either in the immediate vicinity, nearby, or in spirit (Merriam Webster, 2020). In their publication discussing the Boston Marathon bombings, Vitello-Cicciu and Quinn found that nurse leaders promoted their employees' psychological and environmental safety by being present, making daily rounds and speaking individually with their staff (2013). Even in non-crisis situations, the importance of presence has been established. Rosengren et al. described how that clinical nurses require their nurse leader's physical, mental and social presence to support their day-to-day practice and promote clinical excellence (2007). However, this study is the first known qualitative examination of the importance of presence during a time of prolonged crisis such as a global pandemic. In addition, nurse-to-nurse communication, including knowledge sharing and emotional support, significantly impacted our study participants. Collegial information sharing acted as a coping strategy and aided study participants in adapting to the stressful and uncertain circumstances surrounding providing patient care during COVID-19. The nursing profession depends on and expects experienced nurse's guidance and expertise to empower new generations of nurses at every level of practice, in every speciality, and to contribute to the profession's depth and strength (Luis & Vance, 2020).

Similar to the SARS crisis, limited information about COVID-19 was available at the initial outbreak. Technological advancements in electronic, online, virtual platforms and social media have added measures to allow rapid communication and education (Wong et al., 2020). This research found various communication platforms useful, including online, virtual and person-to-person (Raderstorf et al., 2020). However, despite advancements in technology, recommendations for utilizing social media for crisis communication are ongoing, given limitations in transmission, accessibility and risk reduction (Lin et al., 2016). Aligned with our study, an investigation by Labrague et al. found that emotional support from trusted colleagues and top organizational leaders improved healthcare professionals' coping and resilience (2018). Organizational leaders in our findings encouraged nurses to utilize system-wide resources such as EAP and pastoral care personnel. Unit leaders encouraged the use of debriefings and sending electronic 'feel good' articles. Finally, the nurse-to-nurses sharing of their feelings of working through this highly stressful crisis was invaluable.

IMPLICATIONS FOR NURSING POLICY AND HEALTH POLICY

Effective communication is critical to support nurses through extended periods of crisis. COVID-19 represents a unique contemporary challenge to the nursing workforce given the high stress and prolonged strain it has created for

both human and healthcare supply resources. There is value in nurses' presence at local, unit level and organizational leadership levels to convey critical information that directly informs leadership decision-making during unprecedented emergencies such as the COVID-19 pandemic.

Organizational and unit-level nurse leaders must be cognizant that their physical presence reassures the staff nurses when they communicate openly, honestly, and in a timely manner. As the liaisons between the organizational and staff nurse, the unit-level nurse leaders are positioned to model and facilitate effective communication. Organizational and unit-level nurse leaders should work in partnership to develop and implement programmatic solutions to optimize clinical outcomes. Organizations invest in the knowledge and skill of nurse leaders because they directly impact patient outcomes. Therefore, investing resources to improve nurses' experiences with communication should be regarded as equally important. The pandemic has unveiled an emergency juncture with both chronic high stress and high stakes for nurses. Policies that support an increased structure for effective communication across levels allow nurse leaders the ability to foster a sense of care and concern for nurses and mitigate issues as they arise.

This study is novel in its timely representation of the experiences of a diverse group of nurses during the first wave of the COVID-19 pandemic. Limitations of this study include its cross-sectional design, capturing each nurses' perspective at a single point in time, limiting our ability to describe how nurses' experiences and perspectives have shifted over the course of the pandemic. Furthermore, transcripts were not returned to participants for comments or corrections, nor did participants provide feedback on the findings. Future research may consider a longitudinal design to capture the arc of nurses' experiences over time, or perhaps utilize survey methodology to quantify the prevalence of the qualitative themes described by the sample of 100 nurses interviewed for this study.

CONCLUSION

This qualitative examination of US nurses' experiences providing patient care during the first wave of the COVID-19 pandemic discusses the importance of effective communication at the organizational level, unit level, and among nurse colleagues. Nurses interviewed reported the value of communication in the form of presence, education and emotional support across these three levels. Based on these findings, organizations should understand that nurse-to-nurse communication provides nurses the opportunity to deliver compassion to one another. Nurse-to-nurse communication offers opportunities for sharing knowledge and experiences. The ability to support communication develops trust and builds collaborative relationships. Policies that improve communication can mitigate workflow breakdowns, decrease errors and attenuate the effects of ineffective treatment regimens during times of crisis. Examining existing crisis communication policies and procedures across healthcare organizations is imperative to maintain highly relevant, innovative and data-driven policies and strategies that are fundamental to preserving quality patient care and supporting optimal nursing practice.

CONFLICT OF INTEREST
No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS
Study design: SDS. *Data collection:* SDS, RSS, DB, SK, CS, TNP, EA, LC, LMC, KWR. *Data analysis:* SDS, RSS, DB, SK, CS, TNP, DR, RW, EA, SL, JDT. *Study supervision:* SDS, TNP. *Manuscript writing:* SDS, RSS, DB, SK, CS, TNP, DR, RW, SL, JDT. *Critical revisions for important intellectual content:* JDT, SDS.

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REFERENCES
American Association of Colleges of Nursing. Nursing fact sheet. Available at: https://www.aacnnursing.org/news-Information/fact-sheets/nursing-fact-sheet [Accessed 1st December 2020].

Cypress, B.S. (2017) Rigor or reliability and validity in qualitative research: Perspectives, strategies, reconceptualization, and recommendations. *Dimensions of Critical Care Nursing*, 36(4), 253–263. https://doi.org/10.1097/DCC.0000000000000253

Edmonson, C., Sumagaysay, D., Cueman, M. & Chappell, S. (2016) The nurse leader role in crisis management. *Journal of Nursing*

Administration, 46(9), 417–419. https://doi.org/10.1097/NNA.00000 00000000367

Eldridge, C.C., Hampton, D. & Marfell, J. (2020) Communication during crisis. *Nursing Management*, 51(8), 50–53. https://doi.org/10.1097/01. NUMA.0000688976.29383.dc

Hsu, Y.-C., Chen, Y.-L., Wei, H.-N., Yang, Y.-W. & Chen, Y.-H. (2017) Risk and outbreak communication: lessons from Taiwan's experiences in the post-SARS era. *Health Security*, 15(2), 165–169. https://doi. org/10.1089/hs.2016.0111

Knupp, A.M., Patterson, E.S., Ford, J.L., Zurmehly, J. & Patrick, T. (2018) Associations among nurse fatigue, individual nurse factors, and aspects of the nursing practice environment. *The Journal of Nursing Administration*, 48(12), 642–648. https://doi.org/10.1097/nna.00000 00000000693

Labrague, L.J., McEnroe-Petitte, D.M., Leocadio, M.C., Van Bogaert, P. & Cummings, G.G. (2018) Stress and the ways of coping among nurse managers: an integrative review. *Journal of Clinical Nursing*, 27, 1346–1359. https://doi.org/10.1111/jocn.14165

Lin, X., Spence, P.R., Sellnow, T.L. & Lachlan, K.A. (2016) Crisis communication, learning, and responding: best practices in social media. *Computers in Human Behavior*, 65, 601–605. https://doi.org/10.1016/j. chb.2016.05.080

Liu, H. & Liehr, P. (2009) Instructive messages from Chinese nurses' stories of caring for SARS patients. *Journal of Clinical Nursing*, 18(20), 2880–2887. https://doi.org/10.1111/j.1365-2702.2009.02857.x

Luis, C. & Vance, C. (2020) A pandemic crisis: Mentoring, leadership, and the millennial nurse. *Nursing Economics*, 38(3), 152–163.

Merriam Webster. Presence. Available from: https://www.merriam-webst er.com [Accessed 1st December 2020].

Paquin, H., Bank, I., Young, M., Nguyen, L.H.P., Fisher, R. & Nugus, P. (2018) Leadership in crisis situations: merging the interdisciplinary silos. *Leadership in Health Services*, 31(1), 110–128. https://doi. org/10.1108/LHS-02-2017-0010

Polit, D.F. & Beck, C.T. (2020) *Nursing research*. Philadelphia, PA: Lippincott Williams & Wilkins.

Raderstorf, T., Barr, T.L., Ackerman, M. & Melnyk, B.M. (2020) A guide to empowering frontline nurses and healthcare clinicians through evidence-based innovation leadership during COVID-19 and beyond. *Worldviews on Evidence-based Nursing*, 17(4), 254–257. https:// doi.org/10.1111/wvn.12451

Rosengren, K., Athlin, E. & Segesten, K. (2007) Presence and availability: staff conceptions of nursing leadership on an intensive care unit. *Journal of Nursing Management*, 15(5), 522–529. https://doi. org/10.1111/j.1365-2834.2007.00712.x

Tong, A., Sainsbury, P. & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357. https://doi.org/10.1093/intqhc/ mzm042

Tseng, H., Chen, T. & Chou, S. (2005) SARS: key factors in crisis management. *Journal of Nursing Research*, 13(1), 58–64.

Vitello-Cicciu, J.M. & Quin, M. (2013) Looking through the eyes of nursing leaders: the Boston marathon tragedy. *Journal of Nursing Administration*, 43(9), 436–437. https://doi.org/10.1097/NNA.0b013 e3182a23be3

Wong, A.S.K., Ooi, C.C., Leow, M.Q.H., Kiew, Y.S., Yeo, K.C.W., Tan, S.G. et al. (2020) Adapting lessons from SARS for the COVID-19 pandemic— Perspectives from radiology nursing in Singapore. *Journal of Radiology Nursing*, 39(3), 164–167. https://doi.org/10.1016/j. jradnu.2020.06.008