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"If I can't do it, who will?" Lived experiences of Australian emergency department nurses during the first year of the COVID-19 pandemic

Megan R. Jackson, BN (Hons), RN, Joanne E. Porter, PhD, MN, GradDipCC, GradDipHSM, GradCertHeD, BN, RN, Blake Peck, PhD, BN (Hons), RN, Christopher Mesagno, PhD, MSESS, BS

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Running head: Lived experience of Australian ED nurses during first year of COVID-19 pandemic

Authors

1. **Megan R. JACKSON* (corresponding author)**
BN (Hons), RN
Research Fellow, Institute of Health and Wellbeing
Collaborative Evaluation and Research Group (CERG)
Federation University, Churchill, Victoria, Australia
Email: m.jackson@federation.edu.au
ORCID: 0000-0002-6589-1284
Twitter: @MegjacksonRN

2. **Joanne E. PORTER**
PhD, MN, GradDipCC, GradDipHSM, GradCertHeD, BN, RN
Professor, Director of Collaborative Evaluation and Research Group (CERG)
Federation University, Churchill, Victoria, Australia
Email: Joanne.porter@federation.edu.au
ORCID: 0000-0002-1784-3165

3. **Blake PECK**
PhD, BN (Hons), RN
Associate Professor, Nursing, Institute of Health and Wellbeing
Federation University, Ballarat, Victoria, Australia
Email: b.peck@federation.edu.au
ORCID: 0000-0002-2444-9780

4. **Christopher MESAGNO**
PhD, MSESS, BS
Senior Lecturer, Institute for Health and Sport
Victoria University, Melbourne, Victoria, Australia
Email: chris.mesagno@vu.edu.au

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ORCID: 0000-0001-9417-4359
Twitter: @CMesagno

Author contribution

Author (1) was responsible for the conception of the study, undertaking the collection and interpretation of data and main drafting of the manuscript. Author (2) was the primary supervisor to Author (1) and assisted with interpretation of data, review of manuscript and provided expert guidance throughout the project. Author (3) provided expert methodological guidance throughout and assisted in the drafting of the manuscript. Author (4) provided expert guidance throughout the project and assisted with the interpretation of data and review of the manuscript. Author (1)(2)(3) and (4) revised the manuscript and Author (1) made the final revisions to the paper and submitted.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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Ethical Statement

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Title:

"*If I can't do it, who will?"* Lived experiences of Australian emergency department nurses during the first year of the COVID-19 pandemic

Abstract

Background. The World Health Organization (WHO) estimates that approximately 180,000 healthcare workers have died in the fight against COVID-19. Emergency department (ED) nurses have experienced relentless pressure in maintaining the health and wellbeing of their patients, often to their detriment.

Methods. The aim of this research was to gain an understanding of lived experiences of Australian ED nurses working on the frontline during the first year of the COVID-19 pandemic. A qualitative research design was employed, guided by an interpretive hermeneutic phenomenological approach. A total of 10 Victorian ED nurses from both regional and metropolitan hospitals were interviewed between September to November 2020. Analysis was undertaken using a thematic analysis method.

Results. A total of four major themes were produced from the data. The four overarching themes included Mixed Messages, Changes to Practice, Living Through a Pandemic, and 2021: Here We Come.

Conclusion. ED nurses have been exposed to extreme physical, mental, and emotional conditions as a result of the COVID-19 pandemic. A greater emphasis on the mental and emotional wellbeing of our frontline workers is paramount to the success of maintaining a strong and resilient healthcare workforce.

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Key Words

Emergency department; Covid-19; Pandemic; Lived experience; Qualitative; Nursing; Australia

Background

The World Health Organization (WHO) declared coronavirus disease (COVID-19) a global pandemic on March 11, 2020. The virus was formally recognized as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), identified in 114 countries and the first known pandemic caused by a coronavirus.[1] Globally within weeks, hospitals and urgent care facilities were overrun by an influx of patients requiring acute care management, with field hospitals and semi-trailers converted into refrigerated morgues to assist when existing facilities reached capacity.[2] Within one year of the COVID-19 pandemic, the virus had resulted in 82,659,573 cases and 1,872,945 deaths globally.[1] Locally, Australia did not see the rapid increase in COVID-19 cases at the beginning of the pandemic, with EDs paradoxically experiencing a decrease in hospital presentations early in 2020.[3, 4] These presentations however, rebounded and significantly exceeded pre-pandemic levels, further increasing pressure on the health professionals as well as the healthcare system itself .[5] Australia continued to face a steady increase in COVID-19 case numbers and death rates became a daily staple. Many uncertainties persisted in areas of health system management as well as available treatment solutions and their subsequent success, leading to social unrest.[3] In an effort to meet the expected demand for overwhelming numbers of acutely unwell patients, conversations were being had about the retraining of recently retired nurses, recruitment of registered nurses working outside of their routine clinical environment and fast-tracking final year nursing students into hospitals to assist clinically in the increasing demands on the healthcare system.[6] Across the pandemic, EDs serve as gateways for the severely unwell creating a tension between responding to rapidly developing information about the seriousness of the virus in the face of providing time critical care for patients.[7, 8] The WHO estimated

that by October 2021, 180,000 health care workers had died in the fight against COVID-19.[9] A comprehensive literature review was undertaken to demonstrate the impact of the first six months of the pandemic on frontline nurses.[10] Findings suggested that the frontline nurse population have experienced fear for their own safety and that of their loved ones, ethical and moral challenges in the face of prioritizing resources, injuries from the wearing of Personal Protective Equipment (PPE) and negative effects of physical and mental exhaustion as a direct result of the pandemic.[10] Within a year of COVID-19 onset, emergency nurses expressed greater intent to leave the profession within 5 years.[11] Typically, the ED is renowned for high and complex workloads within a very dynamic environment, all exacerbated in the face of the pandemic and creating a tipping point for many nurses who sought to leave the profession.[11, 12] While research has examined the impact of COVID-19 on the wellbeing of frontline nurses through studies of psychometric measures such as satisfaction[13, 14] and fear[15-17], there remains a gap in our understanding on the specific effects to the ED nurse population. It is paramount that investigation into the experiences and needs of the ED nurse workforce continue to better understand and improve the working conditions for critical members of our society and workforce.

Material and Methods

1.1 Aim

The aim of the research project was to gain an understanding of lived experiences of Australian ED nurses working on the frontline during the COVID-19 pandemic.

Research questions that were addressed included:

1. What are the lived experiences (e.g., feelings, attitudes, and perceptions) of Australian nurses working in the ED during the COVID-19 pandemic?
2. What perceived impact does working in the ED during a global pandemic have on nurses?

1.2 Design

The study employs a qualitative research design, informed by an interpretive hermeneutic phenomenological approach.[18] Data collected in this study was interpreted using the hermeneutic

circle of questioning. As outlined by Gadamer, the researcher comes with their own pre-understandings that should not be neutralized, but recognized in the research process as providing context to the person's life world.[18] The 'fusion of horizons' between participants and researcher provides the rich new understandings presented. In using a qualitative research method incorporating an emergent design, it allowed for reflection, learning and ongoing decision making to be applied throughout the data collection process, ultimately leading to three stages of data collection using the same sample of 10 ED nurses.[19] This paper will explore findings from 2020, the first of three stages of data collection in a larger PhD research project. This longitudinal PhD project explored ED nurse experiences through the duration of the COVID-19 pandemic, with data collection occurring in 2020, 2021 and 2022. Each emerging year of the pandemic brought new challenges and perspectives within global societies and workforces: therefore it was crucial to represent each year, captured in its entirety.

1.3 Population

The study population comprised of 10 Australian ED nurses residing in Victoria, with four from regional hospitals and six from metropolitan hospitals. As per the study inclusion criteria, all participants were Registered Nurses (RN) having worked clinically in a publicly funded ED following announcement of COVID-19 in Australia on January 22, 2020. Participants were recruited from the state of Victoria only, nurses from other states were excluded. Participants ranged from 23 to 58 years of age and varied from newly graduated nurses to nurse unit managers (NUM), having one to 38 years of clinical experience.

Table 1.0 Participant characteristics

Participant characteristics	***n* or mean**
Gender	
Male	2
Female	8
Age (years)	38.9
Country of birth	
Australia	8
Kenya	1
New Zealand	1
Education level	
Undergraduate degree	4

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Post-graduate qualification	2
Master's degree	2
Doctoral degree	2
Working history (years)	17.1
Employment region (Victoria)	
Metropolitan	6
Regional	4
Employment status	
Casual or temporary	1
Part-time	7
Full-time	2
Marital status	
Single	4
Married	6
Children or caring responsibilities	
Yes	7
No	3

1.4 Recruitment

Recruitment was undertaken using a snowballing methodology. Advertisements in the form of status posts and flyers were posted on social media websites Facebook, Instagram, and LinkedIn. Participants expressed interest by contacting the research team for more information. Participant eligibility was screened by the research team, where study inclusion criteria were reiterated to interested participants. Once study details were outlined and eligibility criteria was confirmed, participants were provided with the plain language information statement and consent form to return prior to their scheduled interview session. The relevant University human research ethics committees granted ethical approval for this project.

1.5 Data collection procedure

Data were collected using individual semi-structured interview sessions to ensure privacy and depth of discussion. Due to COVID-19 restrictions and the safety of the research team and participants, all interviews were conducted virtually through Microsoft Teams and Zoom, with audio recording undertaken through the software. Interviews were conducted by the lead author, a PhD candidate and Registered Nurse with experience in emergency nursing who was not currently working in a clinical capacity. Guided by hermeneutic data collection methods, participants were asked a series of open-ended questions regarding their emotional responses, attitudes and experiences during their

time working during the COVID-19 pandemic. Additionally, verbal consent was recorded prior to proceeding with the interview. Data collection was undertaken in September to November 2020, with interviews ranging from 32 to 103 minutes in duration. Data saturation was achieved by the eighth interview, with two additional interviews undertaken to confirm this theory. Saturation occurred when no new information and themes were presented in interviews, and it was identified that there was sufficient data to appropriately replicate the study.[20]

Example of participant questions:

- Tell me about some of the experiences and observations you made at work during the COVID-19 pandemic.
- What were your feelings towards coming to work during the pandemic?
- As more time passed and the pandemic progressed, how did your feelings and attitudes change about the pandemic and your working environment?
- Where there any challenges throughout your shifts during the pandemic?
- Thinking about your experiences, what benefit, if any, did this clinical environment give to you?

1.6 Data analysis

Data were transcribed verbatim and underwent thematic analysis using the Braun and Clarke[21] six step approach to thematic analysis. Data analysis occurred over three days with members of the research team involved in the creation of codes. Step 1 involved distributing de-identified transcripts randomly amongst the research team, drawing out codes individually to avoid bias in results. During step 2 and 3 of analysis, author one and two collaboratively refined the codes to generate themes. In step 4 and 5, robust discussion within the research team of the appropriate codes to include and exclude was undertaken to ensure an accurate representation of participant responses. Step 6 of analysis; documentation of findings, was then undertaken. To avoid biases and premature assumptions imparted on future data collected in this longitudinal study, analysis of each stage of data collection was delayed until all data was collected. A preliminary review of research findings including

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transcripts, field notes and observations after each data collection stage was undertaken by the research team to maintain a reflexive approach and inform questioning in interview sessions.

1.7 Rigor

Trustworthiness in qualitative research must be addressed to ensure the reliability and validity of the data and findings. Criteria of credibility, dependability, confirmability, transferability and authenticity assist in indicating the rigor of the project and the chosen methods.[19, 22-24] Credibility was achieved in the study through peer debriefing with senior members of the research team and a methodological expert helped to ensure consistency between the method and hermeneutic foundations. Dependability was realized through research process logs, documenting meetings and research activities that are traceable and confirmed by all members. Confirmability was accomplished in the collation and review of the aforementioned process logs and debriefing process, in addition to using a tested and confirmed methodology. Although specific findings may not be generalizable to other populations, effort to achieve transferability for this research was demonstrated through the documented robust methods, processes, and rich portrayal of study outcomes. Finally, authenticity for this project was maintained in the detailed representation of participant responses, who varied in skill level, age, and demographics.

Results

Data analysis resulted in a total of four major themes being extracted from the data. These themes represent those attitudes, emotions, and experiences for ED nurses during the first year of the pandemic. Major themes included Mixed Messages, Changes to Practice, Living Through a Pandemic, and 2021: Here We Come.

Figure 1 Major theme model.

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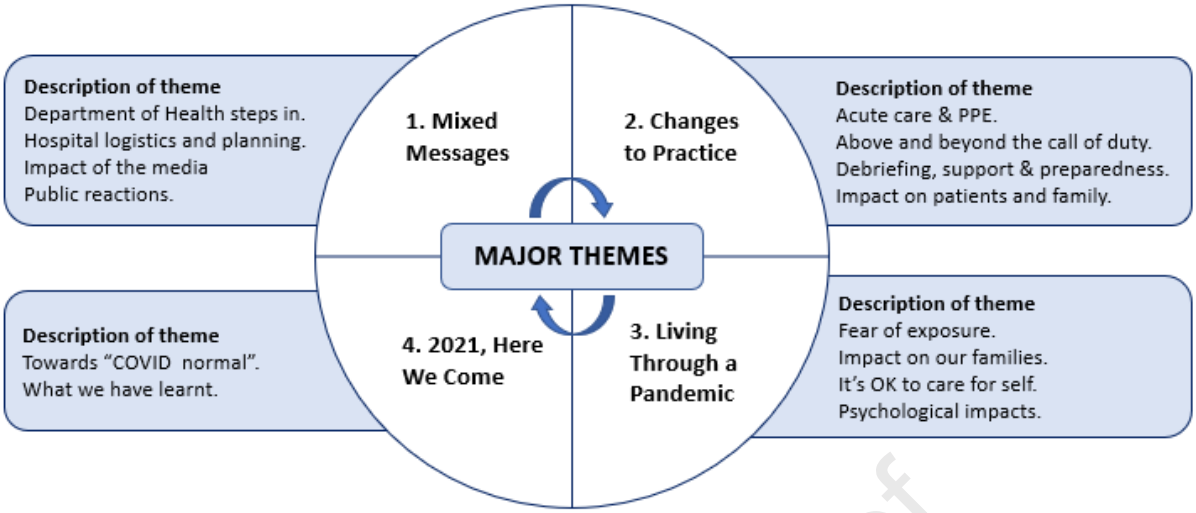

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174 ***2.1 Mixed Messages***

175 The first major theme "Mixed Messages" embodied the tension ED nurses experienced with
176 receiving a multitude of messages from media and government while they rapidly prepared for the
177 unknown. The images coming from overseas of the destruction COVID-19 had caused in a few short
178 months left ED nurses feeling uncertain as to how Australia might be impacted. Nurses outlined their
179 fears, coming to terms with the gravity of the situation:

180 *"I was glued to the news… what was evolving and what was happening overseas, then what*
181 *was happening here, sort of that hunger for information". P5*

182 The influence of the media was soon realized within nursing teams, impacting staff behavior:

183 *"[the media] increased anxieties and frustrations through staff worrying about things and*
184 *hearing different stories and nothing really aligning that respect. I found it hard to switch off*
185 *because of the media". P10*

186 Nurses were grateful with the portrayal of healthcare workers through media being "*from a*
187 *kind perspective*" (P6). The world now had a greater understanding of the important, rewarding, and
188 often challenging work ED nurses do, regardless of a global pandemic. ED nurses were however, met
189 with both positive and negative experiences with patients at the beginning of the pandemic. Public
190 reactions were often endearing, with the offerings of "*free coffee*" (P6), meals, and public cheers in
191 the community. Conversely, on the frontline, nurses were facing violence and distrust:

"We're being physically and verbally abused out there. And I guess, it makes you really tired and really jaded about the public. They're really ungrateful." P7

There was difficulty in getting patients to adhere to government guidelines such as mask wearing, with ED nurses facing backlash due to "*conspiracies*" (P3) and lack of personal responsibility.

The physical changes that took place within the department to manage the virus were immense, often resulting in strained relationship between staff and executive management of the hospitals. Workplace configurations were changed to separate COVID and non-COVID patients, with procedures and protocols developed to protect staff and patients during this time:

"I think every shift you'd turn up, things would be different. Different protocols that have been put in. Sometimes hour by hour things would change". P5

ED nurses described the wave of "*rapid-fire sequence*" (P10) directives received from the Department of Health and Human Services (DHHS) as overwhelming. The impact the pandemic had on the health system did not go unnoticed by the ED nurses, which caused fear and distress:

"That is the biggest fear I think for me, is just watching the health system, which was already pretty rooted to start with, just completely collapse. And watching workmates who I love… have to deal with tha.t" P9

Throughout the planning process, senior nursing staff were concerned about the capacity of the health care system to potentially manage the cases that were being recorded overseas:

"When New York was being hit, they had all these refrigerated morgues outside the hospital. Those were some of the discussions we had that, God forbid if we go into a similar state, do we have the resources? Do we have the capacity?" P2

There was a desire to change the "*them and us*" (P6) relationship between staff and executive management, with staff believing fears and concerns may have been mitigated if management had consulted with them earlier in the progression of the pandemic.

2.1 Changes to Practice

The second major theme "Changes to Practice" outlined the transformations that took place within acute care during the first year of the pandemic, and how the ED nurses prepared for these changes both mentally and physically. Changes to clinical procedure and protocol were required to combat COVID-19 safely within the ED, with ethical concerns that came with these changes. Aerosol generating procedures were particularly high risk due to the danger of spreading the virus to staff and other patients:

> *"We have to put a plastic bag over your head… it just feels, just wrong, and very confronting for the staff, family, patients, everybody." P9*

Nurses battled with their employers regarding PPE, with their organizations trying to "*conserve PPE for when they really needed it*" (P6). The effort of wearing PPE for long hours took its toll on ED staff, developing pressure sores, and missing toilet and water breaks to conserve PPE supply:

> *"I'm just a ball of sweat all the time… Sometimes I don't even know where the sweats coming from, so it's been very physically uncomfortable." P9*

ED nurses highlighted that their focus had always been on their patients, however they were now having to "*rewire ourselves*" (P5) and put their own personal safety above all else.

A lack of resources, staffing and treatments increased uncertainty for ED nurses, further exacerbating the ethical dilemmas they faced daily:

> *"I think that was a bit of a daunting experience… that thought of potentially we're gonna be the ones that have to make decisions of… who we are going to try and help and who we are just going to have to make comfortable." P5*

With the changes to clinical practice guidelines, ED nurses felt that their patients were receiving "*substandard care*" (P8). This went against the foundations of nursing practice, leaving staff feeling frustrated with the loss of small personal touches normally achievable in nursing. Refusing entry to families was highlighted as one of the greatest ethical and moral dilemmas for staff, who were trying to understand the frequently changing directives while simultaneously relaying this to their patients:

> *"Nobody really explained to them* [the patient] *that they weren't allowed to have any visitors,*

and that they were going to be transferred to a department where they were basically in lockdown." P8

This refusal of entry exacerbated the concerns of staff particularly when their patients were unstable in their condition, or likely to die. Normal conversations around death and dying had become more difficult due to the COVID-19 conditions:

"This man was doing very poorly… and the family couldn't come in straight away… And I just felt like that robbed him of an opportunity to see his wife, then when he did see his wife, he was unconscious. I just thought that was really devastating." P6

When reflecting on and managing the varied emotions that ED nurses experienced at this time, they described the lack of clear debriefing opportunities and emotional support available during the first year of the pandemic. Nurses described the pain they felt not being able to provide comfort to their colleagues due to PPE and physical distancing restrictions:

"I just wanted to give her [junior staff member] a hug, and I couldn't… it was really Terrifying." P9

Newly graduated nurses outlined their feelings of isolation from other nurses, with no other graduating class having faced a first year like 2020. In the chaos of preparing for each new wave of the pandemic, their opportunities for debriefing diminished:

"We weren't supported as a graduate nurse in the way that we probably should have been. It wasn't a priority, sort of left a little bit fending for yourself." P4

Formal department debriefings occurred after critical events, however informal debriefing with colleagues provided the most benefit to ED nurses wellbeing and reflective practice.

Preparedness of the nurses and their EDs differed from a junior and senior perspective. Senior staff were involved in conversation on how to use ventilators in innovative ways from a resource saving perspective. Concerns were raised about the preparedness of physical environments, with the lack of single positive pressure rooms:

"I think that's one of the things that scared me the most, is performing procedures in areas that weren't designed to do so." P10

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Senior staff recognized how crucial it was to have an awareness of their behavior and emotions while on the floor, as junior staff looked up to them as a "*voice of reason*" (P6) in times of need. Both junior and senior staff realized that teamwork played a vital role in how they managed their workloads:

"It's [the pandemic] *made people work better together, because you really do have to rely on someone else when you're looking after patients like that. It makes you work as a team." P1*

The pandemic had provided the opportunity to make the department more "*collegial*" (P9), sharing knowledge, skills and support both internally and with neighboring hospitals.

Although many hospitals provided redeployment opportunities for staff who could not work on the frontline, the call to service was strong for many ED nurses, with some feeling as though there was no option to walk away:

"What was in my mind is if I can't do it, who will do it?" P2

Working on the frontline reignited the passion for the profession, with ED nurses finding renewed strength in the perseverance of themselves and their colleagues:

"This is why I've got such a passion for it, because I've seen the work that we do, and I believe in it. The staff are really strong." P7

Newly graduated nurses shared that it was "*exciting*" (P1) to "*jump straight into it*" (P4) when entering the department for the first time, regardless of the pandemic. The junior nurses had no means of comparison to what nursing was like beyond COVID-19, therefore appreciating the "*COVID allocation"* (P1) of high-acuity patients.

The new process of triaging patients due to physical changes to the departments was a learning curve for ED nurses. New departments and triage centers were being built external to the main hospitals, consisting of "*just a tent and some chairs*" (P5). Staff had to manage traffic and long lines of patient presentations among their acutely unwell patients, with some patients experiencing extremely long wait times:

"I get a bit anxious because patients can deteriorate when they're sitting in those wait chairs and I don't have room for them. They're saying they're in pain, it's frustrating to me because I can't help them until I've got space." P3

The lack of space in the hospital and fear from the public resulted in poor outcomes from patients. Patients had succumbed to their disease process due to presenting so late:

> *"I would very confidently say that all those people* [3 patients] *would have survived, and all of them didn't survive because they waited so long to come." P6*

This additional layer of pressure due to lack of space and resources impacted ED nurses further, who were already making high-acuity decisions often on their own.

2.2 Living Through a Pandemic

The third major theme "Living Through a Pandemic" described the emotional experiences and moral challenges ED nurses faced both at home and in the workplace during the first year of the COVID-19 pandemic. A range of emotional responses from feeling "*scared*" (P7), "*anxious*" (P6), "*anger*" (P9), "*fatigue*" (P3) and "*overwhelmed*" (P4) were experienced by ED nurses during the first year of the pandemic:

> *"Everyone was freaking out, there was not a great deal of good communication. People were just doing what they thought was best… they weren't necessarily following due process or best evidence base at the time." P8*

Following fear came anger, with senior nurses outlining the anger they experienced from colleagues in the frequent changes of protocol:

> *"…We had to deal with a fair bit of anger from staff. And my response was, yeah, that's sort of fair enough. It's fair enough for you to be angry." P9*

Fatigue began to set in, resulting from lockdowns external to the workplace and it being "*mentally exhausting*" (P5) managing patient flow in the department.

ED nurses experienced fear towards contracting COVID-19 both at work and in the community, with those feelings at times impacting the care for their patients:

> *"I found that I've had to… cluster my care… to reduce the amount of times that I was going in and out of the room." P5*

Without a vaccine and appropriate treatments available in 2020, ED nurses were worried about contracting COVID-19:

"I would be concerned if I did get it [COVID-19], *because I don't wanna end up on a ventilator, I don't wanna end up not being able to breathe." P3*

Fear experienced at work began to extend beyond the hospital, being "*too scared to go out anywhere*" (P7), with fears of being exposed to the virus in public, or potentially spreading COVID-19 to the community. To avoid bringing COVID-19 home to their families, ED nurses changed their home and personal routines to keep family and friends safe. Many nurses outlined feeling "*paranoid about what we would take home to our families*" (P9):

"I would come home in the garage, come through the back door and straight into the laundry, put my uniform into the hot wash before I'd come in contact with anything else, then go and have a hot soapy shower before I saw any of my family." P8.

Ongoing discussions and plans were made with family to protect them from COVID-19, and what it would mean if their loved ones were to contract the virus:

"If I got it, by the time I realized I had it, it would probably be too late anyway, and the family would have it." P9

Some nurses distanced themselves from extended family and friends, while others experienced family and friends avoiding contact with them due to their high-risk work. When managing these varied emotional experiences, ED nurses employed protective strategies to manage their wellbeing and identify when they needed a break. Some decided it was time to step back and take time off clinical work for a few days to reset and find passion for their profession again:

"I think everyone's cup is about three quarters full and it's only taking very little for people to say, that's enough. I'm really happy that my staff have been able to come to me and talk to me about it and discuss when they need leave." P10

Specific coping strategies of ED nurses included saying "no" and being able to voice when they had enough, having a mental distinction between work and home life and engaging in physical activity, and walking and being out in the sunshine.

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2.3 2021: Here We Come

The fourth and final major theme "2021: Here We Come" provided a reflection into the ED nurses experience of a pandemic, highlighting benefits both personally and professionally and hopes for the future. Although negative experiences were plentiful for ED nursing during the first year of the COVID-19 pandemic, a reflection on learning experiences and positive times produced optimism:

> *"I was learning a whole new skill set and everything was new again and I kind of like that… To be challenged again and learning new things again, almost like we had to snap the system and put it back together in a slightly different way." P9*

COVID-19 had been an "*exceptional experience*" (P2) for many ED nurses, finding strength in "*being able to say, hey, I nursed through a pandemic*" (P3). Through this "*baptism of fire*" (P6), a mix of emotions emerged. Some nurses felt "*guilty*" (P9) for experiencing the pandemic positively (e.g., strengthened family and collegial bonds), while others felt confident that if more waves of the virus were to come, they would feel prepared:

> *"Maybe one good thing that we can learn out of this is disaster preparedness, and maybe health care institutions doing more disaster drills in relation to getting prepared." (P2)*

ED nurses described their adjustment to COVID-normal as surreal, comparing it to "*Stockholm syndrome*" (P9) when reflecting on the last 12 months. The potential for a vaccine was an exciting prospect, however questions about vaccine hesitancy from community and nursing staff was highlighted. When reflecting on whether ED nurses could face future waves of the virus, optimism was evident:

> *"I think we would be much better placed to go for round two. I wouldn't ask for it too soon though (laughing)." P10*

On reflection, ED nurses questioned whether this first year of COVID-19 would "*change the way we're gonna nurse forever"* (P3), with some unwavering in their support for their future career in the department and profession.

Discussion

The aim of the research project was to gain an understanding of lived experiences of Australian ED nurses working on the frontline during the COVID-19 pandemic. These findings present a snapshot in time of 2020; the first year of the COVID-19 pandemic within Australia, and how this affected our ED nurses.

This examination of the lived experiences of regional ED nurses versus metropolitan ED nurses revealed similar feelings surrounding the impacts of the media, experiences of wearing PPE, emotional responses to the virus, and hopes for the future. Regional nurses in this study, however, recognized they may have had more time to prepare policies and procedures around COVID-19 management than their metropolitan counterparts. Despite this additional preparation, studies suggest that mental health impacts of the COVID-19 pandemic may still be prevalent in regional and rural nurses, even with lower caseloads.[25] This is hypothesized as being due to limited access to specialist medical support, inadequate infrastructure, and varied recruitment and retention of staff.[25]

A noteworthy finding from this study was how ED nurses respond to external influences such as media and conversations had within their workplaces. These influences appeared to shape how nurses responded to their lifeworld, and the subsequent emotional experiences that guided their behavior and understanding at this time. Despite their training and advanced education within infection control standards, the ED nurses remained fearful of bringing COVID-19 home to their families. These findings were similar to Ali et al.[14] who found that nurses who are parents think and behave more like civilians rather than health professionals despite their training. Furthermore, literature suggests that ED nurses who were parents carried the increased burden of fear of infecting children and experienced heightened demands of childcare with school closures.[8, 17] The majority of ED nurses in this study were parents or had caring responsibilities (n = 7), potentially illuminating why nurses were not immune to the anxieties and fears associated with the pandemic and its impact on themselves, family, friends and workmates.

In this study, ED nurses were appreciative of the community support they received because of their profession. However, many highlighted that they were just doing their job as they had been trained, business as usual. Similarly, offerings of free coffee and meals were endearing, but did not assist in the management of emotional, mental and physical pressures of the pandemic. These findings

were supported within international literature, where dehumanization of ED nurses occurs when they are labelled as 'superheroes', assuming they have superhero powers that make them immune to the pressures of their role.[26] Being labelled as someone who can do the impossible removes the human limitations of these nurses, and potentially undermines the professional role and training required to be an emergency nurse.[27, 28] The ED nurses in this study were vulnerable to the many changes and dangers that COVID-19 presented during the first year, and highlighted the need to create a stronger focus on nurse support and wellbeing within organizations.

Limitations

Despite the success in recruitment of participants for this project, potential limitations were identified in the timing of the COVID-19 pandemic. Due to the increased strain placed on healthcare workers, nurses may have been reluctant to engage in any further activity such as research outside of working hours. Due to the longitudinal nature of this study, formal analysis for each individual data set was delayed until all data had been collected to avoid premature conclusions being drawn. Although this ensured future data collection would not be impacted by prior assumptions, it resulted in the delay of reporting findings. In addition, although an appropriate cross-section of emergency nurses was achieved in this project, findings may not be generalizable to other Australian states or countries with a single state sample represented within this study. Furthermore, there was an overrepresentation of female nurses within the sample, with an underrepresentation of male and gender diverse populations. Despite these limitations, the findings demonstrate important learnings from the COVID-19 pandemic that may assist in future pandemic and epidemic management planning.

Implications for Emergency Nurses

Findings from this study highlight the need for ED nurse wellbeing protocols to be implemented within the department to protect the mental and physical wellbeing of the workforce. This current need to highlight wellbeing needs of ED nurses is ever-present in the continued nature of the COVID-19 pandemic globally. In the United States, current evidence suggests that ED nurses are leaving the profession to change careers at higher rates than non-ED nurses, citing insufficient staffing

and physical demands of the work post-COVID-19.[29] In Australia, ED nurses cited since the onset of COVID-19, a lack of connection with colleagues and their organization increased their intentions to leave the profession.[11] This study provided ED nurses a platform to voice their experiences, emotions and attitudes to working in the ED during the pandemic. Facilitating discussion and debriefing through storytelling also allowed ED nurses in this study an opportunity to engage in reflective practice. Study findings suggest that sharing their voices, reflecting on their practice, and debriefing are ways nurses in high-risk environments find wellbeing, build resilience and discover healthy coping strategies. To date, there remains limited available literature on ED nurse specific lived experiences during the COVID-19 pandemic, particularly within Australia. To ensure new learnings, reflections, and past experiences are not lost as the pandemic evolves, it is vital to historically represent these findings of the ED nurse population. This study presents findings from one of three stages of data collection for the broader longitudinal project, undertaken from 2020 to 2022. Subsequent findings will be made available post analysis.

Conclusion

ED nurses have been exposed to extreme physical, mental, and emotional conditions as a result of the COVID-19 pandemic. The range of mixed messages received from media and organizations, experienced changes to clinical practice, maintenance of livelihoods beyond work, and uncertainty of what the future may hold had a profound impact on our frontline healthcare workers. Although educated and experienced in their role, ED nurses are not immune to the fears and uncertainty a global pandemic carries. A greater emphasis on the mental and emotional wellbeing of our frontline workers is of paramount importance for the success of maintaining a strong and resilient healthcare workforce.

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References

1. World Health Organisation. Coronavirus disease (COVID-19) pandemic 2022. https://www.who.int/emergencies/diseases/novel-coronavirus-2019.
2. Marshall B. Impact of COVID-19 on Nurses' Mental Health. *Iss in Mental Health Nurs*. 2020;41(10):853-4 10.1080/01612840.2020.1819083.
3. Australian Institute of Health and Wellafare. Hospital admissions rose as COVID-19 restrictions eased in most states and territories in 2020–21 [press release]. 2022.https://www.aihw.gov.au/news-media/media-releases/2021/june/hospital-admissions-rose-as-covid-19-restrictions
4.Li C, Sotomayor-Castillo C, Nahidi S, Kuznetsov S, Considine J, Curtis K, et al. Emergency clinicians' knowledge, preparedness and experiences of managing COVID-19 during the 2020 global pandemic in Australian healthcare settings. *Aust emerg care.* 2021;24(3):186-96 10.1016/j.auec.2021.03.008.
5. Australian Institute of Health and Welfare. The first year of COVID-19 in Australia: direct and indirect health effects. 2021. https://www.aihw.gov.au/reports/burden-of-disease/the-first-year-of-covid-19-in-australia/summary.
6. Jackson D, Bradbury-Jones C, Baptiste D, Gelling L, Morin K, Neville S, et al. Life in the pandemic: Some reflections on nursing in the context of COVID-19. *J of clinical nurs.* 2020;29(13-14):2041-3 10.1111/jocn.15257.
7. Whetzel E, Walker-Cillo G, Chan GK, Trivett J. Emergency Nurse Perceptions of Individual and Facility Emergency Preparedness. *J of Emerg Nurs.* 2013;39(1):46-52 10.1016/j.jen.2011.08.005.
8. Xu S, Yang Q, Xie M, Wang J, Shan A, Shi F. Work experience of triage nurses in emergency departments during the prevalence of COVID-19. *Intl emerg nurs.* 2021;56:101003-10.1016/j.ienj.2021.101003.
9. World Health Organisation. Health and Care Worker Deaths during COVID-19. 2021. https://www.who.int/news/item/20-10-2021-health-and-care-worker-deaths-during-covid-19.
10. Jackson MR, Porter JE, Mesagno C. Exploring the experiences of frontline nurses during the first 6 months of the COVID-19 pandemic: An integrated literature review. *Nurs Open*. 2023;10:2705-2719. https://doi.org/10.1002/nop2.1534.
11. Cornish S, Klim S, Kelly AM. Is COVID-19 the straw that broke the back of the emergency nursing workforce? *Emerg medicine Aust*. 2021;33(6):1095-9 10.1111/1742-6723.13843.
12. Gorman VL-A. Future Emergency Nursing Workforce: What the Evidence Is Telling Us. *J Emerg Nurs.* 2019;45(2):132-6 10.1016/j.jen.2018.09.009.
13. Coffré JAF, Leví Aguirre PdlÁ. Feelings, Stress, and Adaptation Strategies of Nurses against COVID-19 in Guayaquil. *Investigación y educación en enfermería*. 2020;38(3) 10.17533/udea.iee.v38n3e07.
14. Ali H, Cole A, Ahmed A, Hamasha Sd, Panos G. Major Stressors and Coping Strategies of Frontline Nursing Staff During the Outbreak of Coronavirus Disease 2020 (COVID-19) in Alabama. *J of Multidis Healthc.* 2020;13:2057-68 10.2147/JMDH.S285933.
15. Labrague LJ, Santos JAA. Fear of COVID-19, psychological distress, work satisfaction and turnover intention among frontline nurses. *J Nurs Manag.* 2021;29(3):395-403 10.1111/jonm.13168.

16. Galehdar N, Kamran A, Toulabi T, Heydari H. Exploring nurses' experiences of psychological distress during care of patients with COVID-19: a qualitative study. *BMC Psych.* 2020;20(1):489-9 10.1186/s12888-020-02898-1.
17. Cui S, Jiang Y, Shi Q, Zhang L, Kong D, Qian M, et al. Impact of COVID-19 on Anxiety, Stress, and Coping Styles in Nurses in Emergency Departments and Fever Clinics: A Cross-Sectional Survey. *Risk Manag Healthc Policy.* 2021;14:585-94 10.2147/RMHP.S289782.
18. Gadamer HG. *Truth and Method.* Revised ed: Continuum Press; 2003.
19. Polit DF, Beck CT. *Nursing research : generating and assessing evidence for nursing practice*. Tenth edition.. ed. Beck CTa, editor. Philadelphia: Wolters Kluwer Health; 2016.
20. Fusch P, Ness L. Are We There Yet? Data Saturation in Qualitative Research. *Qual report*. 2015;20(9):1408 10.46743/2160-3715/2015.2281.
21. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Research in Psych.* 2006;3(2):77-101 10.1191/1478088706qp063oa.
22. Guba EG, Lincoln YS. Epistemological and Methodological Bases of Naturalistic Inquiry. *Edu comm and tech.* 1982;30(4):233-52 10.1007/BF02765185.
23. Guba EG, Lincoln YS. Competing paradigms in qualitative research. In: Denzin NK, Lincol YS, editors. *Handbook of qualitative research*: Sage Publications, Inc; 1994. p. 163-94.
24. Connelly LM. Trustworthiness in Qualitative Research. *Medsurg Nurs*. 2016;25(6):435-6. https://pubmed.ncbi.nlm.nih.gov/30304614/
25. Tham R, Pascoe A, Willis K, Kay M, Smallwood N. Differences in psychosocial distress among rural and metropolitan health care workers during the COVID-19 pandemic. *Aust J Rural Health*. 2022 10.1111/ajr.12873.
26. Rossi S, Cosentino C, Bettinaglio GC, Giovanelli F, Prandi C, Pedrotti P, et al. Nurse's identity role during Covid-19: Perceptions of the professional identity of nurses during the first wave of infections of the Covid-19 pandemic. *Acta bio-medica* [Internet]. 2021. 92(S2):[e2021036 p.]. https://doi.org/10.23750/abm.v92iS2.11959
27. Stokes-Parish J, Elliott R, Rolls K, Massey D. Angels and Heroes: The Unintended Consequence of the Hero Narrative. *J of Nurs Scholarship*. 2020;52(5):462-6 10.1111/jnu.12591.
28. Yim Bolduc C. Stop Calling Nurses Superheroes: Medscape; 2022. https://www.medscape.com/viewarticle/976190.
29. Norfull A, Cato K, Chang BP, Amberson T, Castner J. Emergency Nursing Workforce, Burnout, and Job Turnover in the United States: A National Sample Survey Analysis. *J of Emerg Nurs.* 2023;49(1) https://doi.org/10.1016/j.jen.2022.12.014.

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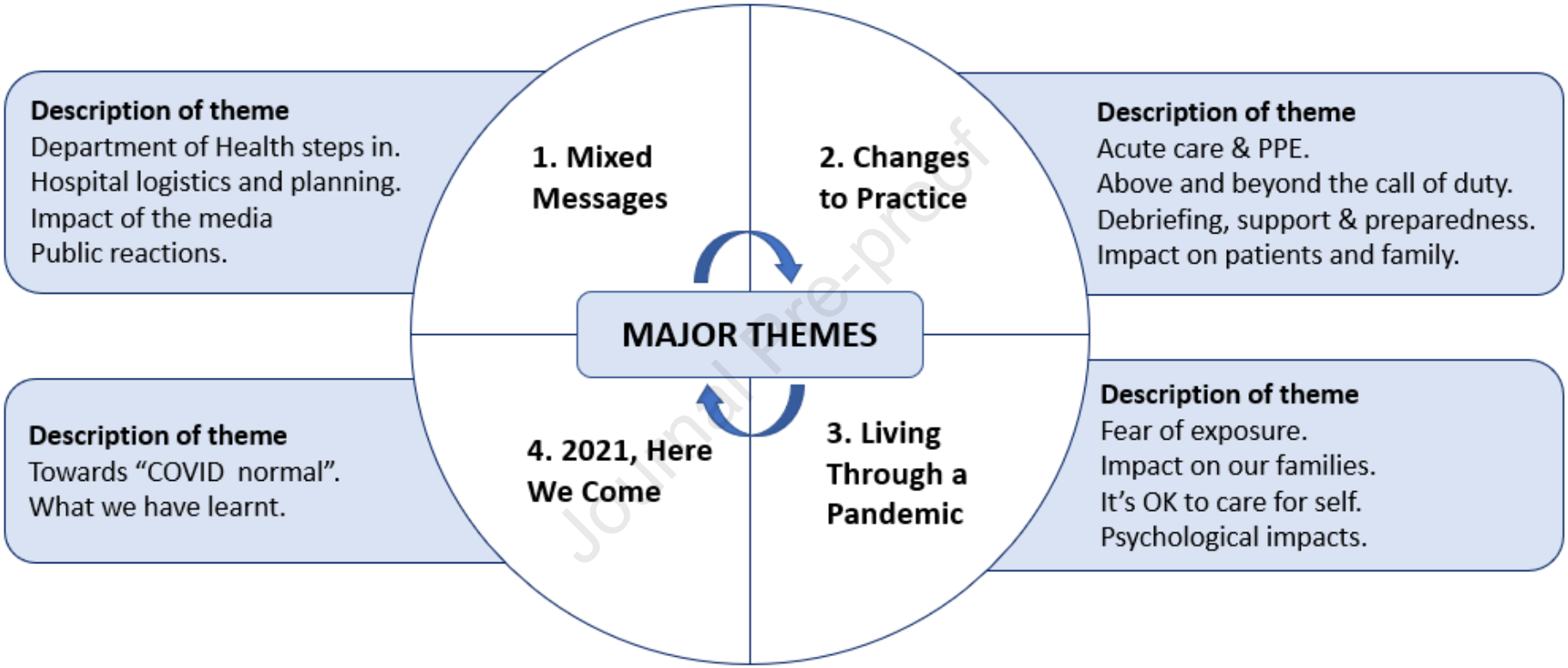
Figure 1 Major theme model



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Approval

Human Research Ethics Committee

Principal Researcher:	Associate Professor Joanne Porter	
Co- Researcher/s:	Dr Christopher Mesagno Dr Ainsley James	Ms Megan Jackson
School/Section:	**School of Health**	
Project Number:	**A20-095**	
Project Title:	**Emotional responses of Nurses working in the Emergency Department during the COVID-19 pandemic.**	
For the period:	04/08/2020 **to** 15/06/2021	

Quote the Project No: A20-095 in all correspondence regarding this application.

Approval has been granted to undertake this project in accordance with the proposal submitted for the period listed above.

Please note: It is the responsibility of the Principal Researcher to ensure the Ethics Office is contacted immediately regarding any proposed change or any serious or unexpected adverse effect on participants during the life of this project.

In Addition: Maintaining Ethics Approval is contingent upon adherence to all Standard Conditions of Approval as listed on the final page of this notification

COMPLIANCE REPORTING DATES TO HREC:

Final project report:
15 July 2021

The combined annual/final report template is available at:

https://federation.edu.au/research/support-for-students-and-staff/ethics/human-ethics/human-ethics3

Fiona Koop
Coordinator, Research Ethics
4 August 2020

Please note the standard conditions of approval on Page 2:

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STANDARD CONDITIONS OF APPROVAL

1. Conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC.

2. Advise (email: research.ethics@federation.edu.au) immediately of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project.

3. Where approval has been given subject to the submission of copies of documents such as letters of support or approvals from third parties, these are to be provided to the Ethics Office prior to research commencing at each relevant location.

Submission for approval of amendments to the approved project before implementing such changes. A combined amendment template covering the following is available on the HRE website: https://federation.edu.au/research/support-for-students-and-staff/ethics/human-ethics/human-ethics3

- Request for Amendments
- Request for Extension. Note: Extensions cannot be granted retrospectively.
- Changes to Personnel

4. Annual Progress reports on the anniversary of the approval date and a Final report within a month of completion of the project are to be submitted by the due date each year for the project to have continuing approval.

5. If, for any reason, the project does not proceed or is discontinued, advise the Committee by completing the Final report form.

6. Notify the Ethics Office of any changes in contact details including address, phone number and email address for any member of the research team.

7. The HREC may conduct random audits and / or require additional reports concerning the research project as part of the requirements for monitoring, as set out in the National statement on Ethical Conduct in Human Research.

Failure to comply with the *National Statement on Ethical Conduct in Human Research* 2007 (Updated 2018) and with the conditions of approval will result in suspension or withdrawal of approval.

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Amendment Approval

Human Research Ethics Committee

Principal Researcher:	Associate Professor Joanne Porter	
Co- Researcher/s:	Dr Christopher Mesagno Dr Ainsley James	Ms Megan Jackson
School/Section:	**School of Health**	
Project Number:	**A20-095**	
Project Title:	**Emotional responses of Nurses working in the Emergency Department during the COVID-19 pandemic.**	
For the period:	31/03/2021 **to** 15/06/2022	

Quote the Project No. A20-095 in all correspondence regarding this application.

Amendment Summary: N/A

Extension: The completion date for this project has been extended from 15/06/2021 to 15/06/2022

Personnel: N/A

Please note: Approval has been granted to undertake this project in accordance with the proposal and amendments submitted for the period listed above. Ongoing ethics approval is contingent upon adherence to the Standard Conditions of Approval on Page 2 of this notification.

COMPLIANCE REPORTING TO HREC:

Annual report due:
4 August 2021

Final report due:
15 July 2022

The combined annual/final report template is available at:

HREC Forms

Fiona Koop
Coordinator, Research Ethics
31 March 2021

Please note the standard conditions of approval on Page 2:

Journal Pre-proof

STANDARD CONDITIONS OF APPROVAL

1. Conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC.

2. Advise (email: research.ethics@federation.edu.au) immediately of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project.

3. Where approval has been given subject to the submission of copies of documents such as letters of support or approvals from third parties, these are to be provided to the Ethics Office prior to research commencing at each relevant location.

4. Make submission for approval of amendments to the approved project before implementing such changes. A combined Amendment request template is available for the following:
   - Request for Amendments
   - Request for Extension. Note: Extensions cannot be granted retrospectively.
   - Changes to Personnel

5. Annual Progress reports on the anniversary of the approval date and a Final report within a month of completion of the project are to be submitted to the Ethics Office by the due date each year for the project to have continuing approval.

6. If, for any reason, the project does not proceed or is discontinued, advise the committee by completing a Final report form.

7. Notify the Ethics Office of any changes in contact details including address, phone number and email address for any member of the research team.

8. The HREC may conduct random audits and / or require additional reports concerning the research project.

Failure to comply with the *National Statement on Ethical Conduct in Human Research* 2007 (Updated 2018) and with the conditions of approval can result in suspension or withdrawal of approval.

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