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Walden University

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Cynthia Rodriguez

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Walden University
2023

Abstract

Nurses' Lived Experiences Caring for COVID-19 Patients in the United States

by

Cynthia Rodriguez

MSN, Walden University, 2016

BSN, Walden University, 2014

ADN, Henry Ford College, 1999

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

May 2023

Abstract

The COVID-19 pandemic has affected healthcare services and delivery and may leave unprecedented effects on nurses' physical and mental health. Research is sparse on the pandemic's effects on nurses, but studies have identified the stressful factors that may contribute to nurses' health and well-being. The purpose of this qualitative interpretive phenomenological study was to understand the lived experiences of nurses caring for COVID-19 patients in the United States and discover how their experiences impact them on a personal and professional level. Hans Selye's general adaptation theory served as the theoretical basis for this study with Edmund Husserl's life worldview used as the conceptual model to guide the analysis. Nine semistructured interviews were conducted online via Zoom with nine registered nurses recruited purposively through social media and professional organizations. Interviews were transcribed verbatim, with transcripts analyzed using a modified van Kaam's approach. Results included four themes: (a) secondary trauma, (b) burnout/ compassion fatigue, (c) post-traumatic stress disorder (PTSD), and (d) turnover/leave nursing. Recommendations for future research are to develop and test programs that support nurses in maintaining good physical and psychological health along with providing a more supportive working environment. The findings of this study have potential implications for positive social change that may promote a healthier workforce better prepared for future workplace stressors such as Covid-19. Nurses who are supported physically and psychologically may have a more positive experience during high stress workplace events resulting in a stronger, effective nursing workforce.

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Dedication

I dedicate this dissertation to all the nurses who cared for COVID-19 patients. I understand the sacrifices you have made during this pandemic. I understand and empathize with the fear and challenges you endured including organizational inefficiency in supporting nurses and living with the uncertainty and psychological burden of the disease throughout providing care for COVID-19 patients. I commend all nurses; you have done what nobody else will do, in a way nobody else can do, and you're still standing. Nursing is highly important for a community's health and well-being everywhere—that is why you need to be supported. A special thank you to all the nurses who have participated in my study for providing a visual of all you have sacrificed and suffered in caring for COVID-19 patients. You are not alone.

Most importantly, to my sweet mother, who passed away in 1999. With love, with hope, with kindness, and with guidance, you have taught me from your heart to be the strong woman I am today. There is no one as perfect as my mother; a soul that can be both strong and delicate. There is not a day that goes by that I do not wish you were here by my side through my journey. I am who I am because of you.

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This has been quite a challenging doctoral journey. A quote from Dalai Lama explains this journey the best stating “no matter what is happening, no matter what is going on around you, never give up.” I have been incredibly blessed to have a strong support system through this journey. My children, Luis and Gabrielle, you have been patient and supportive, cheering me on through all the struggles and ups and downs. Because of you, I did not give up. To my friends, you have been there for me, supporting me close and far, even if I could not give you much of myself. And, above all, to our almighty God, my constant source of strength, guidance, and inspiration, for without Him this could not be possible.

I would like to express my deep and sincere gratitude to Dr. Anna Valdez (my first committee chair). This study would not have been possible without you encouraging me to think outside the box. You have provided invaluable guidance through the first half of my dissertation. Your vision, sincerity, passion, and motivation have deeply inspired me. It was a great privilege and honor to have you as my chair. You have touched me deeply.

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Chapter 1: Introduction to the Study

Introduction

The first coronavirus disease of 2019 (COVID-19) case was reported in Wuhan, China, in late 2019 (Lin et al., 2020). A novel virus called severe acute respiratory syndrome coronavirus 2, or SARS-CoV-2, is the cause of COVID-19, which is in the coronavirus family. The coronavirus is a large family of viruses that cause disease in humans and animals. Severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), and COVID-19 are the most pathological diseases caused by human coronavirus (Li & De Clercq, 2020). The coronavirus that causes COVID-19 produces respiratory failure in patients, many times leading to death (Zhu et al., 2020). In the beginning, this virus severely affected elderly people and people with underlying diseases, placing them at increased risk. However, as the disease progressed, COVID-19 has become prevalent, affecting people in every age group, gender, and health status worldwide (Shrivastava & Shrivastava, 2020). As of March 18, 2021, worldwide, there were 120,667,101 confirmed cases with 2,670,274 deaths (World Health Organization [WHO], 2021). At the same time in the United States, there were 29,260,772 cases and 531,855 deaths (WHO, 2021).

Many of the patients who experience signs of severe COVID-19 are admitted to the hospital in the intensive care unit (ICU; Qarawi et al., 2020). These COVID-19 patients are usually under strict isolation. Additionally, the hospitalization of these patients can last from weeks to months (Bearman et al., 2020). The primary caretakers of COVID-19 patients are nurses. The acuity of COVID-19 patients is so severe it requires

nurses to be specialized with expertise and knowledge in critical care. For the safety of staff and patients, specialized equipment, personal protective equipment (PPE), and a supportive infrastructure are necessary (Huh, 2020). However, the COVID-19 outbreak has overwhelmed medical facilities and staff, leading to treatment confusion related to the unknown nature of the disease, social isolation, and widespread transmission, placing added stress on healthcare workers and healthcare systems (Guo, 2020). This has created a challenge for organizations to ensure quality nursing care (Qiu, 2020). Nurses caring for COVID-19 patients may be subjected to an increased risk of exposure, extremely stressful working conditions, increased influx of hospitalized patients with limited capacity, and substandard patient to nurse ratios (Qiu, 2020).

In China, where the first outbreak of COVID-19 was reported, there was rapid growth of high acuity hospitalized patients, resulting in an insufficient number of staff to meet the demand (Zhang, 2020). This created a rise in infection rates among nurses, leaving the rest to care for double or triple the patient load (An et al., 2020). This increased nursing workload led to nurses being pulled from non-intensive units and pediatric units without proper training for critical care patients with an infectious disease (An et al., 2020). Working under these stressful conditions has led to physical and psychosocial stressors, placing nurses at higher risk for occupational and psychological disorders (Zhang, 2020). The experiences of nurses in China caring for COVID-19 is mimicking the experiences of nurses dealing with the SARS pandemic, resulting in several problems such as uncertainty of the disease, information mismanagement, feelings of anger and guilt, unpreparedness, fear of death, loneliness, and physical and

psychological disorders (Chung, 2005). Based on previous experiences with pandemics, it is reasonable to assume that nurses working in such physically and emotionally challenging situations may experience fatigue, burnout, mental exhaustion, and emotional detachment (An et al., 2020). Therefore, it is essential to focus on nurses caring for COVID-19 patients in the United States to understand their lived experiences.

The purpose of this qualitative study is to provide insight into the experiences of nurses caring for COVID-19 patients and how those experiences impact their personal and professional lives. This study may contribute to positive social change by providing evidence of nurses' experiences to better understand the impact caring for COVID-19 patients has on their lives. Understanding this impact is imperative to grasp the reality of the immediate and long-term implications for nurses who have been providing care during the COVID-19 pandemic. My study could aid in understanding how COVID-19 may contribute to nurses' stress, secondary trauma, and burnout. Adverse outcomes related to psychological trauma may include staff turnover, leaving the nursing field, and mental health issues including depression, anxiety, posttraumatic stress disorder (PTSD), secondary traumatic stress, and substance abuse (Foli & Thompson, 2019). In addition, the International Council of Nurses (ICN) COVID-19 Update (2021) suggested that the stress and emotional trauma nurses face from COVID-19 poses an immediate danger to the profession and future of global health systems. Other studies in Turkey (Cici & Yilmazel, 2020) and China (Wang et al., 2020) have demonstrated similar results in their increased incidence of anxiety and stress among nurses caring for COVID-19 patients in an unwillingness to practice their job in the future. Little is known about the lived

experiences of nurses providing care during COVID-19 in the United States. Information from this study can be used to create a stronger nursing workforce, prepare for future pandemics, and facilitate nurse retention leading to positive social change through a healthier nursing workforce for this pandemic and future large-scale illness events.

This chapter will begin with the background for this study; this will include a summary of the existing literature gap, the problem statement, purpose statement, and primary research question. In addition, an overview of the theoretical framework, nature of the study, definition of key terms, discussion of assumptions, scope and delimitations, and limitations of the study will be included. The conclusion of Chapter 1 will consist of a discussion of the significance of the study and a transition to Chapter 2.

Background

COVID-19 is a newly emerged infectious disease first identified in Wuhan, China, in late December 2019 (Hui et al., 2020). Soon after, China reported a large cluster of cases of pneumonia associated with a local seafood market in Wuhan (Holshue et al., 2020). On January 7, 2020, Chinese health authorities confirmed the cases were COVID-19 (Holshue et al., 2020). As of January 20, 2020, a total of 9,976 cases had been reported in 21 countries, including the United States (WHO, 2021). To protect the public and world health, on January 23, 2020, the Chinese government ordered a shutdown in Wuhan due to the extreme outbreak of COVID-19 (Holshue et al., 2020). However, in Washington state, on January 19, 2020, a 35-year-old male presented with a cough and a high temperature for four days, stating he recently returned home from Wuhan, China, where he visited his family (Holshue et al., 2020). On January 20, 2020, the Centers for

Disease Control and Prevention (CDC) confirmed the patient tested positive for COVID-19, the first case reported in the United States (Holshue et al., 2020). Shortly after, on January 20, 2020, the WHO (2021) declared the COVID-19 outbreak a global emergency. With COVID-19 cases on the rise worldwide, the WHO declared COVID-19 a global pandemic on March 22, 2020, its first designation since declaring H1N1 influenza a pandemic in 2009 (WHO, 2021). Many patients coming to hospitals with COVID-19 experience severe symptoms requiring oxygen therapy or other inpatient interventions; many require admission to the ICU (Wu & McGoogan, 2020).

COVID-19 is an emerging disease with many unknowns that created challenges in caring for patients with this infection. Challenges included the increasing need for qualified staff to care for such critical patients, enough PPE to protect staff, diagnostic testing access, availability of beds and ventilators, and rising mortality (Lippi et al., 2020). Between January 20, 2020, and March 3, 2021, over 28 million confirmed cases of COVID-19 with around 510,900 deaths occurred in the United States (WHO, 2021).

As the COVID-19 pandemic continues to surge across the world and the United States, hospitals face a crisis-level shortage of beds and staff to provide adequate care for patients. This shortage has created overwhelming working conditions for healthcare workers, primarily nurses (Galehdar, 2021). Nurses, being the largest workforce globally, provide a substantial amount of direct care for COVID-19 patients. Nurses providing care for patients during previous epidemics had reported experiencing a higher level of job stress and mental disorders (Eghbali, 2020). Therefore, it is imperative to understand the

lived experiences of nurses in the United States caring for COVID-19 patients during this sustained pandemic.

In this study, I plan to address a gap in knowledge of the lived experiences of nurses in the United States caring for COVID-19 patients, as this is a new disease, and there is limited information about the experiences of nurses providing direct patient care. While a few studies exist in which researchers have examined the lived experiences of nurses outside the United States, I was unable to identify any published studies on the experiences of nurses in the United States. Differences in practice environments and scope of practice between countries could result in different study findings. Therefore, it is crucial to examine the unique experiences of nurses who have been caring for COVID-19 patients in the United States.

Many areas of nursing were stressful even before COVID-19. Since COVID-19, stress has become magnified due to the morbidity, mortality, and unprecedented risks of the pandemic (Kackin et al., 2020). Nurses caring for COVID-19 patients and working in COVID-19 units are at higher risk for burnout and secondary trauma due to stressful working conditions and witnessing significant volumes of disease and death (Kackin et al., 2020). These challenges may lead to nurses experiencing mental or physical health issues resulting in them leaving the nursing field. The findings from my study may provide critical insight into nurses' experiences of stress when caring for patients with COVID-19. Recognizing the factors affecting nurses can help create a healthier and safer workforce, leading to positive social change through a stronger nursing workforce.

Problem Statement

The rapid spread of COVID-19 created a pandemic reaching all parts of the world that started in late 2019 to early 2020. This disease has presented many global challenges to healthcare workers and healthcare systems. The rapid spread of the disease has caused many healthcare systems to be overwhelmed with patients who require intensive care. In addition to shortages of qualified staff, health systems have had difficulty providing adequate access to the equipment needed for care, including ventilators and PPE (Cohen & van der Meulen Rodgers, 2020). For healthcare workers, the COVID-19 pandemic has created dire working conditions that threaten their well-being and ability to perform their job (Arnetz et al., 2020a). Media reports from all over the world have documented extreme working conditions, exhaustion, physical pain from working long hours with face masks and other PPE, fear of catching the disease and passing it to loved ones, and the emotional stress caring for COVID-19 patients (Gonzales & Nasseri, 2020; Jervis, 2020). This added physical and emotional pressure on an already stressed nursing workforce became characteristic of the COVID-19 pandemic. Due to the nature of the virus, there is minimal research available evaluating the impact of COVID-19 on nurses working in the United States. Understanding the impact of caring for COVID-19 patients on nurses is necessary to identify strategies for preventing adverse outcomes, including loss of nurses from the workforce.

How nurses react to the stress of the COVID-19 pandemic must be viewed from an occupational health and safety perspective (Arnetz et al., 2020a). Before the pandemic, stress, compassion fatigue, and burnout were recognized in nurses as a common work

hazard (MarÃa del Carmen & del Mar Molero-Jurado, 2018). WHO acknowledged burnout as an occupational phenomenon rather than a medical condition (WHO, 2019). WHO further identified burnout as the result of chronic work stress that an individual cannot manage, characterized by feelings of exhaustion, job disengagement, and diminished professional fulfillment. The added stress of caring for COVID-19 patients has increased work stress among an already strained nursing workforce, placing them at a higher risk for compassion fatigue and burnout (Arnetz, 2020b; Martínez-López et al., 2020).

While research is sparse on the pandemic's effects on nurses' health and well-being, a few articles identify stressful factors that may contribute to health problems. These include fear of becoming infected or infecting loved ones, fear of the disease, work stress of extremely long working hours, higher than normal patient–nurse ratio, orders/assignments to work outside their specialty, shortage of PPE, and experiencing high levels of patient deaths (Jackson, 2020; Maben, 2020). A better understanding of current working conditions and stress nurses are experiencing during the COVID-19 pandemic could result in positive social change by providing critical insight into the lived experiences of nurses who work with COVID-19 patients. In addition, this information could aid healthcare systems in developing strategies to prevent burnout, improve safety, and plan for future large-scale illness events.

WHO (2021) reported that COVID-19 caused over 2.8 million deaths worldwide, with nearly one fourth of those deaths having occurred in the United States. This has overwhelmed many healthcare systems and healthcare providers worldwide that are

providing direct patient care. These numbers and hospitalizations are anticipated to continue to rise due to new highly contagious COVID-19 strains that have developed in a few countries around the world (Goodman, 2021). This will add to the already overwhelmed healthcare systems and healthcare providers, including nurses who provide direct patient care for extended periods of time (Al Thobaity & Alshammari, 2020). Additionally, the impact of COVID-19 vaccinations, including how long it will take to reach herd immunity, is unclear. This is the first pandemic of this scale in decades, and there is minimal literature on the experiences of nurses providing direct patient care. The specific problem addressed in this study is gaining a better understanding of the lived experiences of nurses caring for COVID-19 patients in the United States.

Purpose of this Study

The purpose of this qualitative interpretative phenomenological study is to understand the lived experiences of nurses caring for COVID-19 patients during this pandemic and discovering how those experiences impact nurses on a personal and professional level. Using a qualitative approach will provide an understanding of lived experiences and the underlying reasons, opinions, and motivations of the participants (Creswell & Creswell 2017). Using a quantitative approach would not countenance this deep understanding, and I explain this in greater detail in Chapter 3. To collect data to analyze to address the gap, I conducted individual semistructured interviews with nurses working in the United States who care for or have cared for patients with COVID-19. Thereafter, qualitatively coding their answers to identify and produce a comprehensible account of their lived experiences.

Research Question

The research question used for my study is: What are the lived experiences of nurses in the United States who have provided care for patients with COVID-19? A qualitative interpretative phenomenological approach was appropriate for this study to aid in understanding the lived experiences of nurses caring for patients with COVID-19.

Theoretical Framework

The theoretical basis for this study was Selye's (1956) model of stress; specifically, Selye's (1950) general adaptation syndrome (GAS). Selye (1956) posited every stress leaves an indelible scar with lasting effects. The GAS model is based on physiological and psychobiology events that threaten an organism's well-being related to stressors leading to a three-stage bodily response. Stress is commonly thought of as mental pressure; however, it also has a physical effect on the body. Understanding the stages the body goes through when exposed to stress will help in awareness of the physical signs of stress when they occur. Selye (1956) explained GAS as the body's way of adapting to a perceived threat to equip it better to survive. Selye's theoretical positions and empirical findings provide many of the principles currently used in stress research and are a common scientific basis for nursing theory, research, and practice (Lo et al., 2018). Selye's GAS can serve as a valuable paradigm for understanding the anticipated stress nurses experience when caring for COVID-19 patients and how that stress may be apparent in their lived experiences.

Selye (1956) described that stressful events threaten an organism's well-being leading to a three-stage bodily response: (a) alarm, (b) resistance, and (c) exhaustion. The

alarm state is compared to the fight-or-flight response, where the body mobilizes resources to react to the stressor. *Resistance* is where the forces will be built up when the stressors are continuous. The *exhaustion* stage will then cause illness if the body is unable to overcome the stress or threat. The determined effect of the ongoing stages underlies the GAS and the concepts of stress-induced health problems (Selye, 1956).

Stress among nurses is one of the most underappreciated yet impactful issues nurses face, amplified by the pandemic (Watts & Thorne-Odem, 2020). This can surface in many aspects of nurses' work and personal life, such as physical, mental, ethical/moral wellness, and compassion fatigue (American Psychiatric Nurses Association, 2020). In addition, sustained stress can have a significant impact on nurse retention rates. Therefore, the tenets in Selye's (1956) GAS stages will provide the framework for this study by guiding the physiological and physiological response to perceived stressful events.

The conceptual model used as a lens for this study was Husserl's life-world view. The fundamental concept of lifeworld suggests the world of lived experiences incorporates how one views phenomena in their conscious experience or everyday living (Lee, 2019). The focus of Husserl's life-world view is on what a person perceives rather than how they perceive it (Lee, 2019). Suggesting that when one can isolate the essences of an invariant feature and structure of a phenomenon, it can be described as precisely as possible, and only our direct and subjective experiences of the world are knowable (Lee, 2019). Husserl's model will help answer the core question: What are the participants' meaning and essence of the lived experience?

Nature of the Study

In my study, I used an interpretive phenomenological qualitative methodology and collected data using individual semistructured interviews. The aim was to explore the lived experiences of nurses who care for COVID-19 patients in the United States. As a research methodology, phenomenology is uniquely positioned to help health professionals learn from the experiences of others by focusing on the study of individuals' lived experiences within the world (Neubauer, 2019). This aligns with the problem of identifying nurses' lived experiences while caring for COVID-19 patients. Cici and Yilmazel (2020) suggested that to identify lived experiences of nurses, it is crucial to conduct studies in the pandemic phase. This methodological approach will provide a deep understanding of nurses' experiences while caring for COVID-19 patients through interviews exploring their individual unique lived experiences.

In this phenomenological qualitative approach, I used purposeful sampling strategies that include snowball and saturated sampling to recruit study participants. Potential sources for recruitment included social media sites and professional nursing organization email lists. Basic demographic information about study participants was gathered, including age, gender, years employed as a nurse, practice setting, and length of time caring for COVID-19 patients. Semistructured individual interviews were completed via telephone or video meeting and were recorded and transcribed verbatim using a secure recording program. An interpretative phenomenological analytical approach was used to allow participants to express their lived experiences the way they see them

(Alase, 2017). This aligns with Husserl's life-world in understanding the content of participants' lived experiences and their meaning of those experiences.

Definitions

Throughout this study, there are key terms frequently used. These terms are defined here to provide a deeper understanding and provide clarity:

COVID-19: A respiratory disease caused by SARS-CoV-2, a new coronavirus discovered in 2019, spread mainly through respiratory droplets when someone infected coughs, sneezes, or talks (CDC, 2021).

Critical care nurse: A nurse who has the knowledge to admit critically ill patients and provide mechanical ventilation, airway suctioning, specialized medications, monitoring, and bedside nursing (Atumanya et al., 2020).

Pandemic: An epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people. (WHO, 2021).

Public health crisis: A situation that affects humans in one or more geographic areas that has an impact on community health, loss of life, and the economy (Hartley & Perencevich, 2020).

Assumptions

The principal assumption formulated in this study were that there would be a range of available participants willing to be part of this study from across the United States. I also assumed that participants would be able to remember experiences that would provide detailed responses that could be translated into rich data. Finally, a third

assumption was that participants' responses would mimic their lived experiences and could be grouped into similar categories.

These assumptions are necessary as they are imperative to be able to conduct the study. I assumed there would be enough volunteers to ensure data saturation was reached. Additionally, I assumed each participant would have vivid recall of their experiences and would provide accurate and honest responses to the interview questions. Capturing lived experiences creates the basis for a phenomenological approach, identifying the necessity of assumption.

Scope and Delimitations

The scope of the study is limited to include English-speaking registered nurses (RNs) working in the United States who have cared for COVID-19 patients in the past year. Participants were recruited through social media sites and professional organization email lists. Exclusion criteria included those who were not current RNs, who have not cared for COVID-19 patients in the United States, and participants with a current or past professional affiliation with me as the researcher.

A notable boundary of this study is the chosen theoretical framework. Selye's general adaption theory was selected as it aligns with the body's way of adapting to a perceived stressor displaying a set of physical responses to that stressor. Another theory that was not chosen was stress and coping theory by Lazarus and Folkman, which focuses on how people manage the adverse effects of stress. Stress and coping theory only describe the adverse effects of stress, not identifying the physical or mental responses to stress as Selye's general adaptation theory does.

The findings of this study may be transferable to nurses who care for COVID-19 patients in the United States; however, results may not be transferable to nurses who practice outside the United States. The United States has experienced nearly one fifth of the world's COVID-19 deaths, even though it accounts for just over 4% of the world's population (John Hopkins University, 2021). Additionally, 23% of the cases recorded in the world have occurred among Americans (John Hopkins University, 2021). These numbers identify the abundance of COVID-19 cases that nurses in the United States would care for compared to the rest of the world. I recruited nurses from across the United States to obtain a broad range of experiences rather than recruiting from a specific facility or geographical location to support potential transferability to nurses in the United States.

Limitations

A potential limitation of this study is researcher bias. I included strategies in my study to specifically address the risk of bias. To reduce the risk of bias, I asked my committee members to review coding to ensure consistency between interpretations (see Creswell & Creswell, 2017). I also reflected and recorded notes, examining and consciously acknowledging the assumptions and preconceptions that may be brought into the research and shape the outcome (see Creswell & Creswell, 2017). A possible limitation of this study is using an alternative approach for conducting interviews using remote interview methods such as telephone and video meetings. Challenges might include missing nonverbal communication during interviews. Nonverbal communication plays a significant role in conveying meaning and emotion, and its loss can affect the

interpretation of the message (McKenna et al., 2017). The transferability of study findings could be limited by the recruitment strategy, which may result in more nurses who engage in social media and professional nursing organizations to be selected as participants (see McKenna et al., 2017). Snowballing sampling may aid in recruiting nurses who would otherwise be excluded from my study.

Significance

This study was conducted to address a gap in understanding nurses' experiences when caring for COVID-19 patients and how those experiences have affected nurses. This study is an original contribution to evidence as a recent literature search resulted in no qualitative studies being identified that address the lived experiences of nurses who provide care for COVID-19 patients in the United States. A few studies were identified that address the lived experiences of nurses in other countries, including China, Australia, and Iran (An et al., 2020; Karimi et al., 2020; Shaban et al., 2020). While the information gathered from these studies is helpful, it is unknown whether the results are transferrable to nurses in the United States. Findings from this study may impact nursing practice by providing insight into the experiences of nurses caring for COVID-19 patients in the United States. Additionally, the study might contribute to strategic planning to address the immediate and long-term impact on nurses and aid in preparing for future pandemics.

The study may contribute to positive social change by providing evidence of nurses' experiences that could lead to a better understanding of the impact of caring for COVID-19 patients on nurses' lives. Understanding the impact and reality of the immediate and long-term implications for nurses who have been providing care during

the COVID-19 pandemic is vital. The results of this study could aid in understanding how COVID-19 contributes to nurses' stress, secondary trauma, and burnout. Research suggests that adverse outcomes related to psychological trauma include staff turnover, leaving the nursing field, and mental health issues including depression, anxiety, PTSD, secondary traumatic stress, and substance abuse (Foli & Thompson, 2019). Additionally, the ICN's COVID-19 Update (2021) identified that the stress and emotional trauma nurses face from COVID-19 poses an immediate danger to the profession and future of global health systems. In other studies, conducted across the world, such as Turkey (Cici & Yilmazel, 2020) and China (Wang et al., 2020), researchers have demonstrated increased incidence of anxiety and stress among nurses caring for COVID-19 patients resulting in nurses' unwillingness to practice their job in the future. Understanding the lived experiences of nurses who provide care to COVID-19 patients can help create a stronger nursing workforce and promote nurse retention, leading to positive social change through a healthier nursing workforce for this pandemic and future large-scale illness events.

Summary

In this chapter, I provided the study's background, gap in knowledge, problem statement, purpose statement, and research question. Additionally, I described the theoretical framework, nature of the study, key terms, details about the study assumptions, scope and delimitations, and study limitations. In concluding this chapter, I have illuminated the significance of the study. In Chapter 2, I present a literature review

approach used to portray the relevance of the problem, literature search strategy, the choice of theoretical framework, conceptual framework, and related key concepts.

Chapter 2: Literature Review

Introduction

The COVID-19 pandemic required nurses to provide care to patients infected with SARS-Cov-2, yet nurses had limited resources and inadequate knowledge about the course of the disease. Nurses were called upon to put themselves at risk to accompany people in care and little is known about the impact this has had on nurses in the United States. The purpose of this qualitative study was to discover new knowledge and build on previous knowledge gained from recent studies related to the lived experiences of nurses caring for COVID-19 patients. In my research, I found minimal to no published literature that was focused on the lived experiences of nurses caring for COVID-19 patients in the United States, a gap in the literature. However, a few studies exist of nurses' lived experiences caring for COVID-19 patients outside the United States (Karimi et al., 2020; Sadang, 2021). In this study, I conducted qualitative phenomenological research using semistructured interviews to explore the lived experiences of nurses caring for COVID-19 patients in the United States.

The COVID-19 pandemic stretched U.S. healthcare settings and staff to capacity. While COVID-19 continues to threaten global healthcare systems and worldwide populations, the impact has been profound on nurses (Gray et al., 2021; Lee & Lee, 2020). Current research has identified fear of contracting and spreading SAR-CoV-2, lack of preparedness by healthcare systems and policies, and lack of supplies for the safety of both patients and nurses during the COVID-19 pandemic (Gray et al., 2021; Lee & Lee, 2020). To date, healthcare systems and nurses continue to be overwhelmed in

waves by the increase in patients with COVID-19 infections (Benton et al., 2020). There remains a lack of hospital beds, PPE, and equipment such as ventilators during these waves of infections; additionally, rapid, and diagnostic tests remain an issue, all creating caregiver fatigue. (Gunawan et al., 2021). In addition, governments, and hospitals continue to deal with the complexity, ambiguity, and uncertainty due to the rapidly evolving disease and the lack of expert knowledge of this evolving novel disease (Djalante et al., 2020). Nurses are the primary caretakers in fighting COVID-19 and play a critical role in testing, treatment, and containment of the virus. Nurses caring for COVID-19 patients sacrifice their lives to care for others (Eghbali et al., 2020). The ICN (2021) confirmed that, as of October 28, 2020, 1,500 nurses had died from COVID-19 in 44 countries. The work of nurses in the United States is invaluable, and the response to COVID-19 would not continue without the dedication nurses have in addressing, treating, and caring for such patients. Literature has revealed that nurses have encountered depression, anxiety, stress, burnout, and even workplace bullying in their battle against COVID-19 (Hu et al., 2020; Sadang, 2021; Ulrich et al., 2020). Much has been surmised about experiences dealing with epidemics and pandemics, which has been compared to nurses' experiences in the 1918 influenza outbreak, H1N1 influenza, and SARS in the United States (Robinson, 2021). However, all three put together do not come close to the COVID-19 outbreak. Therefore, it is essential to identify and understand what nurses are experiencing physically and emotionally to help nurses today and in the future. This study aims to understand the lived experiences of nurses caring for COVID-19 patients and bring those experiences to light.

In this chapter, I illustrate the literature review strategies used to provide evidence for my study’s needs. Additionally, I discuss the theoretical framework and conceptual framework used to ground my research. I summarize findings from an extensive review of literature related to the COVID-19 pandemic, focusing on the impact on nurses.

Literature Search Strategy

The purpose of executing this study was to gain a deep understanding of the lived experiences of nurses who care for COVID-19 patients in the United States. I conducted an extensive literature review to examine what is currently known about the lived experiences of nurses caring for COVID-19 patients in various settings and countries. My literature review was conducted from February 2021 to June 2021 using the following databases: CINAHL, MEDLINE, PsycInfo, SocIndex, ScienceDirect, Academic Search Complete, Gale Academic OneFile Select, Nursing, Allied Health Database, PubMed, Ovid, Cochrane Database of Systematic Reviews, and Sage Journals. While performing database searches, a combination of terms was used to identify relevant literature on lived experiences of nurses caring for COVID-19 patients: *COVID*, SARS-CoV-2, nurse, lived experiences, phemomen*, nurs*, life experiences, phenomenology,* and *burnout.* Publications from January 2020 to present were included in this review.

Theoretical Foundation

The theoretical basis for this study is Selye’s (1965) model of stress, precisely Selye’s (1950) GAS. According to the theory, exposure to a stressor causes an imbalance to occur in the body in response to that stressor or perceived threat. Selye’s (1950) GAS

theory defines the pattern of responses that the body goes through after being exposed to a stressor or perceived threat, identifying three stages: alarm, resistance, and exhaustion.

GAS (Selye, 1950) refers to the physiological and psychological reaction one has to stressors. GAS theory's major assumptions are that (a) the first response to the perception of a stressor is an alarm, which activates the sympathetic division of the automatic nervous system or the fight-or-flight response; (b) the second stage is resistance, where the drain on the body's resources continues; the body cannot maintain this level indefinitely, and its resources will eventually deplete; and (c) the third stage is *exhaustion*. This is where the body's resources become nearly depleted, leading to wear and tear and suppressing the immune system, causing the bodily functions to deteriorate. This causes various health and mental issues, including heart disease, digestive problems, depression, and diabetes (Selye, 1946). Repeated exposure to stressors has cumulative effects.

The main proposition of the theory integrated established concepts regarding the stress response, including Claude Bernard's milieu interieur, or internal environment, and Walter B. Cannon's homeostasis, to provide a unifying model of stress and adaptation (Selye, 1951). The tenet is that all living organisms respond to stress. Anything that causes stress endangers life unless it is met by adequate adaptive responses (Selye, 1951). Selye (1951) believed adaptation and resilience to stress are fundamental prerequisites for life. The GAS theory stress model is based on physiology and psychobiology changes from stress and describes stress as a state produced by a change in the environment and the nature of the stressor (Selye, 1951). Further propositions are that individuals appraise

and cope with stress to reach the goal of adaptation. This process is called *coping with stress* and is achieved through a compensatory process with physiologic and psychological components. However, if the stressor continues beyond the body's capacity, resources are exhausted, and the individual becomes susceptible to disease and death (Selye, 1951)

Early in the development of GAS, Selye discovered that many clinical features of disease result from a failure in the nonspecific adaptive mechanism related to bodily stress (Jackson, 2014). In the middle of the 20th century, Selye's notion of biological stress and its impact on health was adopted and adapted by researchers and scientists in various fields, including medicine and psychiatry (Jackson, 2014). Selye provided an important methodological platform for scientists and clinicians interested in understanding the relationships between stress in an individual's life and disease.

The COVID-19 pandemic has caused a health and social crisis that severely impacts healthcare systems and nurses. The COVID-19 pandemic poses severe challenges to healthcare systems. Hospitals being beyond capacity and lack of availability of ICU beds, respirators, PPE, and qualified nurses have been the most relevant factors (Coffré & Aguirre, 2020). Many hospitals enforced structural changes, increasing nursing workloads and hours worked in a day (Coffré & Aguirre, 2020). This has caused a great deal of threat to patient care and nursing staff, affecting nurses' physical and mental health (Coffré & Aguirre, 2020). Before the pandemic, occupational stress was a fast-growing cause of work-related disease, injury, and mental health issues among nurses and

healthcare staff (Hassan, 2020). Recent events with the COVID-19 pandemic have magnified those numbers (Hassan et al., 2020).

The conceptualization of stress and stress responses has varied in form and content throughout the centuries. As early as Florence Nightingale, stress has been recognized as a challenge to health outcomes (Rice, 2012). Selye's GAS model has been used in research and nursing research over the years, more recently related to COVID-19. Arikan (2021) used GAS theory to understand how stress can trigger physiological and psychobiological changes due to conditions and demands and to enable the understanding of both short- and long-term effects of COVID-19 stress. Trenado (2020) discussed the impact of COVID-19 on stress-related effects on disease and mental health and a need for a documented understanding of the effects. Trenado (2020) considered the effect of stress-related factors into models used for COVID-19 and identified theoretical models of stress by the degree to which they are relevant to adverse environmental conditions and psychological and physiological responses. Suggesting the use of multiscale models allows for consideration of COVID-19 effects on stress at the individual level (Trenado, 2020). Selye GAS model was identified as a multiscale model that focuses on an individual's emotional and physiological responses (Trenado, 2020), which supports the use of Selye's GAS model for this study.

Selye's (1946) model of stress GAS fits my study because of the belief that no matter the stressor, physical or emotional, specific bodily changes will occur. They define stress as the "nonspecific response of the body to any demand" (Selye, 1950). Identifying each period of distress leaves psychological and emotional wear and tear on a person,

sometimes irreversible (Selye, 1977). Nurses that have cared for and are caring for COVID-19 patients across the country have been asked to do the unimaginable, pushing their mind and body to the limit to save lives (Arcadi et al., 2021). GAS will be a helpful model for identifying the physiologic process involved in the relationship between nurses' lived experiences and caring for COVID-19 patients. Additionally, it serves as a paradigm for understanding the symptomatic expression and progression of any physical or mental illness. The GAS theory will aid in identifying nurses' lived experiences related to health outcomes that can be understood for future pandemics.

The research question for this study is: What are the lived experiences of nurses in the United States who have provided care for patients with COVID-19? Selye's general adaptation theory related to this research question in that the research question has to do with focusing on the experiences of nurses during a pandemic caring for COVID-19 patients. Nurses have experienced critical roles and heightened responsibilities during the COVID-19 pandemic. Every day they are at the forefront of the COVID-19 outbreak continuing to be overstretched, experiencing increased workloads and hours worked. The lived experiences of these nurses can be better understood by applying Selye's GAS theory and may aid in interpreting the pattern of responses the body goes through after being exposed to a stressor, alarm, resistance, and exhaustion. This theory will focus on the lived experiences and level of stress to better understand the extent of nurses' experiences when caring for COVID-19 patients.

Conceptual Framework

The conceptual framework basis for this study is Edmund Husserl's (1916) life-world view. According to the framework, the *life-world* is defined as a reflection of the world's immediate or direct experiences in the subjectivity of everyday life (Husserl, 1954, 1970). The fundamental concept is the lived experiences inhabited as conscious beings are incorporated into how the phenomena appear in conscious experiences of everyday life. Meaning isolating essence, invariant features, and structures of a phenomenon can be described as precisely as possible. Husserl's (1954, 1970) life-world includes individual, social, perceptional, and practical experiences that focus on what is perceived rather than how it is perceived. Husserl's (1916) life-world framework posits that to understand individual situations, one must understand them in their lived and worldly context as this is where they have meaning. Life-world allows a researcher to observe and understand the participants' reality in a particular way. Husserl's (1954, 1970) life-world approach of interpretation and understanding of lived experiences are not limited to the transcribed interview but start with the discussion and observation of participants. Dahlberg and Drew (1997) described Husserl's life-world as a nursing paradigm. When nurses use life-world as a paradigm for research, it is based on a phenomenological philosophy and the understanding that the participants and researchers' openness guide the research to the phenomena of their everyday world. Life-world is suggested as a qualified framework for nursing research (Dahlberg & Drew, 1997).

Husserl's life-world is considered a world of what is self-evident, or a given world of one's own experiences (Husserl, 1954, 1970). Believing this concept has a significant role in the ground of all knowledge that lies within the lived experiences (Husserl, 1916). The life-world model is used in research and writings in philosophy and social sciences, specifically sociology, anthropology, and nursing (Farber, 2017). The life-world concept emphasizes the belief in which the world is experiencing the world that is lived, designating life-world as a pre-epistemological steppingstone for phenomenological analysis in the Husserlian tradition (Farber, 2017).

Life-world is understood as one's experiences becoming passively developed in one's ongoing experiences and thought of as a world of a living tradition (Husserl, 1954/1970). Everything one engages in actively or passively has no boundaries expanding indefinitely in all directions, including in the direction of thoughts. This identifies life-world as a fitting conceptual framework for my research to understand human phenomena as it is experienced or lived. Life-world is recognized as a good method for nursing research, as a new topic focusing on the meaning of participants' lived experiences (Cohen et al., 2000). In Norway, Rygg et al. (2021) used Husserl's life-world to identify the lived experiences of oncology nurses using virtual communication to care and communicate with their home cancer patients during COVID-19 to identify their pre-reflective experiences. Identifying the safety and quality of patient care, nurses' lived experiences must be researched during this coronavirus pandemic for future pandemics. Van Oorsouw et al. (2020) in the Netherlands used Husserl's life-world to explore health professionals', including nurses, lived experiences during the COVID-19

pandemic to identify experiences of ethical issues and moral distress. According to this study, an individual's world is based on their firsthand accounts of their experiences, suggesting lived experiences provide insight into the unusual working conditions during this pandemic for possible future ones. Kackin et al. (2020) used Husserl's life-world to determine the experiences and psychosocial problems in nurses caring for COVID-19 patients in Turkey. This framework was used to identify nurses' experiences and psychosocial issues to understand their feelings, thoughts, and perspectives. Using Husserl's life-world, Kackin et al. determined that the COVID-19 outbreak affected nurses psychologically, physically, and socially, and they needed psychosocial support and resource management to deal with the trauma experienced. Husserl's life-world understanding is to arrive at a fundamental understanding of human consciousness through features common to all people who have the experience (Lopez et al., 2004). With that understanding and the examples above of how Husserl's (1916) life-world contributes to research on the lived experiences of a phenomena, this framework fits my study.

Literature Review Related to Key Concepts

This literature review presented the current evidence related to nurses' experiences working with patients who are diagnosed with COVID-19. I explored what is known about their experiences, work environments, and any impact this has had on nurses personally and professionally.

Lived Experiences of Nurses

Several studies have depicted nurses' lived experiences caring for COVID-19 patients during the pandemic, mainly outside the United States. Caring for COVID-19 patients is challenging and stressful. Issues like lack of PPE, increased chances for transmission, enormous patient death rates, and extreme working conditions and workload can lead to stress and burnout, leading to health and mental issues. For example, Sadang (2021) conducted a qualitative study of nurses in the Philippines caring for COVID-19 patients in a hospital setting using individual in-depth interviews. The findings identified nurses experiencing enormous demands, physical and mental struggles in all aspects of their life, lack of support from their organization and government that caused them stress, panic, exhaustion, mental and physical breakdown, and some quit their job (Sadang, 2021). Arcadi (et al., 2021) performed a qualitative study in Italy of nurses' lived experiences when caring for COVID-19 patients in the hospital setting. Individual interviews were conducted using video calls. Study findings identified nurses having uncertainty, fear, helplessness, inadequacy in coping, physical and mental fatigue. Findings also identified that despite the extreme working conditions, the nurses and medical team developed a cohesive and supportive environment allowing them to become more resilient during the pandemic (Arcadi et al., 2021).

Additionally, several studies indicated that nurses experienced anxiety, fear, and overwhelming stress (Chegini et al., 2021: Gunawan et al., 2021; Lee and Lee, 2020) Gunawan et al. (2021) performed a qualitative study in Indonesia using individual online interviews and follow-up text exploring the lived experiences of nurses caring for

COVID-19 patients in a hospital setting. The findings indicated that nurses felt scared, anxious, and stressed. Additionally, nurses expressed that they are pawns in the battle of COVID-19, betrayed by the government and organization. This experience led to a poor state of mental health, developing stress, depression, and other mental health and physical health issues impacting nurse turnover, burnout, and mental health (Gunawan et al., 2021). Chegini et al. (2021) performed a qualitative study in Iran to explore the experiences of critical care nurses caring for COVID-19 patients in a hospital setting through face-to-face and telephone interviews. The researchers also discovered the nurses experienced severe stress, fear, anxiety, and desolation. The researchers further found that nurses caring for COVID-19 patients required psychological counseling to address the impact of their work (Chegini et al., 2021).

Lee and Lee (2020) performed a qualitative study with individual telephone interviews on the lived experiences of nurses in South Korea working at a government-designated COVID-19 hospital to identify negative impacts to guide in developing support programs for nurses facing pandemics. Findings identified were that nurses expressed that they were thrown into a battlefield without preparation, developing overwhelming stress, fatigue, burnout, anxiety, fear, and isolation, causing low morale. These findings suggest nurse burnout affects nurses' physical and mental health, contributing to threatening patient care. Additional findings identify nurses who cared for patients during the MERS epidemic had less anxiety (Lee & Lee, 2020). The study findings suggest that providing compensation for difficult work, psychological support at

a personal level, a sufficient supply of PPE, and pandemic public health policies will aid post-traumatic growth (Lee & Lee, 2020).

Understanding Nurses Working Conditions

It is known that pandemics and epidemics result in significant deaths and socio-economic disruption creating public health emergencies (Fernandez, et al., 2020). In recent years, there have been many infectious disease outbreaks that had the ability to become global pandemics, such as SARS in 2003 (Maunder, 2004), influenza A/H1N1 (swine flu) in 2009 (Fitzgerald, 2009), and MERS in 2012 (Kim, 2018). However, the COVID-19 outbreak has brought this potential into reality, creating a global pandemic. Through the years and currently, nurses play a crucial role in responding to public health crises, including all epidemics and pandemics, by providing direct patient care and aid in reducing the risk of exposure to the outbreak (Fernandez, et al., 2020). During the COVID-19 outbreak, nurses have felt obligated to care for patients despite the dangerous working conditions that they may encounter.

Mo et al. (2020) conducted a cross-sectional online survey investigating the working conditions and work stress among Chinese nurses caring for COVID-19 patients. The findings indicated that the pandemic resulted in widespread extreme workloads and pressure among nurses caring for COVID-19 patients. It was discovered that nurses felt anxiety and helplessness due to heavy patient load, working long extended hours, and poor diet and sleep deprivation all impact nurses' stress load (Mo et al., 2020). Suggested that organizations should offer and provide support systems to improve nurses' mental health during extreme working conditions, such as pandemics. The findings in this study

validated nurses' displayed work stress when caring for COVID-19 patients. A limitation of this study is it used cross-sectional online survey and only included a small area in China.

The impact of COVID-19 has not only impacted hospital-based nursing but has impacted other areas of nursing. Halcomb et al. (2020) conducted a cross-sectional study to explore the experiences of Public Health nurses working outside of hospitals for the Australian government during the COVID-19 pandemic. Researchers discovered that nurses were required to continue face-to-face care without proper PPE due to lack of supplies. Additionally, nurses experienced decreased hours of employment that threatened their jobs and were forced to work in other areas such as hospitals, changing their role and increasing their workload caring for COVID-19 patients. Study findings revealed that beyond significant safety concerns, nurses experience heightened anxiety and job insecurity (Halcomb et al, 2020).

Fernández-Castillo et al. (2021) conducted a qualitative study in Spain to explore the experiences of nurses working in the ICU during the COVID-19 pandemic. Findings indicate that nurses experienced increased workloads requiring them to perform specialized care without education or experience due to a lack of qualified professionals to perform those duties. Additionally, nurses experienced deep anguish, emotional and mental hardship, and the inability to provide proper care and humanization to their patients due to the workload and patients dying alone (Fernández-Castillo et al., 2021). Other non-ICU trained nurses were forced to care for COVID-19 ICU patients, which caused profound stress resulting in nurses vomiting, fainting, and leaving the profession.

Findings suggested a need to provide psychological support and increased training and protocols for ICU nurses for future emergencies. The findings in this study identified the physical and psychological consequences of caring for COVID-19 patients. A study limitation is that participants were recruited using only one ICU unit, reducing the possibility of generalization to other settings.

Arnetz et al. (2020) performed a cross-sectional qualitative study using an open text survey in the state of Michigan in the United States, exploring 695 nurses' perceptions in the initial stages of the coronavirus (COVID-19/ SARS-CoV-2) pandemic. Findings from the study indicated that nurses experienced fear of becoming infected or infecting their loved ones due to the lack of PPE or cleaning supplies to protect them. Additionally, nurses experience overwhelming stress and sadness with the rapid deterioration and death of patients, coworkers, and loved ones due to lack of ventilators, testing supplies, the high workload of extremely ill patients, and improperly trained nurses caring for these patients (Arnetz et al., 2020). Study recommendations include that healthcare organizations need to develop a plan to provide adequate PPE and establish support services for nurses to discuss the stress they are experiencing to improve and maintain nurses' health, safety, and well-being. The findings in this study bring to light the experiences of nurses' stress and extreme working conditions early in the pandemic (Arnetz et al., 2020). However, a weakness may include the study only used three large hospitals in one U.S. state and may not be generalized to other states or countries.

Impact of COVID-19 on Nurses

Understanding the short term and long-term impact of COVID-19 on nurses will provide critical information to aid the United States health care system in preparing for a continuing pandemic and future large scale health care events. To develop a progressive path forward where nurses will be well-positioned and prepared to meet evolving needs of patients, communities, and healthcare systems in the next global threat, it is imperative that research identify issues that have been experienced during the COVID-19 pandemic (ANOL, 2021). The American Organization for Nurse Leadership (2021) conducted a quantitative cross sectional online survey of over four thousand participants that have cared for COVID-19 patients, of which 1000 were nurses working in the United States. Results identified that nurses who cared for COVID-19 patients during the pandemic experienced stress, burnout, understaffing, and believe nursing programs today are inadequate for training nurses to meet the demands of the current healthcare system (American Organization for Nurse Leadership, 2021). With that knowledge, it is imperative to identify and understand the impact caring for COVID-19 patients has on nurses to help support nurses for future epidemics and pandemics. However, there are minimal published studies on the impact COVID-19 has on nurses, especially in the United States.

Sun et al. (2020) used a phenomenological approach to explore the psychology of nurses in China caring for COVID-19 patients. The findings revealed that nurses experience fatigue from the patient load, excessive work hours, discomfort from wearing PPE for long hours, and helplessness from extreme working conditions. However, due to

their experience with the SARS epidemic, these nurses adopted coping measures and received organizational and government support to reduce stress later in the pandemic (Sun et al., 2020). These findings suggest that it is critical for nurses to be supported in the battle against pandemics for improved mental health.

Catania et al. (2021) performed a qualitative study across multiple regions and multiple hospitals in Italy to explore 23 nurses' experiences when caring for COVID-19 patients. Findings demonstrated that nurses experienced extreme stress from the unknown of the virus, fear of infection or infecting loved ones, lack of PPE for protection, and being overworked. Additionally, nurses experienced coworkers and loved ones becoming infected and dying, while many nurses were forced to work on the COVID-19 ICU without proper training (Catania et al., 2021). The study findings suggest that nurse participants in this study have a high incidence of experiencing post-traumatic stress, which may not be apparent to colleagues.

An (2020) performed a cross-sectional online survey of emergency department nurses in China to examine the prevalence of depression and quality of life in caring for COVID-19 patients. Findings revealed that about half of the emergency department nurses suffered from depression. Additionally, nurses reported experiencing excessive workloads and work hours, fatigue, helplessness, fear of contacting or passing the virus, and stress due to increased resuscitation and death of patients (An, 2020). Study findings suggested that nurses who care for or have cared for COVID-19 patients are more likely to suffer from depression and working in any clinical setting with COVID-19 patients is an independent risk factor for poor mental health among nurses (An, 2020).

Shaukat (2020) utilized the Arksey O'Malley framework to conduct a scoping review to summarize the evidence of the physical and mental health impacts of the COVID-19 pandemic on healthcare workers, with nurses being the prominent participants. Physical findings identified the prolonged use of PPE led to skin damage. The lack of proper hand hygiene and PPE caused an increased transmission among nurses, with many experiencing mild or severe symptoms of COVID-19 infection. Many times, COVID-19 infection went on to cause mortality among peers and loved ones. The findings of psychological distress included high levels of depression, stress, anxiety, distress, anger, fear, insomnia, and post-traumatic stress disorder (Shaukat, 2020). These findings suggest that healthcare workers, including nurses, are at risk of physical and mental consequences as a direct result when caring for COVID-19 patients.

As the impact of COVID-19 began to manifest, nurses found themselves in working conditions that they had never experienced before. As identified in the studies above, nurses frequently worked long hours with heavy patient loads and limited access to sufficient PPE to protect them during the evolving virus (An, 2020; Catania et al. 2021; Sun et al., 2020). Challenging conditions on this unrelenting global pandemic have created a perfect storm with the potential to seriously impact nurses' psychological and physical health. It will take time for the toll and impact of the pandemic on nurses to be fully quantified. There may be physical and mental health issues to be identified and remedied. Therefore, studies like those above, future studies, and my study may contribute to understanding the COVID-19 impact on nurses, particularly in the United States. Understanding nurses' experiences when caring for COVID-19 patients provides a

unique lens to view during a global pandemic serving as a starting point to ensure future safeguards are in place to protect nurses' well-being (LoGiudice & Bartos, 2021).

Chosen Methodology

With my study, I want to fill a gap in the literature that focuses explicitly on nurses' lived experiences caring for COVID-19 patients in the United States. As demonstrated above, there are few studies on the lived experiences of nurses caring for COVID-19 patients across the world and even less in the United States. The single US study differs from my study in it is limited to only including nurses from the state of Michigan. To address this current gap in the literature focused on nurses' lived experiences when caring for COVID-19 patients, I performed a qualitative phenomenological study using semi-structured online interviews that include nurses from across the United States.

Neubauer et al. (2019) wrote that phenomenology as an approach to research that seeks to portray the essence of a phenomenon from the perspectives of those who have experienced it. The goal of phenomenology is to describe the meaning of someone's experience both in terms of the experience and how it was experienced (Neubauer, et al., 2019). When qualitative research uses a phenomenological approach, it focuses on what the experience means to a group of people (Creswell & Creswell, 2017). Phenomenology has been utilized in nursing research when exploring nurses' experiences when caring for COVID-19 patients (Catania et al., 2021; Sun et al., 2020), however, findings related to the lived experiences caring for COVID-19 patients in the US is limited.

What Remains to Be Studied

Due to the ongoing pandemic and subsequent waves continuing to evolve, what remains to be studied is nurses' experiences when caring for COVID-19 patients in the United States. It is possible that findings from other countries may have similar results; however, it is also likely that there are unique experiences in the United States based on differences in health systems, roles, and resources. For example, in the United States, the COVID-19 vaccines are available to all eligible adults and children at no cost, yet many Americans have chosen not to take the vaccine or follow mask mandates. Being asked to continue to care for COVID-19 patients who chose not to mask or be vaccinated could contribute to feelings of hopelessness and frustration among nurses in the United States. Gaining a deep understanding of the lived experiences of nurses caring for COVID-19 patients in the United States can aid in developing strategies to reduce the risk of negative outcomes among nurses and hopefully provide improved support, resources, and work environments for nurses. The studies above are just the beginning in understanding nurses' lived experiences when caring for COVID-19 patients. To date, no published studies were identified that specifically explore nurses' lived experiences when caring for COVID-19 patients in the United States.

Summary and Conclusion

My literature review provided an understanding of the published studies that have identified nurses' lived experiences when caring for COVID-19 patients. There are limited studies on nurses' experiences when caring for COVID-19 patients during this pandemic, but none were identified on nurses' lived experiences working in the United

States. Nurses are a vital component of the health care system. Therefore, their health and safety are essential for safe patient care and the control of any contagious outbreak. This proposed study will fill a gap in the research of nurses' experiences during the pandemic. It will also add to the understanding of the impact nurses experienced identifying mental and health outcomes to help develop coping strategies in the post-COVID era.

Chapter 3 utilized a qualitative, phenomenological approach to understand the lived experiences of nurses caring for COVID-19 patients in the United States. It includes a discussion of selected research design, researcher's role, qualitative methodology, and transferability and bias issues.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to explore the experiences of nurses caring for COVID-19 patients in the United States and how those experiences impact their personal and professional lives. In this chapter, I discuss the research design and rationale; my role as the researcher; the instrumentation; the process and procedure for recruitment, participation, and data collection and analysis; and issues of trustworthiness and ethical procedures.

Research Design and Rationale

The following research question is central to the study: What are the lived experiences of nurses in the United States who have provided care for patients with COVID-19? The chosen research design for this study is a phenomenological, interpretative design. According to Eatough and Smith (2008), using this design provides detailed examinations of personal lived experiences producing an account of the lived experiences in their own terms. The primary interests are the person’s experience of the phenomenon and the sense they make of it rather than the structure of the phenomenon itself (Eatough & Smith, 2008). The focus in this study was to understand the lived experiences of nurses who have cared for COVID-19 patients in the United States. To deeply explore this phenomenon, I used a qualitative phenomenological interpretive design with semistructured interviews. Semistructured interviews are an effective method for a researcher to collect data that explores participants’ thoughts, feelings, and beliefs about a particular topic and to delve deeply into personal and sometimes sensitive issues

(DeJonckheere & Vaughn, 2019). Semistructured interviewing serves as a powerful tool for healthcare researchers to use to understand the thoughts, beliefs, and experiences of individuals (DeJonckheere & Vaughn, 2019).

Phenomenology is an approach to qualitative research that focuses on the commonality of the lived experiences within a particular group. The fundamental goal of this approach is to arrive at a description of the nature of the particular phenomenon (Creswell & Creswell, 2017). A qualitative, phenomenological approach was chosen for this study because this research approach focuses on the commonality of a lived experience within a particular group (see Creswell & Creswell, 2017). A qualitative grounded theory approach was not considered because this method enables a researcher to study a particular phenomenon of a group, not the lived experiences of a participant in a group (Chun Tie et al., 2019).

Role of the Researcher

My role in this study was to be the primary researcher and data collector. That role required having direct contact and involvement in participants' experiences, creating a concern of personal and ethical dilemmas. To minimize any ethical dilemmas, I sought to identify any potential personal bias, personal values, experiences, and any other factor that may influence and affect the analysis and results of the study (see Creswell & Creswell, 2017). As a neonatal intensive care nurse, I have not had any experience in caring for COVID-19 patients. However, a few of my colleagues at other hospitals have expressed stressful experiences in caring for COVID-19 patients, and I have seen stories of nurses struggles in caring for COVID-19 patients in the news and media. I understand

this may be a potential bias. Having some experiences on the phenomenon through colleagues and media will require me to set aside any perceptions of those experiences when taking on the role of researcher.

In my research, I addressed ethical issues including confidentiality by providing verbal and written assurance to all participants that any identifying factors, including names, would be omitted from data analysis. Instead, I provided each participant with an identifying number. Additionally, all information collected was maintained as confidential and stored in a password-protected computer.

As a nurse, I have colleagues who continue to experience stressful working conditions caring for COVID-19 patients, and I see continued reports on the news of nurses working conditions with COVID-19 patients. To avoid any ethical issues that may occur from this insight, I ensured there was no personal, work related, or any type of relationship with participants. I did not recruit participants who are colleagues.

Another ethical issue was the sensitive or emotional responses that may occur in the research participants when reliving the working conditions during this pandemic. These memories may bring back anxiety, fear, and sadness. Prior to conducting my interviews, I obtained Walden University Institutional Review Board (IRB) approval to ensure ethical treatment of all research participants. Additionally, I informed all research participants that they were free to end the interview at any time without fear of repercussions or negative effects on the study, and I provided the number to the Federal Emergency Management Agency National Crisis Support Hotline for healthcare workers

experiencing COVID-19 stress if talking about their experiences created additional stress or discomfort.

Methodology

The purpose of this study was to explore the lived experiences of nurses who have cared for COVID-19 patients in the United States. A qualitative phenomenological approach was used as my aim was to describe and explore experiences of individuals who have experienced the phenomenon of interest (see Creswell & Creswell, 2017). In the methodology section, I address all procedures associated with this study and explore the methodical application for selecting participants, the instrument used for the study, data collection, data analysis, and findings.

Participant Selection Process

For my qualitative phenomenological study, the identified population includes RNs who are currently caring for or have cared for COVID-19 patients in the United States. I used purposive and snowball sampling in my study. The main goal of purposive sampling is to focus on particular characteristics of a population of interest, which best enables a researcher to enlist information-rich participants (Creswell & Creswell, 2017). Additionally, snowball sampling expands the sample by asking those initial participants to identify others who should participate in the study (Creswell & Creswell, 2017). Purposive and snowball sampling allow for a small sample to be interviewed as the value lies in selecting information rich cases to gain a deeper understanding of the phenomena (Creswell & Creswell, 2017). Both strategies allowed me to obtain a representative

sample of nurses to interview specific to the research population and interests to achieve rich information.

I acquired demographic information of the study participants to ensure they gained their experiences in the United States. Following verification that participants met the study inclusion criteria, I conducted semistructured one-on-one interviews until data saturation was achieved. These criteria for participation included RNs over the age of 18 with a license in the United States who have cared for or are caring for adult COVID-19 patients. These criteria were selected so the participants would have experiences in the phenomenon of interest to provide an in-depth account of their lived experiences. According to Creswell and Creswell (2017), phenomenological studies generally range from three to ten participants. I aimed to interview 8–10 participants; however, data was collected until no new data were received and saturation occurred (see Creswell & Creswell, 2017). Exclusion criteria included participants who do not hold a RN license in the United States and nurses who have not directly cared for COVID-19 patients.

To recruit participants, I posted a study flyer on social media sites that nurses use, such as Instagram and Facebook nursing groups. See Appendix A for the recruitment flyer. The sample size is less critical in a qualitative study compared to a quantitative study. The factors that determine sample size in qualitative research include appropriate study design, quality of data, and principle of saturation (Maxwell, 2021).

Instrumentation

Using a qualitative approach requires a shared space between researcher and participant during the interview. A researcher is considered the instrument because all

observations, interpretations, and analysis are filtered through their lens (Creswell & Creswell, 2017). For this reason, it was imperative that I constantly reflect on any potential bias I may have introduced while collecting and analyzing the data. Data were collected through one-on-one interviews using open-ended questions, and I recorded observations during the interviews in detailed field notes. Recruitment did not begin until approval from the IRB.

A demographic survey that addresses the inclusion criteria and open-ended questions was used to collect data in this study. Demographic and inclusion criteria were collected using Qualtrics. The first page of the survey was the informed consent with a written selection that the participant agrees to participate in the study. After the participants read the informed consent and agreed to participate, they completed the demographic survey (Appendix B), which included their contact information to schedule the interview (Appendix C). Individual semistructured interviews were conducted using questions developed from a review of literature and evaluation by my committee members. Interviews were conducted through Zoom or telephone, whichever was most convenient for participants. The interviews were audio recorded and downloaded on my password-protected laptop through Zoom, and Otter. Both applications record and provide verbatim written transcripts.

I used semistructured interviews that provide a basic framework of questions to guide the interview, along with follow-up questions to stimulate thoughts to gain a deeper understanding from participants during the interview. The questions were open-ended,

allowing a holistic and comprehensive look at the phenomenon permitting participants to include more in-depth information of their lived experiences.

I approached my research with the utmost effort to ensure the rigor of my study. The credibility of a study is based on how a researcher maintains rigor while collecting data and analysis, clearly linking the research findings with reality to demonstrate the truth of the research findings (Creswell & Creswell, 2017). Additionally, I incorporated factors of trustworthiness that consist of credibility, transferability, confirmability, and dependability.

Procedures for Recruitment, Participation, and Data Collection

To recruit research participants, I used an invitation letter outlining a summary of my study, which included my contact information (Appendix A). This flyer was posted on social media sites frequently used in the United States for recruitment. Nurses who were interested in participating in the study were asked to contact me. I sent them an email that included the informed consent with a link to the survey. The first page of the survey was the informed consent (with a box to select "I consent"). Once that box was checked the participants moved on to the demographic page (Appendix B). A copy of the informed consent was also emailed to participants so they could print and store the consent document. I contacted each participant who completed the informed consent and met the inclusion criteria to coordinate an interview date and time. I answered any questions or addressed any concerns raised by the participants.

Once participants met the inclusion criteria and gave their consent, 30–60-minute interviews were scheduled with an understanding the time frame may run shorter or

longer based on the degree of the answers and follow-up questions. The interviews included a list of predetermined interview questions, along with follow-up questions (Appendix C). Prior to the interview, participants were informed that they could request verbatim transcripts of the interview if desired. All participants were informed the interviews were audio recorded and that they were free to stop the interview at any time for any reason.

When closing and debriefing the interview, I thanked participants for their time and contribution to my research. I restated that their identity would not be disclosed or revealed in the final study and that their responses would be kept confidential. Lastly, I asked them if they had anything else they wanted to add to the interview or if they had any questions.

Data Analysis Plan

I chose to do a qualitative interpretive phenomenological study and sought to describe the essence of a phenomenon by exploring it from the perspective of those who have experienced it, focusing on their values, meanings, beliefs, thoughts, feelings, and experiences (see Maxwell, 2012). It was imperative the chosen method and data analysis coincide. Thereby, the qualitative data that were collected were used to understand the lived experiences of nurses who have cared for COVID-19 patients. After collecting the data, qualitative thematic data analysis was used. This method is defined as the process of systematically searching and arranging the interview transcripts, observation notes, or other nontextual materials collected to increase understanding of the phenomenon

(Maxwell, 2012). Analysis of data was conducted through Moustakas's (1994) approach, which is a modification of van Kaam method of phenomenological data analysis.

I started the analysis with the modified van Kaam method of data analysis by horizontalizing, in which I listed all the relevant expressions and experiences (see Moustakas, 1994). Then I conducted reduction and elimination of participants' lived experiences of the phenomenon to the invariant constituents (see Moustakas, 1994). The next step was grouping the remaining answers into thematic clusters, creating core themes of essence of the participants' experiences (see Moustakas, 1994). I then began creating textual descriptions of each participant's experiences using invariant constituents and themes pertinent to participant experiences (see Moustakas, 1994). Textual descriptions aid in capturing the meaning and depth of the essence of the lived experiences (Moustakas, 1994). Next, I constructed individual structural descriptions of each participant's experiences. Once these statements were complete for all participants and I felt confident no bias influenced the data analysis, the next step was to construct composite structural descriptions (see Moustakas, 1994). The final step in data analysis was a synthesis or composite description that represents the essence of the lived experiences of the participants (Moustakas, 1994). Data analysis was done manually without the use of software.

Issues of Trustworthiness

In qualitative research trustworthiness is the accuracy of a research study, data, and findings (Creswell & Creswell, 2017). Trustworthiness in qualitative research is to support the argument that the research findings are "worth paying attention to" (Lincoln

& Guba, 1985). This is especially important when using inductive content analysis as categories that are created from raw data. Trustworthiness in qualitative studies is about establishing credibility, transferability, dependably, and confirmability.

Credibility

Credibility is an important part of critical research (Ravitch & Carl, 2019). Rigor is an important component in qualitative research as it allows the researcher to establish trust, confidence and consistency in the methods validating the research (Ravitch & Carl, 2019). The process of credibility in qualitative research may include member checking, triangulation, offering thick descriptions, and the use of peer debriefers (Ravitch & Carl, 2019). Member checking is a technique to establish credibility, whereby participants may assess the validity of their statements to ensure and verify accuracy (Ravitch & Carl, 2019). After each interview, participants had the option to receive a document of their interview to check for accuracy and resonance with their experiences caring for COVID-19 patients. Triangulation will be completed by asking the participants the same research question, while having enough participants to reach thematic saturation. Adding to triangulation my dissertation chair, who is a doctoral prepared researcher, independently review the transcripts to evaluate the study findings. This process provides multiple perspectives to be given enhancing the validity of the study (Ravitch & Carl, 2019).

To assure credibility, reflexivity needs to be used to avoid participant expectations and research bias by accounting and reporting all information that may affect data collection, analysis, and interpretation that has to do with researcher/participant beliefs and attitudes (Creswell & Creswell, 2017). Thereby, reflective journaling was utilized as

another technique to document personal thoughts and experiences to become self-aware about any influence that might unconsciously influence the research process.

Transferability

A main tenet of transferability is the degree to which the results of the research can be generalized or transferred to other contexts, while maintaining richness in context detail (Creswell & Creswell, 2017). Additionally, transferability in qualitative research is similar to generalizability or external validity (Creswell & Creswell, 2017). Lincoln and Guba (1985) describe the importance of using rich, thick description to convey the findings as it may transport the reader to the setting and give the discussion an element of shared experiences making the results more realistic and richer. Transferability is dependent on detailed information such as the location of the setting, atmosphere, climate, participants present, attitudes of participants, and observed reactions to achieve a deep understanding so readers can obtain a graphic picture of the phenomenon (Maxwell, 2012). For this research study, I enhanced transferability by doing a thorough job providing extensive detail and thick descriptions of research content and the assumptions that are central to the research.

Dependability

Dependability refers to the stability of the data (Ravitch & Carl, 2019). To achieve dependability or to the extent that the study could be repeated by other researchers, the findings would have to be consistent (Ravitch & Carl, 2019). Meaning if another person wants to replicate my study, they should have enough information from the report to do so and obtain similar findings. Researchers can use an inquiry audit, by

an outside person, to review and examine the process, to establish dependability. Other methods for achieving dependability include triangulation and sequencing of methods to validate appropriate data collection plan was created (Ravitch & Carl, 2019). Both were accomplished using a methodological expert, such as my dissertation chair, who will review the results of the study and ensure that the data collected validates those results and conclusions.

Confirmability

Confirmability in qualitative research refers to the researcher's ability to demonstrate that the data represents the participants' responses and not the researcher's bias or viewpoint (Creswell & Creswell, 2017). Confirmability occurs once credibility, transferability, and dependability have been established (Ravitch & Carl, 2019). Reflective research is important as it produces new insights, which lead the reader to trust the credibility of the findings and applicability to the study (Ravitch & Carl, 2019). A researcher must be reflective, maintaining a sense of awareness and openness to the study results. Additionally, the researcher needs a self-critical attitude, considering how their own perceptions affect the research (Ravitch & Carl, 2019). Another important aspect in qualitative research is a thorough audit trail. An audit trail is a transparent description of the research steps taken from the start of the research to the development and report of findings. These records include notes of information regarding raw data, written field notes and all the steps taken to manage, analyze and report data (Creswell & Creswell, 2017). In my research, reflective journaling and an audit trail was completed from the beginning of my research, throughout the interviews, data analysis, interpretation, and

findings to ensuring rigor in my results by mitigating any bias that may exist and increase confirmability.

Ethical Procedures

Prior to beginning my research, I sought and obtained approval from the Institutional Review Board (IRB) at Walden University (IRB approval #01-19-22-0378855). Prior to submitting my application for IRB, I completed the required training for research with human subjects.

To mitigate ethical concerns surrounding recruitment of participants, a full disclosure of the purpose of the study, an understanding that participants will not be pressured or forced to participate, and participants benefits will be provided (Creswell & Creswell, 2017). Ethical concerns were addressed by providing a full disclosure of the intent of the research along with a signed informed consent prior to collecting data. Informed consent was obtained with the understanding that participants were able to withdraw from the study at any time without any questions. Participants were assured that all identifying information including names, audio recording, and notes will be kept confidential. This material was kept on a password protected computer, password protected Dropbox account, and will be destroyed after the amount of time required by IRB approval. It is understood that access to this data would be limited to myself as the primary researcher, and my dissertation committee that includes faculty members at Walden University.

Lastly, no personal or professional colleagues was recruited. This could represent a conflict of interests, potentially cause emotional harm, or create bias that may diminish the quality of the study (Creswell & Creswell, 2017).

Summary

This chapter has described the chosen research methodology for my phenomenological study, which included the research design, instrumentation, and recruit methods. Additionally, I described the issues of trustworthiness and ethical considerations that are in place for this study. Chapter 4 will provide findings of my study including the data collection and analysis process.

Chapter 4: Results

Introduction

The purpose of this qualitative interpretative phenomenological study was to gain an understanding of the lived experiences of the nurses caring for COVID-19 patients during the pandemic and to discover how those experiences have impacted nurses on a personal and professional level. I used the qualitative approach, collecting data through interviews of open-ended questions and answers regarding the participants’ experiences caring for COVID-19 patients. In this chapter, I describe the setting, provide demographic information for the participants, and discuss the data collection and analysis process. Additionally, I present evidence of trustworthiness and the results addressing the research question. The research question I sought to answer was: What are the lived experiences of nurses in the United States who have provided care for patients with COVID-19?

Setting

Recruitment for the study took place between March 10, 2022, and April 18, 2022. I posted the study flyer and link to the Qualtrics demographic screening tool on Facebook and Twitter. My recruitment materials contained a link to Qualtrics for interested candidates to click on to read the study explanation, complete the consent form, and enter demographic information. Additionally, participants entered their names and contact information so that I could contact them via email to arrange an interview if they met the inclusion criteria. Twelve nurses responded to the survey, all of whom met the inclusion criteria. Nine nurses responded to my email to set up interviews. Zoom was

used for eight of the interviews with video and audio recordings, and one Zoom phone interview was used with audio recording. Otter.ia incorporated in Zoom provided verbatim written transcripts of the interview. The participants were informed they could end the interview if needed due to distress, and I would provide them with resources and referrals to seek mental health support if needed. None of the interviews needed to be stopped or discarded due to stress. All interviews proceeded as planned; there were no unexpected events.

Demographics

I interviewed nine participants for this phenomenological study. Participants lived in different states throughout the United States. Participants' ages ranged from twenties to forties, with a mean age of 30 years old. The inclusion criteria include holding a U.S. RN license and having cared for COVID-19 patients. Regarding gender, there was one male participant and eight female participants. Years working as a RN ranged from new orientation with no experience to 20 years' experience. Table 1 includes demographic information for the participants.

Table 1

Demographic Information of Participants

Demographic information	Number of participants (n = 9)
Gender	
Male	1
Female	8
Age range	
18–25	1
25–35	5
35–45	3
45–55	0
55–65	0
>65	0
Years' experience as a RN	
0–5	4
5–10	3
10–15	0
15–20	2
20–30	0
>30	0
Nursing specialty	
Labor and delivery	1
Critical care	4
Neurosurgery progressive care unit	1
Emergency department	2
Intensive care unit	1

Data Collection

Participants

During the recruitment process, there were 12 clicks on the Qualtrics link. All 12 completed the Qualtrics demographics, consent, and screening form. Of the 12 completed surveys, all participants met the inclusion criteria. I contacted all 12 participants for interviews. Nine participants proceeded to complete an interview.

Location, Frequency, and Duration of Data Collection

Preceding recruitment for my study, I received permission from the IRB at Walden University to obtain data from participants. Study approval was granted on January 19, 2022, and the approval number was 01-19-22-0378855. I recruited nurses who live throughout the United States by sharing my recruitment flyer on Facebook and Twitter. The study flyer included a link to my Qualtrics form, which incorporated the invitation letter, consent, and demographic/screening questions. Appendices A, B, and C contain the invitation letter, consent form, screening questions demographic form and recruitment flyer, respectively.

I interviewed nine nurses who held a RN license in the United States and have cared for COVID-19 patients. All nine interviews occurred between March 10, 2022, and April 18, 2022. Interviews ranged from 27 minutes to 60 minutes. Open-ended questions were used to encourage natural and genuine responses. The interview questions asked were the following:

1. Tell me about your experience caring for adult patients with COVID-19.

Can you elaborate on your experiences?

2. Can you tell me about your role as a nurse while caring for COVID-19 patients? (Unit, shift, assignment).

3. How would you describe your initial experiences in caring for patients with COVID-19?

4. How did stress, if present, impact you physically, mentally, and emotionally?

5. How would you describe the impact that COVID-19 has had on you as a nurse?

6. How did you feel when…?

7. Have your experiences changed over time during the pandemic?

8. How are you feeling now?

9. Is there anything you have not described related to this experience that you would like to share?

I also asked follow-up clarifying questions. Additionally, I asked questions for more detail on certain points. See Appendix D for the interview questions and script used.

After obtaining written and verbal permission, interviews took place over Zoom, eight were audio and video recorded via Zoom meeting and one was Zoom audio recorded over the phone. All recordings were completed through Otter.ai, an application via Zoom. Following each interview, the Otter.ai application sent me a verbatim written transcript of the interview. I read over each transcript multiple times while listening and watching the recordings to make sure what was captured was correct and to correct nursing/health care terminology that Otter.ai did not recognize.

Throughout the interviews, I made field notes about each interview and journaled my thoughts and feelings about the responses and the interview. Following my review of

the accuracy of the transcribed interviews, I sent the corrected individual transcripts to each of the nine participants, asking them if the essence of what they said was captured correctly. I received responses from five of the nine participants affirming the transcript. I did not receive a response from four of the nine participants.

The video and audio recordings and written transcripts were kept secure inside the password-protected application Zoom/Otter.ai. All the written transcripts were sent to the participants via a password-protected e-mail. All journal notes were stored in a separate file in my password-protected laptop.

Variations in Data Collection

I recruited participants and conducted interviews in March and April 2022. Throughout this time, the worldwide COVID-19 virus pandemic continued. Given these conditions, I chose to remotely recruit and collect my data. Recruiting was done by posting my invitation flyer through Facebook and Twitter. The interviews and data collection were done over Zoom meetings and telephone, as face-to-face in-person interviews were not possible or safe for all. There was only one technical difficulty in one of the interviews when the participant's internet signal froze, and I could not hear the participant a few times. The problem was remedied quickly, and questions were re-asked and answered with clarity and a full understanding during the same interview recording.

Data Analysis

Coding Process

After all interviews were completed, I performed a phenomenological data analysis using the method recommended by Moustakas (1994), which is a modified

method of analysis of the van Kaam method. Data analysis was not performed until completion of all interviews. The data analysis began by reading and rereading the interview transcripts and my journal notes. Thereafter, I created an Excel spreadsheet that contained columns for participant number, comments, categories, and themes. I began Moustakas's (1994) reduction process by studying the verbatim transcripts from each participant to form textural meanings and invariant constituents. Reduction continued in the filter process to identify the significant experiences of each participant while eliminating overlapping, repetitive, and vague statements. I created this by identifying keywords and phrases related to the research question. This inceptive step of hand coding parsed out the verbatim words and phrases that concisely portrayed the experiences of nurse participants related to their experiences caring for COVID-19 patients and answered the research question. I continued to analyze the patterns and connections among the words and phrases, along with my journal notes.

Then, initially a horizontalization (Moustakas, 1994) approach was used to highlight significant statements to understand the lived experiences of nurses who cared for COVID-19 patients. This approach assigns equal values to each statement representing a segment of meaning (Moustakas, 1994). Then I clustered the segments into themes and synthesized the themes into a description of the texture (see Moustakas, 1994). Treating all data equally, I carefully read each interview, highlighting with different colors each significant phase and sentence about the purpose of the study. Color coding data assisted with reduction and elimination helping to separate the invariant constituents of the experiences from redundant information. Each word or sentence that

did not capture the experience or highlight the phenomenon identifying the invariant constituents was deleted. After the completion of all the interviews, I hand coded interviews to organize the transcripts via an Excel document into codes identifying thematic categories and invariant constituents. In the Excel document, the invariant constituents from each participant were identified with specific thematic colors. The significant statements found in the Excel document promoted the creation of clusters, resulting in themes for the study (Moustakas, 1994).

Four themes emerged from the data analysis: (a) secondary trauma, (b) burnout/compassion fatigue, (c) PTSD, and (d) turnover/leaving nursing. I looked for discrepant cases from the themes, which revealed that some participants experienced initial support from their organizations. However, that support stopped when COVID-19 cases increased on the unit and participants were no longer supported in any capacity.

Once I generated themes, a review of my invariant constituents was completed ensuring the themes accurately represent the lived experiences. The textural–structural narrative helped guide me to summarize the data presented during the interviews to understand the lived experiences of nurses caring for COVID-19 patients.

To assure validity I used member checking. I emailed each participant their transcribed interview, asking them to review it for accuracy and if needed provide any information for clarification or correction. Five of the nine participants verified accuracy based on the information they provided during the interview. I also participated in peer review by sending my Excel spreadsheet with finalized codes/themes and comments that

included my journal notes to my committee chair to complete her coding process. We came to the same consensus about the themes that emerged.

Codes, Categories, and Themes

Data saturation was achieved with nine interviews. Four themes emanated from the data: 1. Secondary trauma, 2. Burnout/Compassion Fatigue, 3. PTSD, 4. Turnover/leaving nursing. Each participant walked through their experiences during their time caring for COVID-19 patients. Open-ended interview questions permitted each participant to recollect their own unique, individual experience about their time caring for COVID-19 patients, relaying it to me in a way that was important to them.

Secondary Trauma

All participants expressed symptoms of emotional duress experienced by firsthand trauma. Common threads between participants include fatigue, despair, sadness, illness, anger, anxiety, and feelings of hopelessness developing into the themes. These experiences were checked against the data, ensuring themes represent the participant's experiences. Emotions were highlighted by three participants as draining, uncertain, and overwhelming. Participant 1 stated, "every day you go to work, and it is so emotionally draining." This comment also indicates that the emotion was an everyday experience each day worked. Uncertainty surfaced as Participant 2 noted, "not knowing what to do was the worst part of it." Her comment suggests not only emotion, but that experience was no help in caring for those patients. The overwhelming nature of caring for COVID patients was expressed by Participant 3, "hard to describe kind of overwhelming, it felt like life was upside down." This comment aligned with Participant 2, who suggested the

uncertainty of caring for these patients aligns with a "life upside down." The despair experienced by participants caring for Covid patients became apparent. Participant 4 stated, "you're just doing your best and still watching them all die." Participant 5 noted, "COVID patient's feel kind of hopeless, they just get sicker and sicker and eventually die." Participant 4 and Participant 5 comments aligned with despair expressing a loss of hope in better outcomes for their Covid patients. Overwhelming stress was emphasized by four participants, causing physical and mental changes. Participant 5 stated, "sometimes I would not eat for 24 hours, and I was just so tired." "Participant 6 expressed, "you feel like you can't do anything, you can't move, I don't know, I'd never felt that experience of being so tired." Participant 7 shared, "I got a bleeding ulcer from the stress." Participant 8 stated, "I think it also made me hot tempered, I do get more easily annoyed to certain things, just from being with that much stress." These comments align with participants experiencing changes such as fatigue, illness and anger brought on by the stress of caring for Covid patients. These statements led to categories of fatigue, sadness, anger, hopelessness, despair, and illness which translated into the theme of "secondary trauma."

Burnout/Compassion Fatigue

The next most common theme that emerged was related to physiological symptoms and psychological symptoms that affect the overall quality of life. Such as anxiety fatigue, and exhaustion. Along with emotional withdrawal and lack of empathy towards others caused by exposure to human suffering that contribute to developing the theme burnout/compassion fatigue. Participant 1 stated, "I remember those first patients,

it is so crazy to think about. I cry every time I think about it, I did not even want to be around anybody." Participant 2, "Even though I was living with my husband, and we were home together, we didn't do anything, I slept I was unable to give more and that made me really jaded, I just started dreading patient interactions and having to do my job." Participant 3 shared, "I just feel like, I don't even know what my thoughts are anymore." These comments align in participants experiencing emotional withdrawal, lack of connections to others and lack of communication resulting from chronic stress caring for Covid patients. Prolonged stress in caring for Covid patients has identified emotional, physical, and mental exhaustion in four participants. Participant 4 shared, "it's just like a long grind of like terribleness and high patient burdens and overcrowding and just misery"; "it got to the point where it was like I wanted to do the bare minimum to take care of the physical needs of my patient and not get to know you because it's too hard for me." Participant 5 stated, "I've had problems sleeping throughout this time" and "I think it's easy to get kind of bitter or withdrawn or detached because mentally it was just exhausting trying to deal with all of it and care for patients." Participant 6, "almost scared to be at work and it is hard to be at work and wanting to care for people". These statements from Participant 4,5 & 6 all align with a loss of interest and motivation in their role to care for Covid patients. Participant 7 stated, "everyone just died. We didn't have the resources, we didn't have the mental energy, we didn't have the supplies, we didn't have treatments, we didn't have any therapeutics" and "got tough to have the willpower to focus, like you need to, on the nursing medical aspect of it; when somewhere in your soul is kind of telling you that this doesn't matter" and "two years of them mostly just

dying, had gotten me to the point where I didn't really care. I wasn't gonna learn your name. I certainly wasn't gonna learn about you." These experiences emerged and aligned as the theme of "burnout/compassion fatigue".

PTSD

The next most common theme that emerged had to do with self-destructive behavior, social isolation, severe anxiety, agitation, and depression. Most of the participants expressed conditions that have lasted for months, with triggers that brought back memories of the trauma accompanied by intense emotional and physical reactions. For example, Participant 1 stated, "Saw a lot more death, I got super depressed, I was drinking wine a lot more, I wasn't sleeping very good, I felt very isolated." Participant 2 shared "I don't know if I would put myself through that again. I'm getting therapy for post-traumatic stress disorder" and "I don't know my feelings toward it. I mean, there's definitely trauma experienced from it. I definitely carry that with me." Participant 2 comments align with Participant 1 "I got super depressed" identifying mental health conditions that developed following the traumatic event in caring for Covid patients. Participant 3 stated, "It's unbearable, when all of your outcomes are poor, this isn't nursing, this isn't medicine, this is an awful conveyor belt of nothing working" and "you didn't really care what you did, because if I invested there was a two thirds chance you were going to die, I couldn't take that anymore, I'm mentally defeated, I'm physically like, worn down" and "your standard run of the mill ICU, you're not coding two or three people every single shift, you're not given death notices every single shift" and "comfort eating occurred and comfort drinking definitely increased" and "I think there's still

tension, I hesitate to call it PTSD, but there's still I think that lingering trigger of I don't know, worries me that kind of disconnected I have it's just right below the surface." Participant 4, " I have some anxiety, the constant state of not knowing what I'm gonna walk into" and "when it's a COVID patient, it's like, oh, he died, she died, that's no longer like a surprise, so yeah, it's kind of normalized, but in a way that doesn't feel good" and "because of isolation, this is the only thing you're doing with your life, so you're going through all of this, and then you come home and you're just at home" and " I was giving it my all at work, I didn't want to do anything, I felt like I was just so drained". Participant 3 and Participant 4 comments both align with difficulty experiencing positive emotions during the Covid pandemic affecting their mental health and wellness. Participant 5 stated, "it's hard for the people in your life who don't understand that to begin with, to give you the normal support that you need, I really think I might have some PTSD" and "I really think that just kind of took a toll on me, I've thought a lot about finding a therapist." These sentiments and symptoms of changes in physical and emotional reactions in caring for COVID-19 patients and surviving the pandemic led to the theme of "posttraumatic stress disorder (PTSD)".

Turnover/Leaving Nursing

The last most common theme that emerged had to do with the impact of staffing shortages, better work-life balance, mental health at risk, and feelings of lack of appreciation. During the pandemic nurses worked with poor practice conditions, including a lack of PPE, high risk of infection and heavy workloads. All participants expressed feelings of stressful working conditions and the lack of feeling valued.

Participant1 noted, “my hospital was constantly redistributing staff all over the place, so we had new roles; being floated some were scared out of their minds, some don’t have skills, people were so put out of their comfort zones.” “I wanted to leave bedside, but I think it only further cemented that” and “it’s sad to watch your colleagues go, it’s sad to come into a department where you don’t know anyone anymore, because the turnover is so great.” Participant 2, “you’re the only person that patients saw all day, which was felt overwhelming; you’re worried that if the patient died, you missed something, because no one else was in there” and “we’d be so short staffed, that you would basically do everything just on your own.” We lost a lot of staff; it was hard we were in an even worse staffing crunch.” The organization did not increase staffing, which was frustrating when you don’t have good ratios, patients get worse outcomes, you felt kind of bad because some patients are getting worse care because you just can’t take care of patients when you’re stretched.” I thought that I wanted to leave nursing, I just knew that I don’t want to do that for the rest of my life. Participant 3 stated, “we’ve had so much turnover, short staffing we’re running around and not getting breaks and having to do more with less people just was difficult”. Participant 2 and Participants 3 comments aligned with Participants 1 comments “I wanted to leave bedside, but I think it only further cemented that” that short staffing and heavy workloads identified as reason to leave their organization. Participants 4 stated, “I don’t feel like I’ve ever worked a night shift and been fully staffed, that puts a toll on you when you’re trying to get this critical care done and running at 50% staff; let’s just hope this person doesn’t crash while I’m by myself with them” and “I left my first job after 11 months and I have worked at three different

hospitals during Covid." "I worked four to five 12 hour shifts a week that really took a toll on me, it got to the point where I was going to work coming home sleeping, getting up going to work coming home sleeping." I'm really exhausted and numb, I think numb is probably one of the best ways to put it I was just so emotionally drained from the patient population." Participant 5 noted, "you're assigned to COVID unit pretty much every time and it just wasn't good for me, it wasn't good for my mental health, it was just very emotionally tiring; and I knew that I didn't want to do that long time; as a result of COVID-19 drain I left my unit and got a new position" and "it should have been one bedside nurse to two or three COVID patients; most of the times it was one bedside nurse to four COVID patients or if we were very short staffed I would be taking five COVID patients" and "it came a point when for my own emotional health I can't keep giving emotionally to my patients, I recognize the emotions that their feeling, but I need to not let myself get connected". Participant 6, "A lot of people definitely got floated around a lot, also had a major reduction in other team members in COVID areas; suddenly, as a nurse, you're doing, like everything things that you normally don't do, you're cleaning or taking out the trash" and "I've now moved to a different job, I completely change hospitals; left hospital from lack of PPE policy, never getting a break and stress of contracting COVID". And" so we are staffed pretty tight, we're staffed with at least half agency nurses every time I work, making the assignments with patients more acute, which made the assignments heavier" and "I'm definitely, stressed, and overwhelmed." Participant 7 shared, "the ability to be relieved and have coverage definitely decreased during the pandemic; it was far more labor intensive, physically and mentally, probably

even more so mentally." "I left I the hospital, I left for a hospital that only did surgeries, no ER, and we were really able to limit our COVID intake." "A lot of coworkers have moved on to other fields or left nursing altogether." Participants 4, 5, 6, & 7, statements align with common individual factors of stress, burnout, and job dissatisfaction and common organizational factors of heavy workloads and staff shortages as reasons they left their organizations. These statements about heavy workloads, lack of support and risk to mental health and work-life balance led to the theme "staff turnover/leave nursing". Figure 1 and Table 2 further illustrate the themes.

Discrepant Cases

Some of the participants expressed that in the beginning of the pandemic, teamwork, camaraderie, and organization support creating a sense of having control. This quickly changed to lack of teamwork/camaraderie, no organizational support, and having no control. The overwhelming theme that resulted from the data was the emotional and physical turmoil from the lack of teamwork/comradery and organization support throughout the COVID-19 pandemic. This was factored into the analysis by providing both confirming and disconfirming statements in the first categories, themes, and then in the results of the study.

Figure 1

Four Common Themes

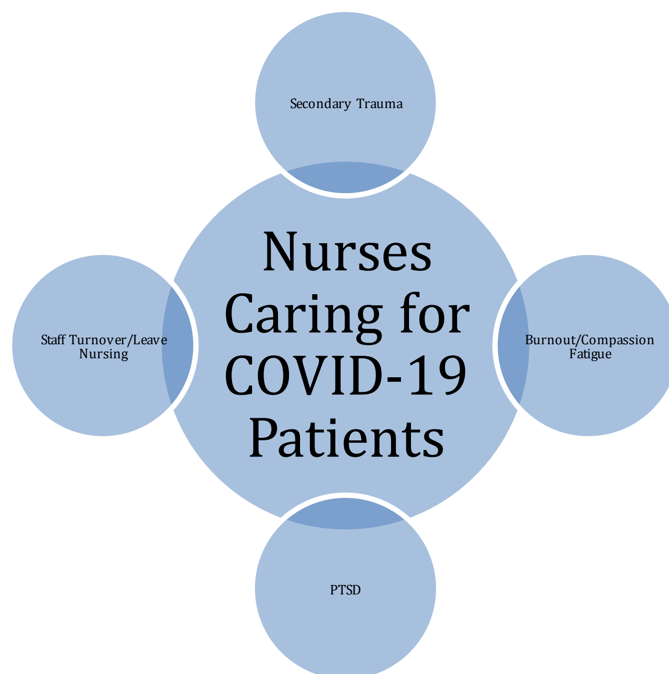

Table 2

Main Themes and Subthemes

Main themes	Subthemes
Secondary trauma	Fatigue
	Illness
	Feelings of hopelessness
	Irritability
	Sadness
	Anger
	Despair
Burnout/compassion fatigue	Emotional and physical exhaustion
	Emotional withdrawal/detachment
	Anxiety
	Lack of sleep
	Fatigue
	Extreme working conditions
	Heavy patient acuity and loads
PTSD	Social isolation
	Self-destructive behavior
	Severe anxiety
	High patient deaths
	Depression
	Emotional detachment
	Insomnia
Staff turnover/leaving nursing	Stressful shifts
	Extreme working conditions and extreme workload
	Lack of supplies
	Lack of staffing
	Long work hours
	Lack of support from management

Evidence of Trustworthiness

Credibility

Attaining credibility in research involves that the results are believable from the perspective of the participant in the research (Patton, 2014). Establishing credibility in my study, I first used triangulation to establish credibility. This involved analyzing the consistency of the nine different participants data sources and utilizing the same interview method. Thematic saturation was achieved with a total of nine participants (Creswell & Creswell, 2017). Adding to triangulation my dissertation chair, a doctoral prepared researcher, independently reviewed the transcripts evaluating the study findings. Merging these multiple data sources provides multiple perspectives to give validity to the study (Ravitch & Carl, 2019).

The second way I established credibility in my study was to participate in member checking. This provides the participants an opportunity to review the validity of their statements to ensure and verify accuracy (Ravitch & Carl, 2019). The findings in qualitative research must represent the participants perspective and are credible in representing their experiences (Ravitch & Carl, 2019). In performing member checking I sent all nine participants a transcribed copy of the interview: checking for accuracy and resonance with their experiences caring for COVID-19 patients. Of the nine participants five responded that the transcription was accurate, four participants did not respond.

The third way I established credibility was reflexivity. This describes the contextual relationship between the participants and the researcher increasing the credibility of the findings and creating a deeper understanding of the research (Creswell

& Creswell, 2017). Through reflective journaling, I examined my own assumptions, beliefs and judgments thinking carefully and critically about how this influenced the research.

Transferability

Transferability is considered when the results of the research can be generalized or transferred to other context or settings, while maintaining richness in context detail (Creswell & Creswell, 2017). In obtaining transferability in my study, I engaged in extensive detailed and thick descriptions by reporting the study's location setting, number of participants, their demographics, atmosphere, and climate, observed reaction, and my feelings as a researcher. Providing readers with the evidence that the research study's findings could be applicable to other context, situations, times, and populations provides the reader with more confidences in the transferability of the research study (Creswell & Creswell, 2017).

Dependability

Dependability in qualitative research is used to measure or demonstrate the consistency and reliability of the study's results; meaning if another researcher performs a similar study, they would be able to achieve the same or similar results (Ravitch & Carl, 2019). First, I performed an inquiry audit by having my dissertation chair examine the data collection, data analysis, and results to validate and confirm that the collected data support the accuracy of the findings. In addition, I used triangulation and sequencing of methods validating appropriate data collection

Confirmability

Confirmability is proving that your qualitative research is neutral and not influenced by assumptions or bias by the researcher (Ravitch & Carl, 2019). To attain confirmability, reflective journaling and an audit trail was created from the beginning of research through data collection. This includes detailing each step of data analysis demonstrating that the findings are not affected by conscious or unconscious bias, but accurately portray the participants responses. My objective was to ensure rigor and to mitigate any bias increasing confirmability.

Results

I sought to understand nurses' experiences when caring for Covid patients during the pandemic. I employed 6 interview questions to answer the following research question: "What are the lived experiences of nurses in the United States who have provided care for patients with COVID-19?". The themes I developed to answer the research question were identified from a thorough review, along with manual coding, of the written transcripts. The themes that emerged from the data analysis include: 1. Secondary trauma, 2. Burnout/compassion fatigue, 3. PTDS, 4. Turnover/leaving nursing. For accuracy of the written transcripts, a review was performed by participants. Additionally, the transcripts, journal notes, codes, themes were independently confirmed by my dissertation chair.

Theme 1: Secondary Trauma

Theme 1 emerged from participants exploring their lived experiences, feelings and psychological hardships when caring for Covid patients. All the participants in this

study shared their Individual experiences when caring for COVID-19 patients during the pandemic. The theme of secondary trauma arrived at as participants experienced fatigue, illness, feelings of hopelessness, despair, sadness, and anxiety while caring for COVID-19 patients. Secondary trauma is described as a stress response reaction that one experiences when being witness to the firsthand traumatic experiences of others (Orrù et al., 2021). For example, participant 1 shared their extreme fatigue and anxiety in caring for Covid patients "I was exhausted all the time" and "there was just so much anxiety" and "I got to the point where the end of my shift I could hardly stand I almost had to call somebody to come pick me up from work instead of driving home because I was just like, I don't even know how I'm getting in my car at this point." Participant 2 shared their emotional stress and despair, "the emotional toll on caring for a patient, you really feel alone" and "it just felt very lonely, you'd be the only one in the whole room for 12 hours" and "this patient was dying, they were just so sick and there was nothing more to do for them it was sad the deaths that we had" and "I'm hearing the family crying, we have glass windows so they could see us withdrawing care and the family wasn't even in the room." Participant 3 expressed feelings of hopelessness, anxiety and despair, "it's like you can't do anything you know, you're just doing your best and you're still watching all die" and "people being floated were scared out of their mind" and "there's a sense of helplessness you go all day, and you take care of an ICU patient and you come in the next day, and they die." Participant 6 noted despair, "I've been working as a nurse since about 2017. I could still probably count all the patients I had taken care of pre COVID who had died at all. And that's a huge change. I don't know the number anymore. But that would

be like, I don't know 50 more" and "I'm definitely like, stressed, overwhelmed." Participant 7 shared feelings of anxiety and fatigue, "You're terrified that you're going to soil your mask, because there might not be a new one for you to get" and "I mean mentally it was just exhausting, trying to deal with all of it and be scared to be at work with it all." Participant 8 stated, "everyone had anxiety over how transmissible it is" and "It's unbearable, when all of your outcomes are poor" and "the worst part is that you get to work, you're going to be overburdened" and "I feel terrible. I'm mentally defeated" and "We were just killing ourselves and having no guidance and the experiences were crummy; things were awful" and "everyone would encounter crap you had not encounter in normal nursing" and "It was brutal, because they just got worse." These quotes reflect the understanding of participants who experienced some form of stress, anxiety, hopelessness, despair, and sadness leading demonstrating multiple perspectives of secondary trauma.

Theme 2: Burnout/Compassion Fatigue

As nurses in the healthcare profession, they are innately ingrained to care for others, show compassion, and provide support because that is what the profession does. All too often nurses put their own health on the backburner to care for others. Nurses caring for COVID-19 patients is physically taxing on their feet throughout long shifts with very few if any breaks (Almomani et al., 2022). Burnout and compassion fatigue describe the state of healthcare professionals expended stress, emotional states, and prolonged duress after events (Sweileh, 2020). Theme two emerged from the participants lived experiences of the phenomenon and their feelings when caring for Covid patients

experiencing job stress causing physiological and psychological symptoms and emotional withdrawal. For example, participant 1 shared their experience stating, “They need to somehow figure out how to decrease the workload for nurses; this isn’t sustainable for anybody” and “It’s sad, I love nursing it’s part of me, you know, but I’d rather go volunteer for a third world country then deal with what we’re dealing with here” and “I wasn’t sleeping very well, either. I’d wake up my mind would be just racing about everything” and “Oh, yeah, the hospital will throw you under the bus first chance to get.” Participant 2 shared their psychological state, “there was less of a reason, during the pandemic, whether that be not exercise as much, eat a little worse, and indulging in more alcohol and bad foods” and “it definitely got tough to have the willpower to focus, it makes it difficult to fight yourself to want to do the work.” Participants 3, 4 & 5 shared their psychological pressure and physical demands due to shortages in healthcare resources and the number of Covid patient deaths. Participant 3 stated, “the short staffing, we’re running around and not getting breaks and, having to do more with less people just was difficult” and “just a lot of like the uncertainty and the fear surrounding it.” Participant 4 noted, “I may be withdrawn” and “I don’t like this, but when you’re living through this kind thing it like gets normalized to some extent, it shouldn’t be normal that everyone you take care of mostly dies, but at some point if you’re doing that for a period of months, it becomes more normal” and “I’ve had problems sleeping throughout this time, sleep is definitely been challenging.” Participant 5 shared their experiences stating, “because I was giving it my all at work when I’m off work, I didn’t want to do anything, because I felt like I was just so drained” and “I would get home from work and be so

drained, I don't even want to eat dinner or drink. I know that I need to do both of those things, but I just want to shower and go to bed. I just felt so drained." Participant 6 noted a sense of frustration and giving up, "reach a point where I was like, I cannot keep doing this, I do not want to keep doing this, I want to crawl out of this" and "the doctors wouldn't even go in there. So, you would be doing all the housekeeping, you would pass all the meals you do you draw their labs, phlebotomy wouldn't go in. You would assess the patient; you'd tell the doctor your assessment and hope it is correct and not die.". Participant 7 shared their individual sufferance, "I felt more like an observer watching things happen. Like we weren't really contributing to their care. We kind of like crossing their fingers hoping they pull through, you know. Yeah, but I don't know. I got nothing." The participants' perspectives above demonstrated an increase of emotional exhaustion and depersonalization being risk factors associated with burnout and compassion fatigue.

Theme 3: PTSD

Over half of the Covid patients admitted to the hospital died. The incredible loss of life had to affect the nurses caring for those Covid patients. Along with the daunting task of caring for critically ill and dying patients, nurses dealt with fears of contracting the virus or giving it to family members due to lack of PPE and unsafe working conditions. Additional stressors nurses' experiences caring for Covid patients is being the only one comforting dying patients as families were not allowed to visit. The participants shared their lived experiences of the stress of keeping their family safe and the emotional burden of caring for Covid patients. The theme of PTSD emerged with participants expressing depression, anger, anxiety, sleep disturbances, and repeated exposure to

mortality and morbidity. For example, participant 1 shared their daily stress in keeping their family safe "I've never washed my hands that much in my life. it's like 100% always in your head. Everywhere you go, everything you do, you're just like, constantly aware of keeping things clean, not touching things, to such an extreme of packing my clothes in the car in a little bag, not even bringing my clothes in the house, I have two young kids and just having a whole separate area of the house for your work clothes, like so many extra layers of precautions that was not in my life before. Just to kind of leave work at work and have this protected safe at home." Participant 2 expressed the emotional difficulty of caring for Covid patients "It was hard to see that so many people died" and "it's just like a long grind of terribleness and high patient burdens and overcrowding and just misery" and "it's just like, this is our life this is never going away, this suckiness and the broken system is just here to say." Participant 3 stated, "I really think I might have like some PTSD from like, my first staff job" and "it's really hard I still don't feel like I have my thoughts together." Participant 4 shared their emotional experience "any time I'm in a social gathering and people start talking about COVID I just don't know like I just I got completely shut down I don't want to talk about it" and "I remember those first patients it is so crazy to think about. I cry every time I think about it was essentially how my career started" and "one of the very first patients I had we had to intubate him, and he didn't want to he had already heard about stuff, he was begging us not to intubate him." Participant 5 noted mental anguish, "you're assigned to COVID unit pretty much every time and it just wasn't good for me. It wasn't good for my mental health. It was just very emotionally tiring." Participant 6 shared, "the COVID patients it's

like it feels kind of hopeless" and "feeling like you don't know what to offer, I think those moments are not easily like left in the past they stick with you" and "have had times where I would come home from work and still be like hearing alarms, in the shower, hearing alarms in my head. I did start seeing a therapist." Theme 3 identified participants' experiences that demonstrate a set of reactions that can occur after someone has been through a traumatic event leading to PTDS.

Theme 4: Turnover/Leaving Nursing

Poor staffing is the cause of nurse attrition, and nurse attrition continues to cause poor staffing. The COVID-19 pandemic brought awareness about unsafe nurse staffing accelerating this alarming cycle. Nurses are leaving their jobs at alarming rates due to unhealthy work environments, inappropriate staffing, and insufficient administrative support, resulting in ineffective patient care. Traumatizing and tired nurses are quitting the nursing field due to the pandemic developing the theme of turnover/leaving nursing. For example, participant 1 states, "They need to somehow figure out how to decrease the workload for nurses. This isn't sustainable for anybody. Until they fix it. I mean, just firsthand, I know so many nurses leaving the bedside or are planning to leave the bedside, myself included" and "I want to leave the profession." Participant 2 noted "a lot of my coworkers would probably just quit if we got another pandemic surg. It was just so taxing mentally and physically, and relatively so unrewarding" and "I left I near the end, I guess midway through 2021, COVID was kind of tapering off. But I left for a hospital that only did surgeries, no er, and we were able to limit our COVID intake." Participant 3 shared, "I don't know, I don't think anger is the right word. But just like being upset with the

system of like, well, why can't we have figured out a better system then I could have been wearing my appropriate PPE in this room. Like, why did it take that long to figure this out" and "there's been several nurses that we've lost due to COVID, or they've left to a different hospital because they didn't like how things were going at our hospital" and "We have so many new people. I've been there for four and a half years and there have been nights that I'm the second most senior nurse on the floor and that's scary." Participant 4 shared their reason for leaving the organization, "I completely change hospitals" and "I found it very corporate in a way that I didn't love. I also kind of felt like unsettled about some of the PPE policies" and "I didn't feel good about it, and I also felt like it was unfortunate the way they just kind had nurses doing all these other roles and kind of pulled back a lot of other services." Participant 5 noted the reason for changing units, "Saturday was my last shift on my old floor, I start in the ER on Wednesday, it was a lateral transfer within the organization" and "in the ERI don't have a chance to get emotionally connected to patients, it's a little easier when I don't have to know how things turn out." Participant 6 and 7 stated reasons their peers left nursing and their thoughts of leaving nursing. Participant 6 stated, "the helplessness of someone making rules that did not see what you're going, that was just very frustrating for all of us that they'd have policies that would just come down from somewhere and you could never, like get in touch with where these policies are came from, but they were just like, you're expected to follow them" and "I was like, at work, I do not want to do this anymore, just once I thought that I want to leave nursing" and "I had decided that bedside nursing is too hard. It's too hard on your body. It's too hard stress level of the 12hour shifts. I just knew

that I don't want to do that for the rest of my life." Participant 7 states, "I'm overwhelmed with the patient loads" and "the parts that still suck is just the systemic issues of like, overcrowding and just having so many more patients, and still, like the burden on the system" and "the floors were even worse, because they started out with three or four that is a problem their patients are, like, in the ICU, it was just, constant RRT, because these people are like barely hanging on. Like, there's no ICU space. So, all these high acuity people that should be in the ICU are hanging out on these floors. And they're like, just barely breathing" and "nurses have left the profession, and nurses are demanding more pay, it's made me just more happily leave bedside nursing" and "it's sad to watch your colleagues go, it's sad to come into a department where you don't know anyone anymore. You know because the turnover is so great". These quotes reflected the participants' outlook on reasons nurses are leaving the profession or changing jobs. The participants identified, traumatized, and tired nurses are quitting due to the pandemic. The stress and lack of support has driven nurses to quit their jobs, worst of all the healthcare systems cannot afford to lose them.

Discrepant Cases

Some of the participants, in the beginning of the pandemic, expressed teamwork/comradery and organization support creating a sense of having control. Shortly into the pandemic that quickly changed to lack of teamwork/comradery, no organizational support and having no control. For example, participant 8 stated, "it felt like everyone coming together step by step on how to don and doff PPE and how to document our procedures to keep everyone safe. It felt like a lot of comraderies, nurses

coming together putting policies together on what to do in the unit. It felt like a lot of optimism and hope. And the hard pivot there, that died about as fast as the patients started to die. Participant 2 stated, "Our facility was always good with PPE. However, in the beginning only the house nursing supervisor had the N95, and they're locked up she will be by to give PPE, it was a really weird vibe, like, well, I'm the one who needs to wear that N95. So why do you have it" and "Our facility is pretty good with keeping to the ratios of two. So, our assignments I would say they stay pretty good, but in a busy ICU during a pandemic they laid off or cut their hours of support staff. Our unit felt more affected by less support staff". Participant 3 stated, "in the beginning, they had all the new protocols to help you kind of guide your care" and "I remember at the beginning, like, there was kind of like a camaraderie and like sense of like, collective spirit and excitement, and like eagerness to help" and "my hospital was constantly redistributing staff all over the place. So, we had new roles" and "People being floated were scared out of their minds, they don't have skills and people were so put out of their comfort zones".

Summary

The research question guiding my study was "What are the lived experiences of nurses in the United States who have provided care for patients with COVID-19?" Nine participants in the interview helped answer the question by sharing their unreserved experiences, resulting in four key themes. Many challenges emerged in nurses caring for COVID-19 patients during this pandemic outbreak. Challenges participants reported include mental and physical duress, anger, fear from risk of infection and transmission to family members, shortage of resources and staff, lack of knowledge and lack of

organizational support. Data from participants interviews illustrate nurses caring for COVID-19 patients needed to have support to cope with the demands of working through a pandemic.

In this chapter, I detailed the setting of the study, the demographics of the participants, data collection and analysis process for my study. Additionally, providing evidence of trustworthiness by demonstrating credibility, transferability, dependability, and confirmability. Thereafter, providing the research question and results of the findings utilizing direct quotes from participants. Chapter 5 will discuss my interpretation of the findings, detailing the limitations of my study, and providing a discussion on the recommendations and implications for future research and nursing practice, and how these findings may facilitate positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to understand the lived experiences of nurses who have cared for COVID-19 patients during this pandemic and how those experiences impacted their personal and professional lives. In addressing the lived experiences of nurses, I conducted a qualitative interpretative phenomenological study using semistructured, individual interviews with nurses working in the United States who cared for COVID-19 patients. A phenomenological approach aligned well with the problem of wanting to understand the lived experiences of nurses because this approach provided a deeper understanding of what nurses' experience during the COVID-19 pandemic and how those experiences impact nurses and the nursing profession. Findings from this study may be used to understand the impact nurses experience caring for COVID-19 patients to identify strategies preventing adverse outcomes, including loss of nurses from the workforce. This may lead to positive social change by providing insight into the working conditions and stress nurses experience during this pandemic, leading to the development of strategies to prevent burnout, improve safety, and create plans for future large scale-illness events.

I conducted nine semistructured interviews with nurses who cared for COVID-19 patients in the United States. At the time, all the participating nurses worked in hospitals in the United States. Data collected during the interviews were analyzed. Key findings included four major themes describing the participants' lived experiences caring for

COVID-19 patients: (a) secondary trauma, (b) burnout/compassion fatigue, (c) PTSD, and (d) turnover/leaving nursing.

Interpretation of the Findings

Conducting this phenomenological study, using Selye's (1956) model of stress, specifically GAS, as a theoretical framework, along with Husserl's life-world view as a conceptual model, allowed me to delve into the lived experiences of nine nurses who cared for COVID-19 patients during the pandemic. The participants were open and frank when describing their experiences caring for COVID-19 patients. The major findings of this study align with previous research published about nurses' experiences when caring for Covid patients. My findings regarding U.S. nurses' experiences confirmed what was previous known about nurses' experiences throughout the world: the physical, psychological, and social burden experienced by nurses when caring for COVID-19 patients.

Almomani (et al., 2022) identified that nurses who cared for COVID-19 patients experienced physical and psychological challenges. My study also confirmed these findings through multiple and similar statements made by the participants that included reports of long work hours, feelings of isolation, and experiences of stress and anxiety caring for COVID-19 patients. Selye's (1956) GAS model is based on physiological and psychobiological events that threaten an organism's well-being related to stressors, leading to a bodily response. Nurses who have cared for COVID-19 patients in my study expressed psychological and physiological duress leading to exhaustion, physical and mental illness, and compassion fatigue. The American Organization for Nurse Leadership

(2021) also found that nurses experienced stress, burnout, and understaffing. Mo et al. (2020) discovered nurses experienced anxiety, heavy patient loads, long work hours, poor diet, and sleep deprivation—all contributing to their stress load. The participants in my study confirmed these same concerns, recounting the stress they experienced dealing with increased COVID-19 cases, patient load and acuity, care-induced anxiety, lack of PPE, stress of morality among patients and colleagues, and stress of protecting self and family members against the virus. All this led to participants stating their experiences with understaffing and burnout. Selye's GAS (1956) is pertinent here as well because the theory serves as a valuable paradigm for understanding the stress nurses experience caring for COVID-19 patients and how that stress is apparent in their lived experiences. Evidence shows that job stress and unsupportive organizations affect workers and organization productivity, resulting in employees experiencing burnout and mental stress (Pérez-Rodríguez et al., 2019).

Participants stated that before covid they worked in high-stress environments and encountered traumatic events throughout their career. But the insufficient resources, lack of nursing staff, limited supplies, high patient deaths, unknown factors of the illness, and changes in virus information and treatment protocols led to severe psychological distress. Severe psychological distress led them to experience anxiety, self-destructive behavior, depression, insomnia, and emotional detachment, which are factors recognized to trigger PTSD. One commonality among participants in my study confirmed Catania et al.'s (2021) findings that nurses experiencing extreme stress caring for covid patients have had a high incidence of experiencing PTSD.

Castillo et al.'s (2021) findings indicated nurses experienced increased workloads requiring them to work outside their specialty, causing nurses profound stress, leading to physical and mental illness and leaving the profession. In my study, participants also echoed that the physical and psychological burdens of caring for COVID-19 patients, and some being forced to work outside of their specialty, affected their decision to change jobs or to leave their jobs temporarily or permanently. The nursing shortage has been prevalent for many years. However, wide-spread burnout driven by the COVID-19 pandemic is still causing major challenges across the healthcare workforce. Sadang (2021) found that nurses caring for COVID-19 patients experienced a lack of organizational support and physical and mental breakdowns, leading to some quitting nursing. Lee and Lee (2020) found that nurses caring for COVID-19 patients developed overwhelming stress and burnout. Participants in my study reported feeling burned out, leading them to leave their jobs or consider leaving nursing altogether. Additionally, participants stated staff shortages followed by work–life balance as reasons for planning to leave their jobs. Some stated they planned to leave their jobs or nursing because their mental health was at risk, and they felt a lack of appreciation.

Based on the overall aggregate data in my study, and comparing it to previously published studies, the experiences of nurses caring for COVID-19 patients is similar across the research. Nurses' responses are related to the burdens experienced caring for COVID-19 patients that affected the relevance of physical, psychological, and social resources to individual needs, affecting health conditions, motivation, severity of stressors, coping strategies, and support systems. In addition, all the participants reported

that caring for patients during the covid pandemic brought significant pressure on them along with feelings of uncertainty and anxiety in providing care, evident by participants leaving their jobs or stating they want to leave nursing altogether.

Limitations

There is some form of bias in all research, and in qualitative inquiry, there is a heightened risk of research bias (Creswell & Creswell. 2017). I am a nurse, and my personal feelings and experiences may have potentially created bias during data collection and analysis. To ensure bias did not influence the study outcomes, an independent inquiry audit was performed by a doctoral prepared nurse. Additionally, I diligently executed reflection and recording of analytical memos and notes, examining and consciously acknowledging assumptions and preconceptions that may have shaped the outcomes.

Another limitation includes using an alternative approach in conducting interviews. Using video and phone interviews has the potential to miss nonverbal communication during the interview, affecting the interpretation of the message. Additionally, recruiting through social media has the potential for limitation, resulting in only nurses who engage in social media and professional nursing organizations being selected as participants.

Recommendations

The reason for this study was to add to the existing literature on the lived experiences of nurses caring for COVID-19 patients in the United States. Most previous published literature contained findings on this topic outside the United States. Although

there is some literature on the experiences of nurses caring for COVID-19 patients in the United States, this study will be an original contribution to the evidence. My study added to this literature by highlighting nurses in the United States working in big cities and their individual lived experiences in caring for COVID-19 patients. Suggestions for future research include additional qualitative study done between rural and urban areas to gain insights into how different settings managed the pandemic and what the nurses' experiences were.

The COVID-19 pandemic has placed the nursing workforce under unprecedented pressure, which in turn has impacted their mental and physical wellbeing. In my study nurses stated experiencing several challenges such as mental and physical duress, lack of PPE, lack of experience, high work stress, fear, anxiety, and lack of organizational support. Arcadi (et al., 2021) had similar findings of nurses experiencing physical and mental struggle in caring for covid patients. Adding nurses who had a supportive environment allowed them to be more resilient during the pandemic (Arcadi et al., 2021). Another study found that nurses caring for covid patients required psychological counseling to address the impact of their working conditions (Chegini et al., 2021). Lee and Lee (2020) findings suggest providing compensation for difficult work, psychological support at a personal level, a sufficient supply of PPE and pandemic public health policies would aid in post-traumatic growth. In addition, Fernández-Castillo (et al., 2021) findings suggest a need to provide psychological support and increased training and protocols for ICU nurses for future emergencies. Current studies are just the tip of the iceberg. There is a need for future studies to gain a deep understanding of the lived

experiences of nurses that have cared for COVID-19 patients to help develop strategies to reduce the risk of negative outcomes among nurses and provide support, resources, and safe working conditions for nurses. Additionally, a qualitative study understanding the multi-sources of psychological and physical stress of nurses caring for Covid patients.

The COVID-19 pandemic has continued for more than two years. Even though the hospitalizations and death rate recently have declined, nurses are still experiencing shortage of nurses, heavy patient loads, and stressful working conditions. Some participants expressed extreme stress, despair, hopelessness, PTSD, fatigue, depression, and illness due to stress. Selye's (1946) GAS model involves physiological and psychobiological changes as a result of prolonged stress. In the GAS model, initially, one can deal with stress without bodily changes. However, as stress continues for long periods of time, exhaustion sets in. In the last stage, exhaustion, it becomes harmful because chronic stress leads to decreased in life quality and affects function. Participants stated that they do not know the full impact of the pandemic on their mental and physical wellbeing yet. Therefore, measures such as workshops and counseling could be provided to nurses to reduce stress and anxiety. Still, these interventions could also be areas of future research to determine if they are effective and appropriate. Future research should also be conducted to determine how adaptability and resilience influence how a nurse deals with stress. High-stress areas such as the emergency department and ICUs deal with high-stress levels without the added burden of a pandemic. Research with nurses in these areas could provide insight into how they manage their stress on a typical non-Covid day. Participants shared the unfavorable working conditions and harsh environments they

endured caring for Covid patients. There are limited studies exploring nurses' work environments while caring for Covid patients. Future studies should be conducted to understand the full impact of nurses' work environments. This will assist the policy makers and healthcare organizations in developing policies to enhance support, creating healthy work environments for nurses, and improving care provided to patients.

Implications

The results from my study are supported by literature in understanding nurses' experiences when caring for COVID-19 patients and how those experiences have affected them: along with adding to the understanding of how COVID-19 contributes to nurses' stress, secondary trauma, burnout, PTSD and leaving the profession. In this study, nurses experienced risk to their psychological and physical well-being caring for Covid patients. The implication for positive social change brings awareness of the stressors, mental duress, and unsafe work environments nurses endured that correlate to the emotional and physical well-being resulting from nurses caring for Covid patients to policy makers, nurse leaders and healthcare organizations and other resources who serve the nursing community. Findings highlight the importance of helping nurses cultivate resilience and reduce stress.

Positive social change is feasible at the organizational level if healthcare organizations consider establishing counseling programs that promote nurse mental health and support their productivity in a crisis, with emphasis on self-care activities. Additionally, providing disaster-emergency-preparedness training to keep nurses prepared for another large-scale illness. Now that more is understood about what factors

that have caused nurses adverse outcomes during the covid pandemic, steps can be taken to address the causes and potentially reduce the immediate danger to nurses and the nursing profession by providing authentic, transparent, and caring nursing leadership and offering ongoing psychological support.

Nurses comprise the largest component of the healthcare workforce and are crucial in delivering care, closing health disparities, and improving the nation's health through providing patient care and patient education (Llop-Gironés et al., 2022). Positive social change is attainable at the health and community level by developing and implementing programs to support and improve the mental health and well-being of nurses to keep them in the nursing profession. Addressing workforce challenges and keeping nursing a desirable and supportive profession could improve patient outcomes and stability of nursing workforce improving the healthcare sector. Without supportive programs and action taken to improve the mental health and well-being of nurses, every part of the healthcare sector, notability patients and those who care for them could be at risk.

At the societal level, positive social change is possible with the results of my study in that we have new information about the unique experiences of nurses that have cared for COVID-19 patients. The risk perceived by the participants suggests that policymakers should develop and have a plan in place to guide nurses in the present and future large-scale illness events. For instance, develop a plan, continually update nurses with all the current guidelines that are issued by healthcare bodies such as WHO and CDC and provide them with all the protective supplies to stay protected, as well as the

latest evidence-based practice. Understanding nurses experiences when caring for COVID-19 patients during this pandemic may serve as a starting point to ensure future safeguards are in place to protect nurses wellbeing (LoGiudice & Bartos, 2021) This study was vital to understand the lived experiences of nurses that provided care to COVID-19 patients to help create a stronger nursing workforce and promote nurse retention leading to positive social change through a healthier nursing workforce for any large-scale illness events.

In this study, participants shared their emotional struggles and their family's inability to understand the devastation they went through. This has not only affected them emotionally but has affected their families too. It is known that nurses stress and anxiety can affect their quality of life and the family unit (Çelmeçe, & Menekay, 2020). The Covid pandemic has thrust nurses and their families into new territory. Programs focusing on nurses' mental health for this population is essential to thriving. The implication for social change for the individual and family brings awareness of stressors that correlate to emotional well-being resulting from therapy and supportive services to help nurses and their families process their feelings in maintaining quality of life and the family unit.

My study used phenomenological research to understand the meaning of the participants experiences and focus on their experiences of a phenomena. Phenomenological research was chosen as this method studies lived experiences to gain a deeper insight into how the participants understand those experiences (Neubauer et al., 2019). Additionally, this method requires the researcher to set aside their prejudices and a

priori assumptions and focus mainly on the immediate experiences (Creswell & Creswell, 2017). Lastly, it requires the researcher to first describe the lived experiences objectively and then reflect on the description with reference to the existing theories about the phenomenon. Phenomenological research design fits my study, as it aims to uncover nurses' experiences when caring for Covid patients and how they experienced it, gaining a deeper understanding of the phenomena. Empirical implications in using phenomenological research were based on observed and measuring phenomena deriving knowledge from participants actual experiences.

The theorical bases for my study include Hans Selye general adaptation syndrome (GAS; 1956) and the conceptual model used as a lens for this study is Husserl's lifeworld (1916). The GAS model is based on psychological and psychobiological events that threaten an organism's well-being related to stressors leading to bodily changes (1956). Husserl's (1916) lifeworld contributes to my research by identifying nurses' experiences firsthand accounts described as precisely as possible. Both models support my study and provide structure for my research by guiding me in developing the research questions that seek to describe participants' lived experiences, participants selection criteria, and qualitative analysis. Both theoretical positions and empirical findings provide many of the principles currently used in stress research and are common scientific basis for nursing research, theory, and practice (Lo et al., 2018). Understanding the multi-sources of psychological and physical stress of nurses caring for COVID-19 patients may help healthcare organizations and government agencies in developing access to supportive

services, resources, and programs for current and future nurses in an effort to support and maintain nurses' well-being.

Conclusion

In this study I examined nurses who cared for COVID-19 patients and their lived experiences. The results have shown that these nurses experienced severe physical and psychological anguish in caring for COVID-19 patients. Nurses are still experiencing incredibly stressful and challenging working conditions, without supportive services to aid them. The ill preparedness of supportive services continues to increase nurses physical and psychological stress. This results in nurses leaving the organizations they work for or leaving the profession all together.

There is an opportunity to possibly influence the decline of nurses leaving the profession. Programs should be developed and administered to support nurses experiencing psychological difficulties to ensure current and future safeguards are in place to protect nurses' well-being. Additionally, developing strategies and educational programs helping nurses adapt to their jobs and preventing burnout when (not if) another large-scale illness occurs.

During COVID-19 nurses experience high levels of physical and psychological stress because of the effects and consequences of the disease. There is a need to focus on nurses' well-being and mental health. Supporting nurses in maintaining good psychological health and resources to adapt to hard working conditions could help nurses lessen their own psychological and physical stress, while providing a more supportive environment. This may allow nurses to become more resilient and improve their mental

health. Additionally, providing supportive services to nurses who cared for COVID-19 patients has the ability to create a stronger nursing workforce and promote nurse retention leading to positive social change through a healthier nursing workforce.

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Appendix A: Recruitment Email/Flyer

Dear Nurse,

My Name is Cynthia Rodriguez, and I am a PhD student at Walden University. The proposed study in this letter is being conducted as part of my doctoral research. The study is being completed independently and is not affiliated with any hospital or healthcare organization. I am interested in learning about your experiences as a nurse who has cared for COVID-19 adult patients.

The purpose of this study is to explore the lived experiences of nurses that have or are caring for COVID-19 adult patients. The benefit of your participation in this study is to shed light on the experiences of caring for adult COVID-19 patients through the eyes of a nurse. As a nurse that that has cared for COVID-19 patients, you provide unique insight and experiences that will be of great assistance in helping to explore how caring for COVID-19 patients is experienced by nurses.

Your experiences may potentially help facilitate positive change in the nursing field by allowing other nurses, administrators, and employers to learn through your experiences and how those experiences may have potentially impacted you personally and professionally. If you are a registered nurse in the United States and have or are caring for COVID-19 adult patients in the United States, your participation is requested. If you do not have a registered nurses license in the United States or have not cared for an adult COVID-19 patient, you are excluded from participating.

If you agree to participate in this study, I will send you a consent form for review. Using a link to a survey tool, I will have you consent to participate in the study and complete a brief demographic survey. The preferred method of interviewing would be in Zoom or by phone. This interview should take no longer than 60 minutes of your time. You will be asked a series of open-ended questions regarding your experience of caring for COVID-19 patients in the hospital setting. Your participation in this study is voluntary and can be ended at any time during the interview process.

If you are interested in participating in this study, please email me at cynthia.rodriguez2@waldenu.edu and I will respond to set up a day and time to meet on social media. Additional questions or concerns may also be addressed by contacting my dissertation committee chair Dr. Anna Valdez at anna.valdez@mail.waldenu.edu. Thank you for your consideration in participating in this study!

Kind Regards,

Cynthia Rodriguez
Walden University

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Nurses who Cared for COVID-19 Patients Needed
I am seeking registered nurses who have cared for COVID-19 patients in the United States to voluntarily participate in one-on-one interviews lasting 30-60 minutes.

Study Purpose
The purpose of this study is to gain an understanding of nurse's experiences of caring for adult COVID-19 patients

Inclusion Criteria
Have experience in caring for adult COVID-19 patients in the hospital setting in the United States. Hold a Registered nurse license in any state in the United States.

If you are interested in participating in this study, please use this link to review the informed consent and complete a short demographics survey.
https://qfreeaccountssjc1.az1.qualtrics.com/jfe/form/SV_6gRFbDzMtPMBMQ6

If you have questions about the study, please contact:

Cynthia Rodriguez
Cynthia.rodriguez2@waldenu.edu
313-673-4300

Appendix B: Demographic Form

Please indicate your gender

- o Woman
- o Man
- o Non-Binary or Non-gender conforming
- o Other

Current age range

- o 18-25
- o 25-35
- o 35-45
- o 45-55
- o 55-65
- o >65

How many years of experience do you have as a registered nurse?

- o 0-5 years
- o 5-10 years
- o 10-15 years
- o 15-20 years
- o 20-30 years
- o > 30 years

Do you hold a registered nurse license in the United States?

- o Yes

- No

Have you cared for adult COVID-19 patients in the United States?

- Yes
- No

What is your specialty of nursing?

____

Please include your name and contact information. This information will be used to schedule your interview and will be maintained confidentially.

Name:____

Email:____

Phone number: __________________________________

Appendix C: Interview Protocol

Introduction

Thank you for taking the time to meet with me today to assist in my doctoral dissertation research.

Prior to Beginning

First, I want to remind you that this interview is being recorded. If at any time you wish to not answer a question or stop the interview process, you may do so without any judgment or impact to you. Participating in this interview should not pose any risks beyond those of typical daily life. There is no personal benefit to you. However, this research may have a positive impact on nurses for future pandemics. Interview recordings and full transcripts will be shared with you, upon request. Transcripts with identifiers redacted will be shared with my university faculty along with my analysis of the interviews. The interview recording and transcript will be destroyed as soon as possible within IRB guidelines.

Introductory statement

The purpose of this study is to explore the lived experiences of nurses caring for adult COVID-19 patients in the United States. As a nurse who has care for adult COVID-19 patients, you provide unique insight and experiences that will be of great benefit in helping to explore how caring for COVID-19 is experienced by those in the nursing profession.

Interview Questions

Tell me about your experience caring for adult patients with COVID-19.

Can you elaborate on your experiences?

Follow up questions

Can you tell me about your role as a nurse while caring for COVID-19 patients? (Unit, shift, assignment).

How would you describe your initial experiences in caring for patients with COVID-19?

If mentions stress, how did the stress impact you physically, mentally, and emotionally?

How would you describe the impact that COVID-19 has had on you as a nurse?

How did you feel when…?

Have your experiences changed over time during the pandemic?

How are you feeling now?

Is there anything you have not described related to this experience that you would like to share?

Closing Statement

Thank you for taking the time to meet with me and share your personal experiences. Before we close, do you have any questions regarding the interview?