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The Lived Experience of Emergency Department Nurses During the First Surge of the COVID-19 Pandemic a Qualitative Phenomenological Study

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ABSTRACT

Objective: The purpose of this study is to explore the experiences of Emergency Department nurses working during the first phase of the COVD19 pandemic.

Background: The impact of the first wave of COVID-19 pandemic to the national health care system was unexpected and devastating in many ways. Emergency Department nurses were overwhelmed with very little time to process this situation. Guidelines kept changing for dealing with this pandemic. Registered nurses working in the Emergency Department, as first responders, were called upon to make decisions for which they were not prepared.

Methods: A purposive sample of 15 registered nurses working in the Emergency Department during the first phase of the COVID-19 pandemic were recruited using snowball technique. Data collection was conducted using unstructured interviews. Data were analyzed using Colaizzi's phenomenological method which guided this study.

Results: Analysis of the data revealed six essential themes: uncertainty and fear; overwhelmed and fatigued; stoicism and resilience; teamwork, ethical dilemma, and spirituality. These themes highlighted the failures in policy to address the health and well-being of Emergency Department nurses as they respond to public health disasters such as the COVID-19 pandemic

Conclusion: Emergency department nurses were affected physically, emotionally and professionally by the pandemic. Looking at the beginning of the pandemic, effective strategies for future crises should be developed so that nurses do not succumb to the stresses that Emergency Department nurses were confronted during this crisis.

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Introduction

Nurses working in the Emergency Department (ED) of hospitals are among the first members of the health care team who are required to provide direct care for patients. This places certain burdens on these frontline health care professionals as; by helping save lives, they put their own lives at risk. However, there are protocols and equipment in place to minimize these risks. These protocols were abandoned during the first wave of the Coronavirus disease 2019 (COVID-19) pandemic, as roles and responsibilities for nurses shifted rapidly to accommodate patient surges and the sudden unanticipated demand for health care services. Equipment and other resources were strained or were non-existent as ED nurses were operating in survival mode [1]. Nurses reported inadequate supplies of Personal Protective Equipment (PPE), and insufficient knowledge and skills for responding to the pandemic [2]. This pandemic was declared as the worst public health emergency in more than 100 years [3].

The purpose of this study is to explore the experiences of ED nurses caring for patients with COVID-19 during the first wave of the pandemic. Very little was known about the disease prevention, pathophysiology and/or treatment during the first wave of the virus. At that time, the mental health and lives of these nurses were placed at high risk [4-5]. It is important therefore, to explore the lived experiences of these nurses. Understanding their experiences will provide insights that might contribute to the development of strategies that can impact policy, patient outcomes, and the health and well-being of nurses in preparation for future public health challenges and/or pandemics.

Background

The novel COVID-19 is a respiratory virus that is related to the severe acute respiratory syndrome (SARS) virus with pneumonia-like symptoms. The disease first emerged in Wuhan China in November 2019 and was so contagious that it quickly spread to other countries. After more than 118,000 cases were detected in 114 countries with 291 identified deaths from this disease, the World Health Organization (WHO) declared it a pandemic in March 2020 [6]. During that same month, a national emergency was declared in the United States and several states began to implement shut-downs to prevent the spread of COVID-19 [7].

By April 2020, the US had 18,000 confirmed deaths and more than 500,000 confirmed cases of COVID-19 and New York became the hotspot with 159,000 confirmed cases [7]. As critically ill patients showed up in EDs, health care workers were faced with many challenges. There was limited information on protocols for prevention, transmission, and treatment of the disease. Information about prevention and control of the disease were inconsistent and health care professionals themselves were not sure of how to avoid contracting this life-threatening disease, or even how to care for patients with COVID-19. ED nurses were following the old Centers for Disease Control and Prevention (CDC) guidelines to manage these patients who were showing up in overwhelmingly large numbers and acutely ill. Once it was realized that COVID-19 was spread primarily via respiratory transmission1 [8]. A huge challenge for health care workers was the unprecedented shortage of PPE. There were shortages of gowns, eye shields, masks, ventilators, and even body bags. Long standing infection protocols had to be disregarded as front-line workers were forced to ration the limited resources. This shortage of PPE coupled with the deadly nature of the disease put these nurses at great risk. Information on protecting the health of nurses caring for patients during a pandemic such as COVID-19 is sparse. Spencer reported that according to a Kaiser Health News/Guardian project, in the first year of the pandemic, more than 3,600 frontline workers in the US died during this time from the disease [9]. The survey found that more than half of those who died were younger than 60 and that nurses died in higher numbers than physicians.

COVID-19 has been noted to occur in waves and has mutated to the extent that, after the first wave ended in December 2021, a second wave began in January 2022. At that time, there was an unprecedented surge of hospitalizations driven by the emergence of the severely symptomatic Delta and highly contagious Omicron variants [10]. At the time of writing this article, a "tridemic" of influenza, RSV, and COVID is once again overwhelming hospital emergency departments [11]. ED nurses were still at risk as the CDC continued to issue emergency guidelines based on their current understanding of the trajectory of these diseases. In areas where fewer people are wearing masks and more are gathering indoors to socialize even with family, cases of COVID-19 have risen after a peak and decline [12]. Despite these pockets of surges, by June 2021, in many areas of the US, restrictions related to mask wearing and social distancing were dropped in response to a decrease in the U.S. death toll from COVID-19. While knowledge regarding transmission and treatment of COVID-19 is improving, the new variants are challenging the experts who continue to struggle with a response on containment and treatment of the virus and emerging variants such as the BF.7 and BA.5 [7]. Information about prevention and control of the disease are continually changing and long-term prognosis are still not clear. Considering that so much about COVID-19 and the subvariants are still unknown, there remains a lack of consistency in instituting policy recommendations to ensure safe workplace environments to protect workers from COVID-19 [6].

The literature related to COVID-19 is increasing in areas of pathophysiology and medical management. While there is some literature about nurses caring for patients with COVID-19, [13,14]. there is very little about how nurses working in the ED experience the challenges of caring for patients with COVID-19 during the initial phase of the pandemic. Researchers conducted a systemic review of health care workers in three databases during the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak, during the 2012 Middle East Respiratory Distress Syndrome (MERS) outbreak and during the current COVID-19 pandemic. They concluded that the level of disease exposure and health care were significantly associated with worse mental health outcome [13]. Another study on nurses working on inpatient units of a hospital in Iran, showed that the work and lives of nurses caring for patients with COVID-19 were negatively affected [14]. This study, through the voices of these nurses, will elicit ED nurses' experiences caring for patients with COVID-19, during the height of the pandemic.

Method

Study Design

This descriptive phenomenological study explored the lived experiences of ED nurses caring for patients with COVID-19 in the epicenter of the disease during its earliest days. The aim of phenomenology, according to Colaizzi is to gain a deeper understanding of the meaning of people's everyday experiences through the use of a seven-step process whereby each step allows the researcher to remain close to the data in order to understand a phenomenon which is consciously experienced by people themselves [15].

Setting

The study was conducted in New York from March 2021 to July 2021, after the end of the first surge of the pandemic while the nurses' experiences were still vivid. This provided a pure description of participants' experience of the phenomenon of caring for patients with the disease and captured the essence of the phenomenon as it exists in participants lived world experience [16]. Descriptive phenomenology is concerned with revealing the essence of the phenomenon under investigation. It was determined that descriptive phenomenological research would be best suited for this study because it fits with the research question "what is the experience of the ED nurse caring for patients with COVID-19?" ED nurses were chosen because they are among the first members of the health care team that saw these patients and are required to provide lifesaving care as quickly as possible before transferring them.

Participants

Institutional Review Board approval was obtained from the University where the researchers are affiliated. Participants were assured of confidentiality; pseudonyms were assigned to each participant and all identifying information were removed from the transcripts. Persons meeting the inclusion criteria were informed about the purpose of the study, criteria for inclusion, their right to decline and/or withdraw from the study at any time and that there may be one to three interviews lasting no more than one hour each. Informed consents were obtained from those who agreed to participate in the study. Participants also agreed to be interviewed and recorded via Zoom. This study involved minimal risks for participants. Prior to interviews a short demographic form was completed by participants.

Recruitment

A purposive sample of 15 nurses who work in the ED were recruited from a major hospital in New York. Inclusion criteria

were Registered nurses working in the ED who cared for patients with COVID-19 during the initial surge of the virus. Participants ranged from 23 to 59 years of age.

Data collection

Unstructured face-to-face interviews were conducted to allow participants to provide descriptions of their experiences. Participants were encouraged to talk freely and to tell their stories in their own words. Each interview lasted approximately one hour. The interviews were recorded via Zoom and transcripts were provided to qualitative researchers to be sure they met the criteria for descriptive phenomenology.

The first author conducted the interviews, and all the researchers participated in conceptualizing and analyzing the data. The interview began with a broad open-ended question: "Tell me what it was like working in the Emergency Department during the COVID-19 pandemic?" Based on participants' answers, follow-up and probing questions were asked to allow participants to elaborate and provide examples on topics discussed. Field notes and reflective journals of each interview were created and maintained to provide an audit trail. All electronic data was obtained via a secure encrypted line which was accessible only to the researchers. Transcripts, field notes, journals and storage devices were secured in a locked cabinet when not in use. After 15 interviews, no additional themes were uncovered, and the researchers determined that data saturation was achieved [17].

Trustworthiness according was established by verifying codes and meanings with the participants [18]. Great care was taken to use the participants own words and descriptions as recorded. Descriptions of themes and categories were analyzed by two experts in qualitative research who compared categories and themes with the data. Participants verified the accuracy of interpretations.

Data analysis

Data analysis consisted of organizing and coding the data so as to remain in its naturalistic form, congruent with descriptive studies [18]. This descriptive phenomenological study employed Husserl's (1913/1962) philosophical approach and Colaizzi (1978) method of data analysis. Colaizzi's method provides a rigorous analysis, to allow the researcher to stay close to the data with each step of this method. This method was suitable for this study as it relied on rich data from the participants about their experience with face-to-face interviews that were used to identify, understand, and describe the experiences of participants and reveal emergent themes. Colaizzi's seven steps of data analysis provided clear, logical, and sequential steps that can be used in phenomenological research [15]. The steps were used as follows: familiarization was accomplished by reading all transcripts to get a sense of the experiences and their meaning for the participants; significant statements that were relevant to the phenomenon being studied were identified; investigators examined the data line by line, identifying significant experiences, expressions, and body language of participants, which were noted in the investigator's memos; after carefully looking at the significant statements, meanings were formulated as the researchers reflexively "bracketed" their beliefs or pre-suppositions so as to stay close to the phenomenon as experienced by the participant; meanings were clustered into themes being careful to avoid any pre-suppositions; themes were incorporated into an exhaustive description of the phenomenon which was then condensed into a fundamental structure of the lived experience of nurses working in the Emergency Department during the COVID-19 pandemic; a description that captured the essence of the experience was created; and the results were validated by the participants in order to compare the researcher's descriptive results with the interviewee's experiences.

The use of conventional content analysis allowed commonalities to be identified and coded as a way to organize and understand data [19]. Data were read and phrases were extracted from participants' own words. Relevant excerpts were coded and them grouped into categories. Patterns of meaning were identified and organized into themes. The goal of this analysis was to capture the essential themes from the perspective of the participants so that meanings of the lived experience can be described.

Results

The purpose of this study is to explore the experiences of ED nurses caring for patients with COVID-19 during the first wave of the pandemic. ED nurses were chosen because they were among the first group of health care providers who had to make life and death decisions about how to ration care and equipment while providing care to patients during the pandemic. Demographic data included participants' name, age, sex, education level, years working in the ED, marital status and contact information (Table 1).

Table 1: Demographic Characteristics of Study Participants

Variable	N (%) Total = 15
Gender	3 (20%)
Male	12 (80%)
Female	
Highest educational level	
Bachelor's degree	13 (87%)
Master's degree	2 (13 %)
Marital status	
Single	9 (60%)
Married	4 (27%)
Divorced	2 (13%)
Years in Emergency Department	
0 – 5 years	4 (27%)
5- 10 years	5 (33 %)
Longer than 10 years	6 (40%)

Six essential themes were identified from analysis of the data. The essential themes defining nurses' experiences of caring for patients during COVID-19 were: uncertainty and fear, overwhelmed and fatigued, stoicism and resilience, teamwork, ethical dilemma, and spirituality (Table 2).

Uncertainty and Fear

The theme of uncertainty and fear was expressed by all participants. They reported confusion about changes in long standing infection protocols. Uncertainty about effective disease control was voiced by Sam: "I was terrified. What is this? Where did it come from? What will happen next." Sarah spoke about not having clear protocols to guide decisions: "…things changed day by day, it was perilous, it was chaos, it was confusion." Fear of self-contamination and of contaminating family members due to the unknown trajectory of the disease and lack of PPE was articulated. Ellen spoke about not wanting to go in the patients room because "…I was worried about my family, my kids, no I couldn't take it home." Mary revealed that she was "…terrified…cannot survive

this, I'm left with PTSD".

Overwhelmed and Fatigued

All participants described how overwhelmed and exhausted they were. They described feelings of hopelessness, helplessness and burn out. Participants stated that they dreaded going into work because the increased workload and complexity of care they needed to provide. Carol explained: "I was drained, no energy to carry on, it was hopeless, I gained no strength from my patients and coworkers. I lay helpless on my couch on my days off." As Janet stated: "It was frustrating, it was exhausting, I cried every day." Diane confessed "Caring was abstaining from doing too much. I just couldn't do more. My colleagues died, I couldn't take it and I gave up…just too tired"

Stoicism and Resilience

These participants were working on the frontline and were providing care under challenging conditions. They were returning to a chaotic environment every shift. They were triaging based on potential survivability. Despite not having clear protocols as to what to do, they expressed the need to display a brave front for their patients. John stated that it was like "boot camp…a war zone, but we had to keep on going" As Karen put it. "I had to give care without expressing any feelings…this is not what I'm accustomed to." Paul added: "I just had to do what came to mind because routine care was thrown out." Estelle illustrated her resilience when she said she just "took time out to cry then get back to the job at hand."

Teamwork

Participants reported that the demands of their workload and scarcity of PPE, ventilators, and other resources fostered a reliance on coworkers for strength and support. Such support systems are essential during times of crisis such as during the pandemic. As Shirley voiced. "I couldn't do this alone…my coworkers and managers supported me. My colleagues needed me; the physicians depended on me to give care. I had to constantly help my colleagues who were drowning, I couldn't leave them to suffer." Ethel stated: "We had to save as many lives as we could with what we had. My colleagues had to constantly reassure me that it was OK to do what we did."

Ethical Dilemma

The theme of ethical dilemma was described in terms of changes and inconsistencies in established protocols, nursing care, ambivalence, and selfishness. Joanne said "I couldn't support the families…patient families were left in limbo…my family was left uncared for…" Carol explained "I couldn't touch my patients; I left medications on the table and quickly exited the room. Care was severely compromised" Marilyn confesses that she "…hid from my patients so I wouldn't take the virus home." Paul revealed: "Many did not receive quality care. Could you blame me?"

Spirituality

The theme of spirituality was recurring as many participants reported that they reached out to a higher power. Estelle related what was voiced by most participants: "I relied on meditation, prayer and music to get me through…this is my calling, I had to care for them." Sarah voiced: "Every day I prayed in my car before I went into work." As Sam stated: "Many times I wanted to give up, but my faith kept me going."

Table 2: Essential Themes and Thematic Elements

Essential Themes	Units of Meanings/subcategories
Uncertainty and fear	*Inconsistent changes to previously accepted protocols Unknown trajectory of the disease Risk of transmitting the deadly disease to self and family Fear of death Lack of PPE*
Overwhelmed and fatigued	*Frustration with inability to devote enough time to patients Burn out from patient acuity and patient workload Exhaustion physically and mentally Feeling hopeless and helpless*
Stoicism and resilience	*Staying calm amid chaos Returning to turbulent environment every day Displaying a positive demeanor to patients and their family Doing what needs to be done despite unfamiliar burnout*
Teamwork	*Offering to support colleagues Relying on colleagues for physical and emotional support Heightened need to work as a team Collaboration with others on the health care team*
Ethical dilemma	*Ambivalence about going into patients' room Dissonance between caring for patients and caring for self Unable to support patients physically and emotionally Inconsistencies and changes in established protocols*
Spirituality	*Reliance on a higher power for strength Taking time out to pray for patients Praying for courage to go into work every day Meditation*

Discussion

The purpose of this study was to explore the lived experiences of Emergency Department nurses during the first wave of the COVID-19 pandemic. The findings of this study identified six essential themes: *uncertainty and fear; overwhelmed and fatigued; stoicism and resilience; teamwork; ethical dilemma; and spirituality* as described by the participants.

Nurses in this study expressed many emotions about their experiences while caring for patients during the period of the first wave of the pandemic. They were anxious and depressed due to the uncertainty of the disease trajectory and fear of infecting themselves and family with this deadly disease. This caused then to become terrified when they went to work and when giving direct care to patients. They were fearful of contracting the disease and taking it home to their families. Some participants stated that they tried to avoid, as much as they could, going into these patients rooms. They reported feelings of frustration and helplessness because they were not able to support their patients physically and emotionally. Participants felt isolated from their own families but played the role of surrogate family to patients. For these participants, the caring actions that they believed as the conduit for health care delivery were now redefined as they were forced to adapt their care to this unfamiliar environment bounded by the physical barriers of PPEs and trying to keep from infecting themselves. They were fatigued but determined to give their all, not only to patients but also to their coworkers. They were grateful for the support from colleagues. They prayed together and meditated alone. These ED nurses found ways to suppress anxiety when caring for patients during the height of the pandemic. They put on a brave front so as not to alarm patients and families despite their overwhelming fatigue. As the participant Mary noted, "I'm left with PTSD."

Limitation

The nurses who participated in this study were in a unique position. They were recruited from a large medical center in the epicenter of the pandemic during the first surge of the pandemic in the US. During this period their experience may have been different from other ED nurses in other geographic regions both in newness and severity of illness.

Implications for Practice

Results of this study highlighted the failures in policies to address the health and well-being of ED nurses as they respond to public health disasters such as the COVID-19 pandemic. Nurses are traditionally grounded to provide selfless devotion to care for those whose lives are entrusted to them. That is exactly what these participants did, often at the expense of their own physical and mental health. The Committee on the Future of Nursing 2020-2030 has acknowledged that there will be future public health emergencies. ED nurses are among the first responders to health emergencies [10]. The committee concluded that a national strategic plan needs to be developed to support nurses in being prepared to respond to these disasters to preserve nurses' health and well-being. This Committee made several recommendations. Recommendation 8 suggests that nursing and non-nursing stakeholders should protect nurses as they respond to health emergencies such as the COVID-19 pandemic and other natural disasters.

ED nurses are encouraged to assess their own welfare and take necessary steps to preserve their health and well-being when they are on the frontline of care. Nurse educators should integrate strategies for self-care throughout the curriculum so that when nurses are faced with catastrophes such as the COVID-19 pandemic, they are prepared to provide emergent patient care while protecting their own physical and mental health.

Nurse administers should not only provide in-service for patient education, but also for nurses on best practices that will have a meaningful impact on their own health and well-being during times of crisis. These administrators should be required to provide time and a safe space for nurses to renew and resume when they feel pushed to the limit. Policy makers have a responsibility to review current policies so that resources such staffing and equipment are adequate in times of crisis. Having more nurses involved in policy making can address this. ED nurses need ongoing support to maintain their health to ensure that they can provide safe quality care to their patients.

Conclusion

The public health crisis is not over and in fact, it is expected that there will be surges of the disease due to the emergence of new variants. However, there is a need to look at the beginning of this pandemic as a starting point to develop effective strategies so that nurses do not succumb to the stresses of future crises. Today, nurses still cannot let their guard down because, according to the experts, many offshoots of the variants will emerge. During this study, the Delta and Omicron variants were circulating simultaneously in the US. The CDC reported that as of December 25, 2021, 59% of all COVID-19 infections were caused by Omicron and 49% by the Delta variants [7]. The COVID-19 vaccines offer some protection against new virus variants. Those who are vaccinated are mostly protected from the worst outcomes. As of December 2021, 62% Americans are fully vaccinated against COVID-19. However, roughly 38% remain unvaccinated [7]. COVID-19 cases appear to be surging among the unvaccinated. The emerging evidence suggests that COVID-19 will still do terrible damage among the unvaccinated in the US and worldwide. As of this writing, hospitals are still being overwhelmed with admissions because of the tridemic which includes COVID-19. Nurses find themselves in fear of future waves of cases as they remain vigilant in caring for patients infected with the variants of the virus. This means that it is likely that nurses working in the ED will have to live with these unrelenting surges. Those who contract the disease after vaccination are considered breakthrough cases therefore, even if they are vaccinated, these nurses are still at risk to contracting COVID-19 as hospitalizations continue to spike. It is challenging for these nurses to avoid succumbing under the weight of crises such as this. For nurses working in the ED whose goal is to save lives, strategies and policies must be put in place to support and maintain their physical and mental wellbeing to allow them to provide the best care possible for their patients.

Understanding ED nurses lived experience is important in planning and managing future outbreaks. Future research is needed to study nurses' experiences in subsequent surges and throughout the trajectory of the disease. Obtaining the experiences of ED nurses on a local, national, and global level is also recommended. Such research could provide insights into the differences encountered by nurses in this global pandemic. As the pandemic occurs throughout the country and the world, articulation of these findings will provide validation for other nurses in similar circumstances [20].

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