Keywords Resilience/Nurse retention/
Post-traumatic stress disorder

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In this article...

- Interviews with nurses and midwives about working during the Covid-19 pandemic
- The key themes in interviewees' experiences of wellbeing, patient care and public opinion
- Recommendations for changes needed to how the NHS and the public view nurses

Psychological impact of the Covid-19 pandemic on nurses and midwives

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COVID-19

Key points

A study interviewed nurses, midwives and student nurses to examine how the Covid-19 pandemic affected their mental health

Limited personal protective equipment, staffing levels and access to support caused nurses distress and negatively affected care provision

Nurses felt under pressure to be resilient, leading to feelings of stress and guilt

Some nurses felt unheard by managers and underappreciated by the public during the pandemic

Nurses' exhaustion contributed to an increase in the number leaving the profession

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Abstract In response to findings of the Impact of Covid-19 on Nurses survey study, conducted in 2020, a subsequent study explored nurses' qualitative experiences of the pandemic; this article discusses the results. Most participants struggled to transition to new working practices in altered care settings with more critically ill patients, and most experienced high levels of stress and psychological distress. Key themes included duty and fear, resilience and stigma, changing public responses, nurses' voices, and leaving the profession. There is an urgent need to support and restore nurses' psychological wellbeing, and to improve their working conditions to enhance retention rates.

Citation Maben J et al (2023) Psychological impact of the Covid-19 pandemic on nurses and midwives. *Nursing Times* [online]; 119: 10.

Before the Covid-19 pandemic, the work of nurses and midwives was characterised by considerable demands, which included long working hours, shift work, staff shortages and, sometimes, challenging and distressing work. These conditions left nursing staff at high risk of experiencing:

- Primary and secondary traumatic stress;
- Burnout;
- Compassion fatigue;
- Moral distress (Kinman et al, 2020).

Previous research has indicated that a link exists between NHS staff's experiences of work, their psychological wellbeing and patient experiences of care (Dawson, 2018); the considerable pressures added by the pandemic, therefore, made already difficult working conditions even harder.

The pandemic had worldwide social and economic effects, with lockdowns curtailing normal life in many countries. Some of its effects are ongoing for those working in the NHS, but staff shortages and poor staff health and wellbeing pre-date the pandemic. The term "state of genuine crisis" was recently used to describe the NHS's long waiting lists, ambulance response times and high numbers of staff resignations (Daniels et al, 2022). Understandably, patients want to receive timely, high-quality care for themselves and their loved ones.

In response to the first cases of Covid-19 in the UK, the Impact of Covid-19 on Nurses (ICON) survey was conducted by Couper et al (2022). In total, 7,840 nurses, midwives and student nurses completed these surveys at three time points between April and August 2020, and described the effects of working during the pandemic on their:

- Psychological wellbeing;
- Ability to access support across the NHS and social care sector.

Of those responding during the pandemic's first wave, 44.6% reported symptoms of post-traumatic stress disorder (PTSD) (Couper et al, 2022).

Aim

We subsequently developed the ICON qualitative study, with the aim of examining, in detail, the effects of the Covid-19 pandemic on frontline nursing and midwifery staff's psychological health. We have previously published some of our findings in academic journals and books – for example, Abrams et al (2023), Conolly et al (2022) and Maben et al (2022) – but, here, we bring together several different aspects of the study into one article.

Method

Our research involved two samples of self-selecting participants from the ICON survey. The first sample included 26 nurses and one midwife. The nurses worked in a range of settings, including intensive care units (ICUs) and mental health and community settings. In total, 18 of the nurses were redeployed, eight of whom went to an ICU. Participants were interviewed on up to four occasions: all 27 participants were initially interviewed in June 2020, 25 were interviewed in December 2020, 26 in August 2021, and 21 in April 2022. The midwife participated in all but the last interview.

We wanted to recruit a more diverse range of nurses, including more students and more nurses who are Black or from minority ethnic backgrounds. The second sample, therefore, comprised 23 nurses, six of whom were Black or of minority ethnicities and four of whom were students. These nurses worked in a range of settings, including care homes. All 23 were interviewed in August 2021; 19 of these were interviewed again in April 2022.

This longitudinal method of repeat interviews allowed the research team to study changes over time, detailing the complexities of participants' journeys. Narrative interviews were used, meaning interviewers turned "questions about given topics into story-telling invitations", asking participants to "tell me" what happened, as outlined by Hollway and Jefferson (2012).

We conducted both a thematic and a narrative analysis. We used NVivo12 to organise the data and developed inductive codes and subsequent themes across the data. Then, to avoid fragmentation of the data, we wrote participant interview summaries, or pen portraits which aided our narrative analysis (Hollway and Jefferson, 2012).

Results

The findings concentrated on the following five key themes:

- Duty, fear and death;
- Resilience and the stigma around psychological wellbeing;
- Changing public responses;
- Nurses' voices: unheard and invisible;
- 'Running on empty' and reasons to leave the profession.

The term 'nurses' is used throughout this article to refer to the nurses, midwives and student nurses who participated in the study.

Duty, fear and death

A key finding was the negative impact of altered working environments on nurses' psychological wellbeing.

Impoverished care

The Covid-19 pandemic caused a change in patient cohorts for most nurses in our study, with many unused to seeing so many critically ill patients and a much higher death rate than usual. We used the term 'deathscapes' to conceptualise the environmental conditions in which nurses worked during the pandemic, when patient turnover was marked by high mortality rates, clinical input had limited effect, and care became task orientated (Maben et al, 2022).

Nurses who were redeployed to ICUs reported the difficulties they experienced as a result of seeing patients who were so ill:

> *"It was distressing, the amount of people just coming into* [the] *ICU. At the peak, I'd say one patient was coming up every day intubated. The normal intensive care nurses were used to it and could kind of just shut themselves off from that and do the job,* [but] *I was like, 'Oh my God, this person was walking around two days ago like me and you, and now they're like this,' and I found it so distressing."* (Nurse redeployed in the first wave)

Although this nurse attributed the difficulties of processing patient deaths to not being used to the ICU, even established ICU nurses described feeling overwhelmed by the sheer volume of deaths and the sense that their actions had very few positive effects on patients' health.

Nurses described the ICU as an almost factory-like "conveyor belt" of death, with no patients' family members present. They explained this was in contrast to the "positive", well-managed deaths that occurred in the ICU before the pandemic, when relatives were often both present and prepared. The exclusion of family members during the pandemic placed more emotional responsibility on nurses to provide end-of-life care and support in an already-stressful environment, which resulted in deaths rarely being perceived as positive experiences:

> *"Within one week, we'd had nine deaths and it was just so traumatic. Not only did we have nine deaths, but the deaths happened in a way that we'd never planned."* (Care home manager)

The unplanned nature of patient deaths increased the trauma associated with the unparalleled number of deaths experienced by nurses during 2020 and 2021.

> ***"The exclusion of family members during the pandemic placed more emotional responsibility on nurses"***

System challenges

In their interviews, nurses reported there being shortages of personal protective equipment (PPE). Many were only permitted to take a very limited number of breaks to prolong PPE supplies; interviewees, particularly those working in ICU, told us this had negatively affected their physical health. For example, they drank less so they needed to go to the toilet less often, which caused them to dehydrate and, in some cases, develop urinary tract infections. They also had less downtime and fewer breaks.

Nurses working in community or care home settings referred to PPE shortages as frequent events:

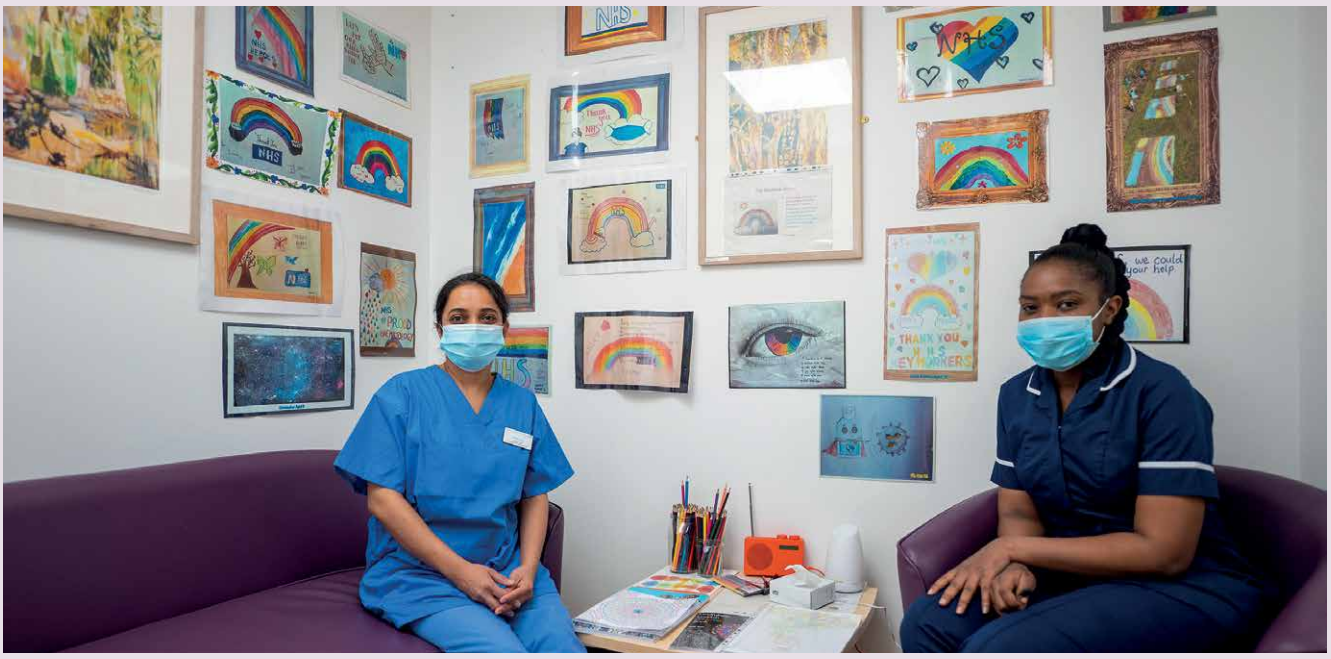
> *"I went* [to see] *a client* [who] *was positive for Covid and* [...] *I made sure that all of me was covered by putting on this bin bag, because we didn't have the things that covered you all the way round."* (Community nurse)

PPE shortages added to nurses' feelings of working in unsafe environments. Interviewees also reported struggling with providing care that conflicted with their values, often due to staff shortages and the care management of critically ill people under extreme circumstances:

> *"No one had the time to sit down with patients and ask them what they wanted; it was a case of, 'They have Covid, they are short of breath* [...] *our only option is to intubate*[...] *Let's just intubate everybody and see how we do, because it's the only option'* [...] *I think* [...] *we should have given our patients a lot more choice."* (Nurse redeployed in the first wave)

The distress or guilt that nurses described about the treatment patients received was moral in nature because they were unable to provide the quality of care

Fig 1. **Nurses in a 'wobble room' during the pandemic**



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they felt they should be delivering, which usually meant involving patients in care decisions (Morley et al, 2020).

Limited choice about being redeployed, and reduced training opportunities directly beforehand, also caused distress:

> *"On the Monday, I went up* [to ICU and] *didn't really get a grasp of any of it, because I was just so overwhelmed. I found it really hard to learn anything that they were showing me. And then, on the Tuesday, we got three hours of training* [and] *I found it really scary, because I was like, 'Oh, how would you even know if something wasn't right?'"* (Nurse redeployed in the first wave)

Research has shown that training deficits can undermine nurses' confidence to enact positive changes and improve patient outcomes (Kinman et al, 2020). Increased incidence of probable PTSD among nurses working through the Covid-19 pandemic has also been associated with:

- Redeployment with inadequate or non-existent training;
- A lack of confidence in infection prevention and control (Couper et al, 2022).

Many of the nurses we spoke to reported experiencing PTSD-related symptoms. Interviewees also described experiencing aspects of burnout, including emotional exhaustion, depersonalisation and a lack of effectiveness at work. The relentlessness of their working days during the pandemic was striking, and they explained that this made it difficult to rest outside of work:

> *"Switching off from work* [is hard]. *Because so much happens in a day, it's like a lifetime every day."* (Nurse redeployed in the first wave)

Support

In terms of psychological support, the NHS provided a substantial national offer for its staff that included mindfulness apps, 'wobble rooms' or quiet rooms where nurses could take a break (Fig 1), and counselling sessions (Blake et al, 2020). However, many study participants reported they had not accessed these interventions, for several reasons, including:

- Limited PPE supplies preventing them leaving the ward;
- Time constraints (not being able to leave patients or take a break);
- Inappropriate timing – for example, if they were in acute distress and accessing the resource was too soon;
- Not wishing to access interventions/resources outside of working hours;
- Sessions not being accessible – physically or remotely – during working hours;
- Stigma and stoicism preventing them from appearing to be 'not coping';
- Not wishing to admit to managers that they needed help;
- Reluctance to seek help within the organisation due to fear of reprisals.

Inadequate staffing levels were also a major inhibiting factor to the implementation of formal and informal interventions. Employers' provisions of psychological wellbeing strategies were often viewed by nurses as almost disingenuous; interviewees felt that these enabled employers to place responsibility for the problems caused by poor working environments and conditions onto nurses:

> *"If you say anything, they're like, 'We're putting everything there for you: the mindfulness* [and] *everything'. And it's almost like it's your fault if you can't cope. It's your fault because they've put the tools there for you, but you haven't got time* [...] *You have other demands on your life but, if you can't cope, then it's your fault because you haven't made yourself resilient enough."* (Hospital nurse)

Instead, participants in our study valued their own support groups held online or on social media platforms, such as WhatsApp (Maben et al, 2022). Here, they shared their experiences with colleagues who had "been through the same thing" and supported each other:

> *"Support-wise, I think we've just got to be there for each other."* (Nurse redeployed in the first wave)

Furthermore, many participants expressed that the research interviews allowed them – often for the first time – to fully explore and acknowledge their feelings, giving them the space to reflect on, and process, what they had experienced.

Resilience and the stigma around psychological wellbeing

Nursing resilience studies have tended to define resilience as a personality trait, with a focus on overcoming adversity and positive adaption; however, we suggest resilience is, equally, an organisational responsibility and should not rest only with individual nurses (Conolly et al, 2022).

Nurses often discussed the concept of resilience in their interviews, and we critically examined how they conceptualised it. They tended to feel puzzled and disappointed, and to blame themselves when they did not feel resilient, despite the traumatic working conditions:

> *"We all just kept going* [... but] *it wasn't okay. And it kind of hits you now, when you think, 'That was rubbish'* [...] *I'm just disappointed* [...] *and ashamed of feeling* [disappointed] *like that."* (Nurse redeployed in the first wave)

The student nurses we interviewed during the first wave of the pandemic described the pressure they felt about being labelled as not resilient enough:

> "[The word resilience has] *been misused and used out of context, because there's this unspoken belief that,* [even] *if you're a student nurse during Covid, you still have to bounce back. You still have to deal with it and, if you can't,* [...] *you're weak or you're not cut out to be a nurse, which is not true* [...] *There's a bit of stigma still there."* (Student nurse during the first wave)

Other nurses told us that, despite realising they were not well and needed to take time off, they felt unable to do so due to the need to look stoical because of the stigma around not being resilient:

> *"I thought that the best course of action was to be resilient and to keep going into work when, in actual fact, I probably would have benefitted from having some time* [off...] *But I just kept on forcing myself to go into work, because I thought it was a good thing to do. Yeah, I think in nursing, we're very good* [at] *caring for the patients, but not actually very good about caring about the staff or ourselves."* (Nurse redeployed in the first wave)

Resilience and the need to keep going caused interviewees who were experiencing stress and/or psychological problems to feel worse. In particular, this occurred when stigma meant they kept working when they needed rest (Conolly et al, 2022).

Fig 2. **A banner outside a care home during the pandemic**

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Nurses' working conditions during the Covid-19 pandemic meant they had no power to change their situation, which severely affected their psychological wellbeing and optimism. Our critical analysis of the concept of resilience highlighted the guilt nurses felt as they believed they were blamed by colleagues for not being 'resilient enough' to cope with the trauma caused by the pandemic. Additionally, they felt that organisational leaders and managers did not take account of the environmental factors and context, such as staff shortages (Conolly et al, 2022).

Like Traynor (2018), we argue that care is required when discussing resilience; there is a need to reframe the concept away from individual or personality traits – not doing so absolves organisations of responsibility. Issues with resilience can be viewed, not only as an organisational problem, but also a societal one.

Similar to the notion of self-actualisation (becoming one's ideal version of oneself), the danger of using the term 'resilience' in this manner is that it "inherently involves understanding oneself as [...] needing to be 'fixed'" (Conolly et al, 2022). The acquisition of resilience can, therefore, be viewed as a never-ending project: one can always become 'better' and more resilient (Conolly et al, 2022). This also neglects the structural issues that may be causing nurses not to cope in challenging situations, such as poor staffing, lack of power to change things, and the increasing complexities of patient care.

Changing public responses

Before the Covid-19 pandemic, nurses and their work went mostly unrecognised and undervalued in public discourse; however, the pandemic highlighted their vital role as key workers (Daniels et al, 2022) when they were lauded as heroes by the government and the media (Mohammed et al, 2021). Initiatives, such as the weekly Clap for Carers (Fig 2) and Captain Tom Moore's walk to raise money for the NHS, positioned the public as grateful recipients of the sacrifice made by nurses and other health workers (Fig 3) (Maben et al, 2022). Many nurses we spoke to initially described enjoying this recognition, which made them feel valued:

> *"When everyone was doing the clapping* [...] *I think we certainly felt* [like] *more of a team and more appreciated than we ever have. People were thanking me for doing a job that I've done for 14 years, and I've never been thanked before."* (Hospital nurse)

However, interviewees reported that the public's view of nurses as heroes waned after the first wave of the pandemic; the Clap for Carers initiative ended, and patients and their families wanted services to return to normal. This affected participants' psychological wellbeing:

> *"It's funny, because that was my comment when they were clapping: I said to my husband, 'This will turn against us because, actually, whilst we're in this euphoric sense* [that] *we're dealing with the pandemic and we're all in it together, that's going to get very tired'* [...] *We just didn't have enough* [of the] *services that we needed to support people for the right thing for them, so I started to get quite a few complaints* [...] *We dealt with people who were very angry, because either they or their relative had not received the right level of therapy."* (Community nurse)

Interviewees reported that the elevation of nurses as heroes made them fall harder

and experience greater emotional strain when the public display of gratitude ceased and they returned to a situation where their work was unrecognised and underappreciated. The advent of Covid-19 deniers and anti-vaxxers also challenged them and affected their psychological wellbeing, as well as adding to their feelings of being undervalued and unrecognised for their work. When interviewees referred to harassment or being confronted by Covid-19 deniers or anti-vaxxers, they discussed how difficult they found it to remain objective:

> *"Having seen what we have and* [having] *worked in* [the] *terrible conditions that we have, for somebody who knows nothing about it to then tell you it wasn't real and that your experience wasn't real, it's very difficult to stay professional, impartial and polite."* (Nurse redeployed in the first wave)

In particular, many interviewees were keenly aware of the attitudes of some friends and family members, who were Covid-19 deniers or anti-vaxxers. This created further conflict, highlighting the differences between these alternative viewpoints and the perspective of mainstream health workers, based on the extreme patient suffering they were witnessing as a result of the Covid-19 virus.

Nurses' voices: unheard and invisible

Although some nurses reported feeling able to speak up, many encountered a "deaf" or hostile response when they tried to raise concerns to senior staff during the Covid-19 pandemic. For some, their managers were "totally invisible", leaving them feeling disregarded (Abrams et al, 2023). Interviewees described feeling like they were "shouting into the ether" when they raised concerns, illuminating the powerlessness they felt during the pandemic. Others felt silenced by feelings of futility and resignation that nothing would change and they would not be heard (Abrams et al, 2023). For example, one interviewee described reporting a problem that was not addressed for many weeks:

> "[I was] *raising this issue* [...] *about the fact that people weren't getting told their* [Covid-19 test] *results over the phone, and* [...] *it was almost being suggested that* [...] *I was being insubordinate and things by raising that as an issue to my managers. And I was thinking, 'This* [...] *is a real issue that hasn't been dealt with'."* (Nurse redeployed in the first wave)

In these situations, some nurses said they felt able to speak out; however, others avoided doing so, indicating that they felt they would be professionally at risk if they were to raise issues. Indeed, many interviewees demonstrated quiescent silence, due to a fear of the consequences of speaking up (Abrams et al, 2023).

Fig 3. **A poster outside a hospital during the pandemic**

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"Employers' provision of psychological-wellbeing strategies was often viewed by nurses as almost disingenuous"

Nurses also reported that the Nursing and Midwifery Council's Code was used against them as an instrument of control to ensure they continued to "suffer in silence". For example, one interviewee referred to a manager citing the document during a discussion regarding redeployment; they felt that this subtle and implicit reference to disciplinary action ensured they accepted redeployment as the only option and removed any ability they had to exercise control.

'Running on empty' and reasons to leave the profession

Nurses found different ways to cope with the impact the pandemic had on their psychological wellbeing, and we observed several ways in which they managed their stress and distress over time. Some continued in their roles as nurses, but some chose to retire during the pandemic, then returned to do bank shifts in the same setting. As one nurse, who was redeployed in the first wave, explained:

> *"I guess maybe I felt very tired. I was aghast looking back over the year. I just thought, 'Actually I feel really, really tired and worn out'. And then* [I] *started to think,* [...] *'How many more years have I got left to work?'* [...] *Maybe I don't have to be on that whole treadmill, and I could retire and come back. And then do a few hours, then* [I] *don't have all the stress as with having a full-time job."*

Another coping mechanism nurses used was to prioritise their psychological wellbeing by taking sick leave or unpaid leave, with a view to returning to work. This often took some time to come into effect, with nurses working while exhausted for a while before realising they were ill. Many of the nurses we interviewed had taken a period of leave due to psychological ill health. Despite expressing guilt about doing so, many interviewees characterised their decision to take time off as an active choice to prioritise their psychological wellbeing:

> *"With me being off with stress,* [...] *I feel a bit guilty because I could work. I'm able bodied. I'm not physically unwell. I could work, but then the effect on my mental health would be worse."* (Nurse redeployed in the first wave)

Other nurses in our study left acute care, albeit temporarily in some cases, by moving from one setting to another (for example, from hospital-based working to a community-based setting) or moving into a less-clinical role, such as one that was not patient facing. The most cited motivation for these moves was the need for a break as a result of emotional exhaustion.

Other interviewees expressed the desire to leave nursing altogether to do something completely different, and several left during the course of our study:

> *"I think a lot of us just feel, certainly myself, that we won't tolerate a lot*

more. I've always loved nursing [...] but in the last sort of six months to a year [...] I don't know, life's too short, and Covid could destroy your family, and why am I putting myself through all this for hardly any money, when I can go and work at an office?" (Nurse redeployed in the first wave)

This is typical of the views expressed by many participants. Most were surprised they were feeling this way, as they never believed they would do anything other than nursing.

In our final interviews, participants described colleagues "leaving in droves" and teams that were seriously depleted, causing a vicious cycle of staff shortages and a desire to leave.

Discussion

The Covid-19 pandemic put global health and care systems under extraordinary pressure, both exacerbating and highlighting pre-existing staff shortages and exposing long-standing deficits and strains in the NHS workforce (Daniels et al, 2022). Our research illustrated the emotionally traumatic and distressing working practices experienced by frontline nurses in altered care landscapes with large numbers of patients who were critically ill or dying.

NHS and social care pandemic unpreparedness (such as inadequate PPE supplies and staff shortages) made an extremely difficult situation untenable for many nurses. This was accentuated by:

- Limited choice about redeployment;
- A lack of training;
- Nurses' basic needs not being met;
- Limited communication from some managers.

These issues greatly affected nurses' emotional and psychological wellbeing. In some instances, nurses felt silenced and unable to speak up, and wanted managers and leaders to work alongside them to share the burden caused by the pandemic. Some interviewees, therefore, felt let down and alone in very challenging circumstances.

It is vital to learn from these experiences and to improve the nursing workforce's working environment and psychological wellbeing in order to shape responses to current and future pandemics, as well as other intensely stressful situations. We call for two fundamental changes in response to this (Box 1).

It is imperative for the long-term psychological and physical safety of the NHS's staff and patients that it:

- Prioritises staff members' psychological wellbeing;
- Builds it into staff members' weekly routine.

There was a 13% increase in the number of nurses who left the profession in the UK in 2021-22 compared with the previous year (Mitchell, 2022). It is imperative that governmental policy makers, along with organisational managers and leaders, work harder to listen to nurses and midwives and improve their working conditions.

Nurses are viewed as one of the most trusted professions in the UK (Ipsos, 2022) but, during the pandemic, they endured intolerable working conditions, and experienced high levels of psychological ill health (including stress, burnout and PTSD) as a result. Furthermore, they are now coping with severe staff shortages, depleted teams and increased patient demand (Daniels et al, 2022). Our research indicates that, to retain our highly skilled nursing workforce, the following are imperative:

- Continued, high levels of public and governmental support;
- Improved working conditions, including pay.

Our study revealed that the effects of the pandemic have been far-reaching for health professionals who worked during it. Interviewees reported feeling "forever altered" by their experiences; it is now time for these sacrifices to be recognised in full by society and the government and for staff to be rewarded in an appropriate manner. **NT**

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Box 1. **Proposed actions in response to the pandemic**

The NHS

We urge the NHS to address the following at a national level:

- Stigma around the psychological wellbeing of staff
- Outdated notions of nurses as inherently stoical
- Conceptualisations of resilience as a valued individual trait, rather than an organisational responsibility (Conolly et al, 2022)

The public

In this post-pandemic phase, and with unprecedented national strike action taken, we invite the public to continue to:

- Value nurses' skills
- Offer empathy and understanding to nurses
- Reflect on nurses' working environments and experiences before, and during, the Covid-19 pandemic

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