The impact of leadership on the nursing workforce during the COVID-19 pandemic

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Abstract

Background: The aim was to determine how the learning about protective factors from previous pandemics was implemented and the impact of this on nurses' experience.

Methods: Secondary data analysis of semi-structured interview transcripts exploring the barriers and facilitators to changes implemented to support the surge of COVID-19 related admissions in wave one of the pandemic. Participants represented three-levels of leadership: whole hospital (n=17), division (n=7), ward/department-level (n=8), and individual nurses (n=16). Interviews were analysed using Framework analysis.

Results: Key changes that were implemented in wave one reported at whole hospital-level included: a new acute staffing level, redeploying nurses, increasing the visibility of nursing leadership, new staff wellbeing initiatives, new roles created to support families and various

training initiatives. Two main themes emerged from the interviews at division, ward/department and individual nurse level: impact of leadership, and impact on the delivery of nursing care.

Conclusions: Leadership through a crisis is essential for the protective effect of nurses' emotional wellbeing. While nursing leadership was made more visible during wave one of the pandemic and processes were in place to increase communication, system-level challenges resulting in negative experiences existed. By identifying these challenges, it has been possible to overcome them during wave two by employing different leadership styles, to support nurse wellbeing. Challenges and distress nurses experience when making moral decisions requires support beyond the pandemic for nurse's wellbeing. Learning from the pandemic about the impact of leadership in a crisis is important to facilitate recovery and lessen the impact any further outbreaks.

Introduction

COVID-19 is an outbreak of a novel coronavirus disease which was declared a global pandemic by the World Health Organisation (WHO) in the early months of 2020. As with many previous viral outbreaks, and other catastrophic scenarios such as wars, acts of terrorism, or natural disasters, nurses were a core element of the frontline response.[1,2] Past viral outbreaks, such as severe acute respiratory syndrome (SARS), Middle East Respiratory Syndrome (MERS) and Ebola, have highlighted the level of exposure nursing staff experience to both the disease and associated stressful stimuli, which often results in high levels of systemic burnout and chronic psychological distress.[3-5]

Times of great systemic change within a healthcare setting can have negative consequences on nurses working on the frontline.[6] There is indeed a lengthy history of nurses feeling as though restructuring at an organisational level often fails to account for their experiences, and that changes may come with many impractical implications on their roles as a result of their voices not being heard by those within the managerial hierarchy.[7] Clear communication and strong visible leadership are elements associated with mitigating the impact high stress events can have on healthcare staff. A lack of clear leadership and regulatory protocols in times of crisis can lead to an increase in psychological distress for nurses.[8,9] In particular, the decisions of nurse leaders (sisters and matrons), and consequently how these decisions are communicated to their teams, have direct impact on the quality of nursing provided during a crisis, and consequently, impact on patient safety.[2] However, it is important to note that nurse leaders may likewise be affected by the choices and communications of their executive superiors. Poor communication from organisational leaders can leave nurse leaders feeling frustrated and anxious providing guidance to their teams which they feel are vague or subject to frequent change in a crisis.[2,10] Nursing leaders therefore have significant emotional weight added to their roles, both in managing their teams, managing the crisis itself, and engaging with the organisation at large. They are often required to adapt quickly to these uncertain circumstances to continue to ensure reliable and safe care for both their staff and the patient base as a whole.[11]

We undertook an evaluation of a large central university hospital in the United Kingdom (UK) at the beginning of the pandemic to determine the impact on nursing of the changes that were implemented to accommodate the increase in COVID-19-related admissions. Given the knowledge of how past pandemics have affected nurse leaders and nurses working at the frontline, this was secondary analysis of data collected in the evaluation to determine how the learning about protective factors from previous pandemics were implemented and the impact of this on nurses' experience. We also aimed to identify if there were more complex occupational challenges needed to be further support nursing wellbeing in future exceptional circumstances.

Methods

Participants

The evaluation was conducted in a large inner-city hospital comprising of facilities on thirteen sites, with 665 inpatient beds, employing over 9,700 members of staff, of whom nearly 3,500 were nurses and midwives. Recruitment to the evaluation was purposeful and conducted in three phases, involving three tiers of leadership (Figure 1). The fourth tier included a convenience sample of clinical nurse specialists (CNS) and clinical research nurses (CRN) who were either redeployed or covered work for colleagues who were redeployed. The aim was to recruit representation from operational leads for all the areas where there were changes, and ten participants for each of the other groups.

Participants were invited to participate through an introductory email from the Nursing and Midwifery Leadership Team, with directions to contact the research team directly to ensure anonymity. The Health Research Authority has the Research Ethics Service as one of its core functions and they determined the project was exempt from the need to obtain approval from an NHS Research Ethics Committee. However, the evaluation was conducted in accordance with the UK Framework for Health and Social Care Research.[12] Participants gave recorded consent and were assured of anonymity and confidentiality. During the interviews with matrons, it was evident that participants were experiencing a degree of distress so interviews with sisters and CNS/CRNs were conducted by researchers who had training in psychology and counselling so they could provide immediate support and signpost to the relevant expertise within the hospital to provide longer-term support.

Data collection

Data were collected through semi-structured interviews conducted through online videoing software by three researchers (LH/AP/RMT). The interview schedule with the operational leads focused on a description of the changes, what worked well, where there were challenges and what could have gone better, and what changes they felt should be implemented as business as usual. The interview schedule for the other interviews reflected on the changes in practice and how this had impacted on their work, how they led their teams (matrons and sisters), impact on the team and the personal impact. The interview schedule was reviewed by the Nursing and Midwifery Leadership Team. Interviews were recorded, notes were made from the interviews from the operational leads and the rest were transcribed verbatim.

Analysis

Data were analysed using Framework analysis[13], which is a five stage process comprising of familiarisation, identifying a thematic framework and indexing the transcripts according to the framework, developing a grid and charting into each theme and finally mapping and interpretation of framework. The secondary analysis for this study was at the point of mapping and interpretation, focusing on the interactions between themes according to the tiers of nursing. Transcripts re-reviewed to ensure all aspects of the overarching theme of leadership had been captured in the original framework, by two researchers . The framework was subdivided into the tiers of nursing so the interrelationships between decision and impact could be identified. Members of the evaluation team were senior nurses within the hospital so to limit bias analysis was undertaken by two people but the framework and subsequent charting were randomly checked by two others. An independent researcher (CV) with extensive qualitative health research experience also reviewed the charting, subsequent interpretation and presentation of the findings. Members of the nursing leadership team identified the relevance to practice and implications for leading exceptional circumstances in the future.

Findings

A total of 48 members of staff participated in the evaluation (Table 1). The findings are presented as a summary of the hospital-wide operational changes followed by the themes that emerged from the interviews with the other three tiers of nursing. For ease of reporting the terms hospital-wide, matron (division), sister (ward/department) and nurse are being used and more granular level detail is not provided to ensure anonymity.

Summary of the operational changes to the delivery of care

A summary of the changes made to the delivery of care across the hospital are presented in Table 2.

There were two key themes that emerged from the data: impact of leadership and impact on the delivery of nursing care. Support quotes are presented in Table 3.

Impact of leadership

The leadership theme had five sub-themes: visible leadership; communication; accuracy and consistency of information; providing support; and impact of decision-making.

Visible leadership

The ‘matron of the day’ was implemented to make leadership visible. It was an important role because it extended cover across the hospital to give an additional safety net. This reduced bureaucracy and facilitated matrons spending more time in the clinical areas. However, some of the matrons felt that this role was unnecessarily and doubled up on work that was already being done. Sisters did not discuss visible leadership, but nurses reported positively to having increased visibility of the matrons as they were more accessible, and they were able to communicate easily with them.

Communication

Matrons felt that matron-to-matron communication was better during the pandemic than it had ever been before. However, they felt that things were changing so fast that there was

often no time to give explanations of changes to their teams. They recognised that this contributed to, and often fuelled their team's anxieties and fears. Sisters reported that sometimes communication was sub-optimal or inadequate, but sisters appreciated the circumstances they were in, and reaffirmed the view of matrons that the style of communication resulted from a state of crisis management, even if it created high levels of uncertainty. Conversely, nurses noted that the daily communications from the hospital were good and kept them informed of what was happening. However, they did not perceive good communication around redeployment, especially from the managers who were leading it. Consultation around redeployment was also not equitable, with some being asked where they wanted to work while others were instructed that they were going to be moved without any consultation.

Accuracy and consistency of information

Matrons felt as if there was an expectation that they were the expert, but the rapidly changing information made it difficult for them to be confident about the accuracy of the information they were distributing. An example of this was the inconsistency of the information around personal protective equipment (PPE), and the frequent change in recommendations. Information was often circulated without any forewarning, so matrons were not always prepared to be able to give the necessary support to their staff. Sisters expressed the same frustration as matrons about the constantly changing guidance, especially around PPE. Nurses reported good communication in the hospital even though they initially felt that they were finding out information through social media rather than their line managers. Nurses were given information by their ward sisters, but often got the impression that the people giving it knew as little as they did. Again, the inconsistent information about PPE was stressful, especially the constantly changing guidance.

Providing support

In addition to visible leadership and effective communication, matrons needed to provide a lot of pastoral care to their teams, which was time consuming. This was also important for staff who were working from home, who equally needed their support, and the acknowledgement that their roles were as important as their colleagues, perhaps in part due to rhetoric at the time focusing primarily on staff working on the frontline. Overall, sisters did not always know where their redeployed staff were working or if they were off sick, so were not able to provide them with any support. There were pressures on some sisters to provide remote support to their team while they were not receiving any support themselves from the matrons. Nurses had a more negative perception of leadership support especially those who were required to deliver frontline care who had not delivered ward-based care for many years. They felt their fears were not taken seriously. Conversely, those who were working from home felt isolated by the focus on supporting nurses working on the frontline.

Impact of decision-making

Perceived poor decision-making at more senior levels impacted elsewhere. For example, matrons felt that the hospital-wide changes that were being implemented did not always align with the workforce requirements. They questioned whether there was enough nursing input into some of the decisions that were being made operationally. Sisters felt that even when they were consulted about some changes, their input was ignored. Concerns were expressed on several safety issues, especially redeployment of staff who had not done shifts

for many years and the decision to move them into COVID-19 areas. The decision to move nurses was also often perceived to be very last minute, in a crisis management manner. Nurses understood that they needed to be redeployed but were confused and sometimes angry about how they had been notified. Some described an anxious and liminal period, having been given a short notice of redeployment followed by an extended period of time waiting to be deployed.

Impact on the delivery of nursing care

The impact on the delivery of care was influenced by redeployment and teamwork.

Redeployment

Initially, there was confusion over the allocation of shifts to redeployed staff so it was not always clear to sisters if shifts were being covered. While nurses were able to organise their shifts, they were not organised in advance in the same way as non-deployed nurses, which had an impact on their personal life. Matrons had organised redeployment early in the planning stages based on their relationships and knowledge of their staff – they knew their teams' personal histories so matched decisions to best fit their emotional situation. The matrons reflected that the general epistemic uncertainty surrounding COVID-19 as the situation developed resulted in the hospital being over prepared to a degree: *'Prepared for a war that didn't come*'. Consequently, there were lots of staff who were redeployed, who did not necessarily need to be redeployed. Furthermore, there was a lack of clarity on the process for transitioning redeployed nurses back into their own roles. This was a frequent enquiry by sisters and nurses, who felt that when it was clear that staff were not needed, they should have been able to go back to their own roles.

A particular challenge noted was redeployment resulted in the workload of redeployed nurses being distributed to those who were not redeployed because care for existing patients still needed to continue. Sisters needed to provide a lot of support for redeployed nurses, especially those who had not been ward based for a long time experienced a lot of anxiety. Similar to matrons, they noted the transition back was often more problematic. Sisters found that they were given no notice or details about when their nurses were transitioning back.

The hospital being over prepared, noted by matrons, was an observation reinforced by nurses who had been redeployed, who found that often there were more staff on duty than patients. They questioned why they could not return to their roles so they could continue their work. Some of the nurses who were redeployed reported that they were not always treated very well and felt that the decision on where to deploy them was made based solely on their clinical background, for example, having to go back into critical care, which had a negative impact on their emotional wellbeing.

Though initially there was a willingness to be redeployed, many felt that after their experiences of being redeployed, they may not be as willing to be redeployed again during a second wave. Again, the transition back to normal roles was another period of anxiety and uncertainty and nurses found that when they did transition back, it was not transitioning back to normal, so they still felt as if they were in *'limbo'*. Often after they had transitioned back,

they found that no one had supported their work while deployed, leaving them with a lot more work to catch up on.

Teamwork

Firstly, the matrons felt that they worked very closely together, which provided them with a lot of support. Sisters also reported that having their team together was important for support; it was felt that it was better to care for a different population than splitting the team. Keeping the team together was enhanced because of the availability of virtual communication, so nurses working from home were able to benefit from the team support. However, sisters who were given a new team to manage, felt isolated. A new team resulted in a change in the dynamic; when non-nursing members of the team tried to enforce a culture from their previous location, this caused conflict. The changed dynamic needed to be managed when the team returned because there was resentment from nurses who were COVID-19 facing when they met members of their team who were not, who were viewed as having worked in a '*bubble'*. However, a positive aspect of the change in the ward team was the lack of role definition so it was a lot easier to manage patient care because everybody was willing to do everything. While some nurses felt that the mechanisms that they and their sisters had put into place to develop a team spirit worked well, e.g., WhatsApp groups, others reported having no line manager contact throughout their redeployment, so they felt very isolated.

There was a general sense that there was a flattened hierarchy and a sense of community, '*everybody was in the same boat'*; medical colleagues were contributing to the delivery of fundamental nursing care that COVID-19 patients required. This flattened hierarchy was helpful for facilitating support for redeployed nurses; grades became irrelevant when seeking and giving advice and guidance. However, nurses were not always welcomed into the teams they had been redeployed to, with examples given of host nurses acting as if they were superior and not acknowledging that those who were redeployed were often experienced and highly qualified nurses.

Discussion

This study reports the impact of leadership on the nursing workforce of the transformation of the workplace to accommodate the COVID-19 pandemic. Previous studies have highlighted protective measures that organisations should implement to minimise the psychological burden on clinical staff of responding to a pandemic. These included clear communication, leadership and access to PPE, as well as access to psychological support, provisions of food and necessities, adequate shift patterns, options of alternative accommodation and access to up-to-date training and education.[14] In this single centre study these recommendations were taken up as policy decisions that were enacted by nurse leaders.

There is a large body of evidence related to leadership in nursing, which mostly supports transformational, relational, collective and ethical leadership being associated with better job satisfaction and improved patient and staff outcomes. This is in contrast to the style of command and control leadership recommended and adopted in many healthcare organisations during the first wave of the pandemic, including the one in which the current

study was based. Typical crisis management includes command and control leadership, with centralised decision-making and communication. The literature reflecting on the organisation of care during the first wave of the pandemic in 2020 reflects this but also highlights the limited nursing leadership embedded within these models of care. For instance Zom et al presented their model of an incident command system, where the structure of the incidence management team did not include nursing. As the fundamentals of nursing care were the basis of treatment for patients with COVID-19, often requiring medical teams to deliver 'nursing' care, this is surprising.

This is in contrast to the model of leadership in the organisation in the current study, where the Chief Nurse worked alongside the Chief Executive and Senior Director Team to ensure collaborative and coordinated delivery of care. The organisational leadership style therefore reflected more the duality of leadership styles shown in participants in Smithson's study. Command and control leadership was necessary to manage the uncertainty of the situation but leading during the pandemic was different to traditional disasters, as these were mostly time limited did not "wax and wane over an indeterminate time". The traditional command model was therefore noted to be insufficient and stifling, so leaders in Smithson's study moved towards relational leadership. This was more 'agile' to the changing situation, while ensuring they were able to reduce staff anxiety.

Similar to other reports of leadership during a crisis, the current study focused on the behaviours related to crisis leadership rather than leadership styles per se. Clear communication has been identified as a protective factor[14] and in this study nurse leaders described a rapidly changing scenario where they were often unsure of the accuracy of the information they were sharing. This was occurring in the context of a rapidly evolving international pandemic and a national response where information was emerging and changing equally rapidly. The theme of communication demonstrates clearly how participants at all levels experienced the uncertainty they were working in as difficult. Their experience of changes during the pandemic were not the direct translation of policy decisions in a linear way top to bottom as systemic thinking leads them to believe it should be but instead the result of a multiplicity of human interactions.[15,16] There was variation in how policy decisions were taken forward and subsequently the local decisions that resulted from them. This was particularly evident in redeployment; previous studies have illustrated the negative impact of the uncertainty associated with deployment in a crisis (Li et al., 2017) and the current study illustrates the challenges of redeploying staff in an unfolding crisis where matching demand and need was unpredictable.

Balancing the competing demands of the organisational policy with the needs of staff has been reported previously as a difficult but core element of daily nurse leadership.[17] Arguably, the work and the impact of these decisions was greater in this case where the language used illustrated the moral distress experienced when making and communicating these decisions:

> *"I felt like a general in the first world war standing back sitting on a horse saying off you go, it'll be okay. You can put your head up and climb out that trench and run across that no man's land. It'll be alright. And hands on heart not actually be 100% sure of what I'm saying…" (Matron)*

The current study highlighted the importance of matrons and sisters' knowledge of their workforce when leading redeployment decisions to ensure the organisational need for safe staffing aligns with the need to protect and support affected staff. This practical decision-making is the professional judgement of the experienced nurse leader and the complexity and impact of such judgements have the potential to lead to the moral distress that has been reported in previous studies.[4,17]

The current study had a number of limitations. Firstly, this was secondary analysis of existing data. While leadership emerged as a key factor, the interviews were not specifically about leadership and therefore more in-depth probing was not undertaken. More detailed understanding of the challenges in leadership could therefore be missed. We were also unable to explore in more detail the different styles of leadership as this was not the focus of the interviews. Commentaries and reflections on leadership in nursing during the pandemic have suggested this required a hybrid between command and control, relational, collective and transformational leadership. This warrants further investigation. Second, individual nurses included CNS/CRNs, who were band 6 or 7 and although they were mostly redeployed, they were all experienced nurses. The study does not account for the experiences of nurses, who continued on their wards, those who were band 5 or below, and international nurses and students on the temporary register. Finally, there were no participants from critical care, only those who were redeployed to these areas so only one perspective is presented. However, despite these limitations this is the first study reporting on nursing leadership during the pandemic. While there are numerous publications focusing on the importance of leadership, these are mostly editorials, commentaries and opinion pieces;[11,18,19] our analysis has provided evidence to support the importance of nursing leadership and the impact this can have on the nursing workforce. Data reflected experiences across numerous roles and grades in the nursing workforce and has provided an in-depth view of nurses lived experiences of leadership during the pandemic. Furthermore, data were collected during and shortly after the peak of the first wave of the pandemic in 2020 so there was less recall bias.

Conclusion

The NHS has never experienced a situation of this magnitude before, so leaders did not know what to expect. Reports from China and across Europe suggested there would be a deluge of sick patients and therefore significant changes were made to the hospital environment and workforce to accommodate this. These changes reflect the protective changes recommended in previous studies of crisis situations in healthcare.[1,3,10,20] This study has highlighted how these changes were taken up in different ways by nurses and nurse leaders in different situations who experienced them in both positive and negative ways. It is important to recognise that the challenges and distress nurses experience when making moral decisions about what to do and what not to do in the complex world of healthcare is not new. It has been argued that collective leadership – as opposed to command-and-control structures – provides the optimum basis for caring cultures (21). Such cultures are vital to maintaining the resilience of nurse leaders in making moral decisions in complex and rapidly evolving situations.

EPILOGUE

The '*war that did not come'* arrived in December 2020 and the importance the hospital placed on learning from the first wave of the pandemic facilitated a relational leadership approach. At the heart were communication, choice and collaboration. There was a need for large numbers of staff to move to the critical care units and surge areas to support the unprecedented numbers of patients requiring intensive care or enhanced respiratory support and to assist in the rapid rollout of the vaccination programme across [location to be added after review]. The observation in the first wave that many staff were willing to be redeployed, supported a volunteer programme and therefore staff had the choice to work in critical care/enhanced care or with the administration of vaccines. This enabled some control over the shifts they worked and were able to balance redeployed work with their existing caseloads so their patients continued to receive support. The hospitals across [location after review] collaborated so there was sharing of resources and expertise, and movement of patients to ensure workloads were distributed evenly across the patch. Finally, the daily communication implemented during the first wave was expanded to include a weekly all-staff virtual briefing where the Chief Executive, Chief Nurse and other members of the senior leadership team could update staff on what was happening across the hospital and answer questions. This was regularly attended by over 700 members of staff (plus those who accessed the recording on the Intranet). This was particularly important for the large numbers of staff required to work at home so they remained connected to the hospital. This approach reflected the key tenets of collective leadership namely distributing and allocating leadership power to wherever expertise, capability and motivation sat within the organisation.

While this epilogue is from the perspective of nurse leaders and researchers who observed the process, it may not reflect the experiences of those nurses whose work was impacted by leadership decisions. However, learning from wave 1 we are confident that our recommendations and conclusion apply now: it is essential the wellbeing of our nursing workforce is prioritised to ensure they can deliver care to the anticipated numbers of patients who are going to require treatment as we move forward.

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Ethics approval: The data used in this study were generated from a project was assessed as service evaluation according to the toolkit published by the English Health Research Authority (HRA). As such, no formal research ethics approval was required. However, all participants consented in according to the UK Framework for Health and Social Care Research.

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Table 1: Summary of participants in the evaluation

Group	Participants
Whole Trust (n=17)	Heads of the volunteer and patient experience service Heads of staff experience/welfare Leads for management of risk Leads for Electronic Health Records and digital healthcare Leads for nursing workforce Deputy Chief Nurses
Division (n=7)	Matrons
Ward/department (n=8)	Sister/charge nurses Senior CNS Senior CRN
Individual (n=16)	CNS CRN

CNS: clinical nurse specialist; CRN: clinical research nurse

Table 2: Changes made to accommodate the delivery of care during the pandemic

Theme	Changes made
Staffing	● All nurses required to go onto an inpatient roster so they could be redeployed to the most appropriate area as needs dictated. ● Nurses needed to be redeployed so the right people were available in the right service at the right time. ● A new actual staffing level was developed with surge and super-surge acuity levels. This was based on ITU guidance working backwards to create different ratios if patients were in ITU, HDU, step down wards or palliative care.
Increased visibility of nursing leadership	● Introduction of the matron of the day. A matron rota was implemented so there was senior clinical leadership 7 days a week.
Staff wellbeing initiative	● Occupational health worked as usual but they had an increase in activity. This involved frequent updates of guidelines as information changed. ● Enhanced support provided by the Staff Psychology and Wellbeing Service, supported by departmental clinical psychologists. ● Numerous initiatives were implemented to improve the staff experience as a result of changes to the way of working during the pandemic, including coordinating and managing the distribution of charitable donations and food, opening of an offsite respite centre.
Supporting patients and families	● Information for patients and families. These needed to be developed more rapidly. ● Visiting was severely restricted. There needed to be a secure process in place, development of a support package: FLO who was the single point of contact for getting information about their relatives in hospital. ● Facilitating and supporting visitors who were able to access the hospital
Training and education	● Refresher training – used a similar model to the flu pandemic, built a package of half day refresher including the electronic health records system. ● PPE training – a task force was set up to deliver sessions across the Trust ● Students and international nurses – NMC opened a temporary register, which enabled 37 international nurses to join the register and start work in the Trust. ● Student nurses – 3rd years in their final 6 months came into the workforce as a band 4 (approximately 70 working under supervision rather than supernumerary); 2nd years continued to be supernumerary so moved to sites away from the site hosting the COVID-19 wards. ● Upskill nurses working on a ward that was converted to a high dependency respiratory unit.

FLO: Family Liaison Officer; HDU: high dependency unit; ITU: intensive care unit; NMC: Nursing Midwifery Council; PPE: personal protective equipment

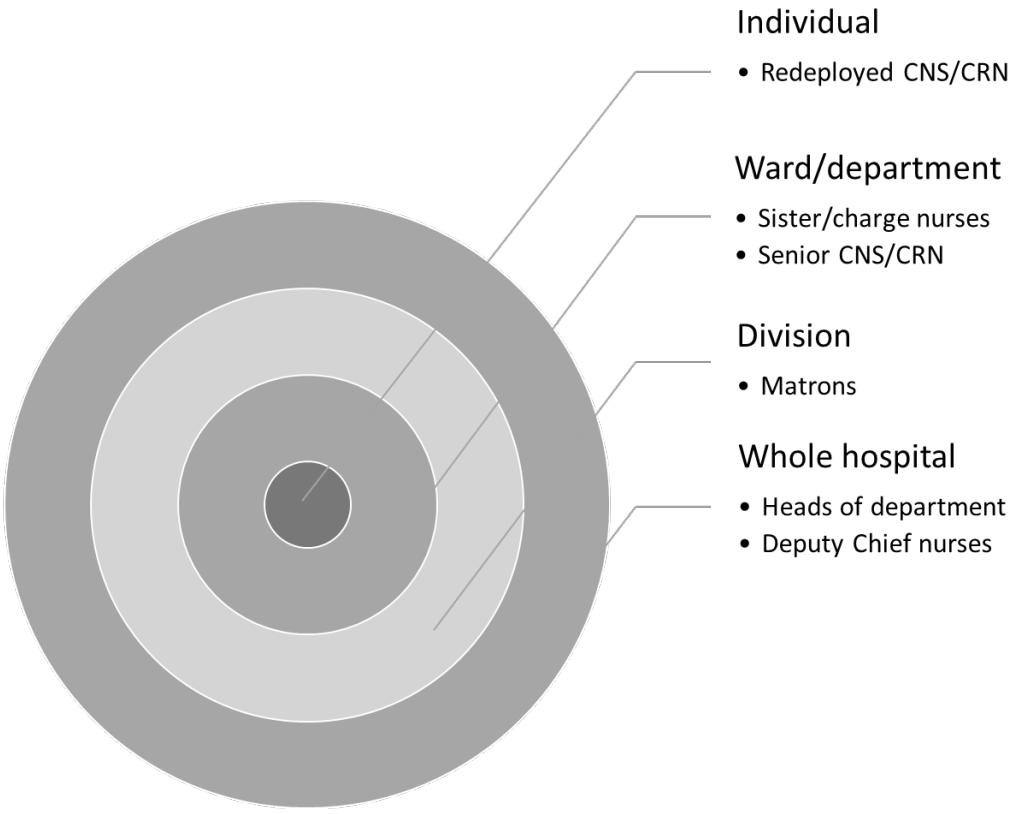
Table 3: Supporting quotes

Theme	Sub-theme	Quote
Impact of leadership	Communication	*"I felt like a general in the first world war standing back sitting on a horse saying off you go, it'll be okay. You can put your head up and climb out that trench and run across that no man's land. It'll be alright. And hands on heart not actually be 100% sure of what I'm saying, passing on is actually going to turn out kosher"(Matron)* *"There was no discussion. So whilst other members of my team were asked where they would prefer to work, and within the hospital, I was just told that this is what I was going to do. I had very little communication, my line manager did very little communication with me"* (Nurse)
	Accuracy and consistency of information	"*There was confusion about the masks, you know, whether we were the third of the mass or the FFP3 so in the end, someday, some nurses wore the surgical mask or some nurses wore the FFP 3 masks, you know, and someday some people wore the full the full surgical gown and other people didn't you know, that that's, that makes things a bit more stressful because it's like, you know, people were doing what they felt more comfortable in. And that will actually maybe…we should know what we're what we're safe in*" (Nurse)
	Providing support	*"The organisation, it's all been about supporting people on the front line or supporting people coming in, and hasn't been that much that has been geared to the people assigned to work at home …I feel a bit invisible"* (Nurse)
	Impact of decision making	*"The communication wasn't great. There was rumours flying around left, right and centre before any of that actually happened. But I mean, I think that was a lot down to decisions not fully being made until, like, very last minute, I think our ward sisters were as honest with us as they could be"* (Nurse)

		"The most stressful time when there was a letter sent… saying nurses will be redeployed, with immediate effects, but then nothing happens for another sort of eight or nine days after so, yeah, that was quite a tense period for everyone. For lots of my team, people I manage. Some were very fearful about where they'd go" (Sister)
Impact of the delivery of care	Redeployment	"*There was a big call to people to be deployed, but we had to ask for them to be able to come back and I think, and, you know, we were getting calls from people saying there was no work and that they had several nurses per patient and on some areas, and I think it would have been helpful for that to be made more explicit*" (Sister) *"Think maybe just for warning the nurses on the wards that it looked like they weren't going to be needed much longer. And they have to think about the fact they may soon be going back to their original role was what happened. They turned up to the ward one day and then we're told we don't need you anymore. And that was that" (Sister)* *"They didn't really think about you as a person when they decided to place you in ICU, they just saw your background" (Nurse)* *"I'm telling you honestly, I cannot do this again. I've done it once. I would, I wouldn't be able to do it again. I had to do it. I did it. But if I have to do it again, my God, it would be very, very challenging" (Nurse)* *"When I'm working from home, it's like there's more pressure; you should answer your email straightaway I, should deal with this right away… They sort of expect you to do more things and to do it very quickly. And to be always, you know, on top, so I can't leave my computer because at nine o'clock somebody emailed me emailing me already and they expect an answer" (Nurse)*

	Teamwork	*“The ward teams were so lovely and everybody just banded together and I'm just so proud to be part of that”* (Sister) *“I just felt that the way I was treated my line manager, not one day from when I was redeployed, ever made contact with me to say, how are you doing? You know, is everything okay? Not once, never heard from her” (Nurse)* *“I felt like the team was not ready to accept us…I understand about that culture…it's a culture inside [CLINICAL PLACE] that […] nurse just felt you're better than the other nurses.”* (Nurse)

Figure 1: Summary of the participants in the study



CNS: clinical nurse specialist; CRN: clinical research nurse