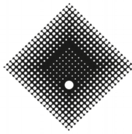

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“I Don't Really Wanna Go Back. I Know What I've Got in Front of Me.” Lived Experiences of Emergency Nurses 2 Years Into the Global COVID-19 Pandemic

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"I Don't Really Wanna Go Back. I Know What I've Got in Front of Me." Lived Experiences of Emergency Nurses 2 Years Into the Global COVID-19 Pandemic

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Contribution to Emergency Nursing Practice

- The current literature on emergency nursing during the coronavirus disease 2019 (COVID-19) pandemic indicates that nurses are experiencing ongoing negative impacts to their overall well-being, with increasing levels of burnout, emotional and physical exhaustion, and the effects of "living with loss."
- This article contributes knowledge to the Australian emergency nursing experience 2 years into the COVID-19 pandemic and after global vaccine development.
- Key implications for emergency nursing practice found in this article include highlighting the negative compounding effect of the COVID-19 pandemic on the emergency nursing workforce, which may be attributed to staff attrition and ultimately poorer outcomes for patients accessing acute care services.

Abstract

Introduction: As the coronavirus disease 2019 pandemic continued into 2021 and beyond, unrelenting work pressures continued to mount on the emergency nursing workforce. In the second year of this longitudinal study on emergency nurse lived experiences, staff outlined the continued strain of the profession, highlighting their increasing levels of burnout and identifying early stages of trauma response.

Methods: This research aimed to continue to explore lived experiences of Australian emergency nurses working on the frontline 2 years into the coronavirus disease 2019 pandemic. A qualitative research design was used, guided by an interpretive hermeneutic phenomenological approach. A total of 9 Victorian emergency nurses from both regional and metropolitan hospitals were interviewed between October and November 2021. Analysis was undertaken using a thematic analysis method.

Results: A total of 3 major themes and 12 subthemes were extracted from the data. The 3 overarching themes included "On the floor each day," "Can I keep going?" and "What's around the corner?" Increasing levels of emotional exhaustion and burnout were evident, with emergency nurses stating their intentions to leave the profession.

Discussion: Deep engagement with participant emergency nurses across 2 years of the coronavirus disease 2019 pandemic has revealed a need for greater emphasis on staff well-being for

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future maintenance of a resilient and healthy workforce. Without this, lack of support for subsequent nursing cohorts may affect the quality and reliability of care being provided in acute care centers.

Key words: Emergency department; Coronavirus disease 2019; Pandemic; Vaccine; Lived experience; Qualitative; Nursing; Australia

Introduction

After emergence in 2020, coronavirus disease 2019 (COVID-19) continued to cause widespread devastation in subsequent years, with mass loss of life, increased morbidity within global populations, and continued strain on health care workers.[1-3] By December 2021, the World Health Organization had recorded more than 290 million cases and more than 5 million deaths globally within the general population and increasing deaths among health care workers.[4]

Some renewed hope for managing the virus was realized in 2021, with the race to develop a global vaccination now well advanced. In early 2021, the COVID-19 vaccination begun its rollout in countries including the United Kingdom, United States, and Australia.[5,6] In the Australian COVID-19 landscape, the second year of the pandemic saw 18 separate lockdown events across all states and territories, with Victorians spending 262 days in lockdown since the pandemic began.[7,8] The impact of extended lockdowns was felt within communities, with Australians experiencing lower levels of overall well-being and life satisfaction and higher levels of psychological distress with feelings of loneliness and isolation.[9] Increasing COVID-19 caseloads and a steady growing demand on health care services led to the mental, physical, and emotional health impacts of the pandemic becoming more apparent in the health care worker population.[10] Despite the development of health care worker well-being initiatives by the Victorian State Government, levels of burnout among health care staff were becoming a chronic concern.[10,11] These concerns were not only becoming evident within Australia, but global increases in psychological distress were becoming apparent in nursing populations. Nurses were dealing with ongoing physical and psychological changes as a result of the pandemic.[12] They were "living with loss," loss of physical health, relationships, and routine, and needed more psychological support than what was being offered.[13]

Within Australia, there remains limited literature on the longitudinal impacts of the COVID-19 pandemic on health care workers, specifically those in ED environments. Furthermore, there is limited global literature on what impact each subsequent year of the pandemic had on the overall well-being of emergency nurses and how the compounding nature of COVID-19 may have contributed to increased attrition rates in the nursing workforce. Findings from stage 1 of this study demonstrated the experiences emergency nurses had during the first year of the pandemic. Lived experiences described by the emergency nurses at this time included managing the changes to clinical practice, impacts of the media, dealing with personal protective equipment (PPE) challenges, managing personal and professional ethical challenges with lack of COVID-19 treatments, and the fear of being infected with the virus.[14]

This longitudinal study aimed to explore the lived experience of emergency nurses throughout the COVID-19 pandemic, with this paper focused primarily on the second year of the pandemic within Australia.

Methods

AIM

This research aimed to continue to explore lived experiences of Australian emergency nurses working on the frontline 2 years into the COVID-19 pandemic.

Research questions that were addressed included:

1. What were the lived experiences (eg, feelings, attitudes, and perceptions) of 10 Victorian nurses working in the emergency department during the second year of the COVID-19 pandemic?
2. What perceived impact does working in the emergency department during a global pandemic have on nurses?

DESIGN

The study used a qualitative research design, informed by an interpretive hermeneutic phenomenological approach.[15] By incorporating an emergent design in this study, it allowed for study evolution during an unprecedented global pandemic.[16] This paper will explore the second of 3 stages of data collection, which was undertaken in 2020, 2021, and 2022. Findings from 2020 have previously been reported.[14] The second stage of this longitudinal study was to capture how the lived experiences of 9 emergency nurses

TABLE
Participant characteristics

Participant characteristics	n or mean
Sex	
Male	2
Female	7
Age (y)	40.3
Country of birth	
Australia	7
Kenya	1
New Zealand	1
Education level	
Undergraduate degree	3
Postgraduate qualification	2
Master's degree	2
Doctoral degree	2
Working history (y)	18.8
Employment region (Victoria)	
Metropolitan	6
Regional	3
Employment status	
Casual or temporary	1
Part-time	6
Full-time	2
Marital status	
Single	3
Married	6
Children or caring responsibilities	
Yes	6
No	3

evolved over the COVID-19 pandemic, highlighting the key moments that affected their feelings, attitudes, and perceptions toward work in the emergency department at this time in history.

POPULATION

The study population comprised 9 Australian emergency nurses residing in Victoria, 3 from regional hospitals and 6 from metropolitan hospitals (Table). All participants were the original sample of registered nurses recruited in phase 1 of this research project in 2020, as outlined by Jackson et al.[14] One participant from the original sample of 10 chose not to participate in the second phase of interviews due to time constraints. Participants ranged from 23 to 58 years of age and varied from graduate to nurse unit manager, having 2 to 38 years of clinical experience. Participants completed a consent form and were provided with a plain language information statement before their scheduled interview, where verbal consent was also attained. The relevant university human research ethics committees granted ethical approval for this project.

DATA COLLECTION PROCEDURE

The original sample of 10 emergency nurses were contacted by email by the lead author to inquire whether they would like to participate in a further interview regarding their COVID-19 experience. Of the 9 participants who agreed to participate for a second interview, additional signed consent was obtained. Data collection was undertaken using a semistructured interview approach, allowing robust discussion of thoughts, feelings, and attitudes from participants. Participants were asked open-ended questions similar to the first phase of data collection in 2020, with the addition of a reflective element. Participants reflected on the key discussion points raised in 2020 to gain an understanding of the changes that occurred or identify similarities in their experiences 1 year on. Data were collected in line with COVID-19 restrictions, with all interviews conducted via Microsoft Teams (Microsoft Corp., Redmond, WA) and Zoom Video Communications, Inc. (San Jose, CA). Data collection was undertaken in October to November 2021, with interviews ranging from 48 to 100 minutes in duration. Data saturation was reached by the 8th interview, with 1 additional interview conducted to confirm this theory. Saturation was achieved when no new themes were recognized within interview sessions, and it was determined that there were sufficient data for the study to be replicated.[17]

Interviews began with an open-ended question in the hope of generating a genuine dialogue. Questions asked of participants included:

- Tell me about some of the COVID-19 experiences and observations you made at work during the last 12 months.
- How does your clinical environment look and function 12 months since we last spoke? What are your feelings and attitudes toward this clinical environment?
- What are your feelings toward coming to work now during the pandemic?
- When I interviewed you 12 months ago, there were a number of key points that you made regarding your

2020 COVID-19 experience; can you describe how you feel about these now?
- What do you think the next 12 months will look like for you?

DATA ANALYSIS

Data were transcribed verbatim and underwent thematic analysis using the Braun and Clarke[18] 6-step approach to thematic analysis. Data analysis was undertaken by all members of the research team to avoid bias and promote unanimous decision-making on research themes. First, researchers distributed the transcripts randomly among the team and then drew out codes individually. Second, the researchers combined initial codes, refining and generating initial themes. Finally, robust discussion on inclusion and exclusion of codes and the formation of major and minor themes was undertaken to ensure participant experiences were represented appropriately.

RIGOR

To highlight the reliability, validity, and rigor of data achieved in this qualitative study, trustworthiness has been addressed with the exploration of credibility, dependability, confirmability, transferability, and authenticity of the project and the chosen methods.[16,19-21] To achieve credibility, a peer debriefing method was used within the research team during data collection. Furthermore, given that this was the second phase of data collection with the same sample of emergency nurses, prolonged engagement achieved deeper understanding of individual nuances of participants from first interviews. Dependability and confirmability were achieved in the rigorous process logs, such as researcher COVID-19 journals, notes from participant interviews, and documentation of engagement with participants shared in meetings among the research team. These shared logs were designed to confirm outcomes, with methods experts ensuring all processes were in line with research frameworks. Although specific findings may not be generalizable to other populations within qualitative research, ensuring robust documentation of data collected, with rigorous research process logs, transferability was achieved. Finally, authenticity of the project was demonstrated in appropriately representing participants' experiences through quote excerpts. By ensuring a broad sample of emergency nurses from varied ethnicities, ages, and experiences, an appropriate representation of the population was achieved.

Results

Data analysis resulted in a total of 3 major themes and 12 minor themes being extracted from the data. These themes embody the experiences of the 9 emergency nurses 2 years into the COVID-19 pandemic and after the development of COVID-19 treatments and vaccines. The 3 overarching themes included the following: On the floor each day, Can I keep going? and What's around the corner? (Figure).

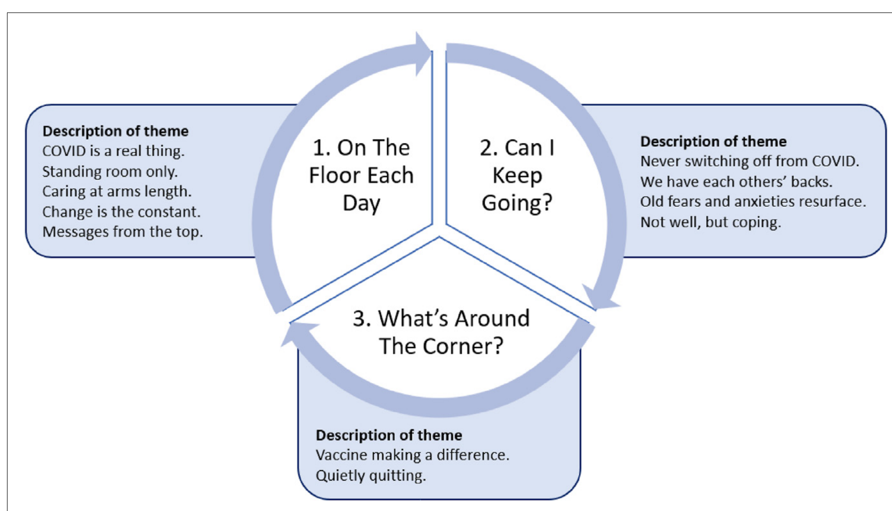

FIGURE
Major theme model. COVID, coronavirus disease.

ON THE FLOOR EACH DAY

In the first major theme, the emergency nurses discussed what it was like to work clinically now 2 years into the COVID-19 pandemic. Here they described the difficulties in treating patients who did not believe COVID-19 was real. The emergency nurses described how their departments now looked and discussed the moral challenges in witnessing substandard care and the inability to provide personal touches to their care with the ongoing use of PPE. The emergency nurses reflected on the changes that were now constant within their departments, and how they were now learning to live with the virus. They identified a lack of transparency from executive departments, with failing communication exacerbating concerns within nursing daily practice.

COVID Is a Real Thing

The emergency nurses described the daily issues they faced surrounding patients who refused to believe COVID-19 was real, despite testing positive and presenting to the emergency department for medical assistance. The emergency nurses "had people [who] refused to get swabbed" (P5), "saying they're unvaccinated and they want to be treated" (P9):

> I feel the frustration because 9 times out of 10 they [the patients] haven't been vaccinated. They haven't been following the lockdown orders, and so it really makes me quite angry and like they've put themselves in this situation. (P5)

The emergency nurses described feeling "annoyed" (P6) with the behavior of these patients who were noncompliant with lockdown orders, because this behavior "affects how I have to work" (P6).

Staff highlighted that "low health literacy and low level of understanding and ability to critically analyze the information" (P6) may have contributed to this behavior:

> We had a woman who came in, she tested positive to COVID, and she just said no, I don't have COVID, COVID's not a real thing. Then she refused to leave the hospital because we haven't treated her pain. And it's like, you've got pain because you've got COVID, and she's like no, it's not a real thing. (P9)

Can't Come in Here, Standing Room Only

The emergency nurses described the increase in presentations they were managing on a daily basis, with the growth of COVID-19 cases in addition to their general acute presentations. They outlined that "wait times for these patients are blown out exponentially and I feel that then the care is substandard" (P8). The emergency nurses described how "you can't keep an eye on what's happening… I can see how the waiting rooms are becoming diabolical" (P9). One emergency nurse described how the waiting room had a makeshift "buddy system" to help with the backlog of COVID-19 patients:

> If anyone's deteriorating, it was whoever the patient's sitting next to is your buddy. One patient would be looking after another patient and alerting each other. There was no way that we can oversee everyone. (P5)

The emergency nurses described how there was "not enough staff to cover the number of patients coming in" (P9); "we all felt very unsafe working out in triage. Quite often it was a ratio of 1:60 and a line 10 to 15 people deep" (P5). Despite these conditions, the emergency nurses were "still very privileged and honored to be there for them [the patients] during one of the scariest times in their life" (P4). With ongoing restrictions preventing family members attending their loved ones in hospital to reduce transmission of the virus, "the [patients] are on their own, so we have people who are very, very sick, very vulnerable without any loved ones beside them. And that is very difficult to see" (P8).

Caring at Arm's Length

The emergency nurses described what it was like having their patients and colleagues unable to see their faces for the last 2 years due to PPE. For patients who were "scared and vulnerable" (P8), the emergency nurses described how "very difficult" (P8) it was that they could not provide more personal care in times of need; "they've got a stranger who is in full PPE as their only support person" (P8):

> The patient hasn't seen my face in 18 months, we've always been behind a mask. Trying to communicate with your patients and sit there, I miss sitting there and holding their hand… You just don't get that rapport, and contact with your patients has changed so much. I do feel like another robot, another PPE face walking into a patient's room. (P4)

Losing this personal touch was "difficult" (P4), how "you don't get to enjoy each other's smile and voice and personality" (P4). This loss was something "I miss a lot in nursing" (P4):

> Communicating with patients, I think wearing masks and goggles and now PPE, a huge amount is lost in what patients see and the emotions that's exhibited and how you convey a message to someone. It's just massive amounts of what we do as nursing staff I think is lost in that. (P10)

With ongoing restrictions on how the emergency nurses could provide their normal care, they were concerned that this would be "the new norm, and nurses now will start accepting the practice as the norm. That worries me and I don't think I want to work in a place like that" (P8). Challenges in "substandard care" and delayed care for patients "goes against all my values of triage and what we do" (P8). These sentiments were shared with senior emergency nurse educators, who were concerned with how the future of nursing care might look:

> My concern was that we were starting to miss things, or not provide the education that we should have around other things that would create big safety concerns later on by not having that information known by nurses. That was my big challenge. (P6)

Despite the challenges emergency nurses were facing, many could still see why they remained in the profession, that it was "special" (P7 and P4). When seeing patients who had recovered from COVID-19, "you go home just feeling like your cup's full" (P4):

> I still really enjoy the job that I do. And I think too, you know it's a shame, to have a love like that, you don't want to lose that. It's a very special place to be. I think you're very privileged being in that position looking after people. (P7)

Change Is the Constant

When reflecting on changes that had occurred within the last 18 months of the COVID-19 pandemic, the emergency nurses recognized that change was now constant. Senior staff described being "expected to read our emails on days off and get across new flow charts, new flow sheets, new workflows, and just as you get a handle on those, it'll change again" (P9):

> I think with the constant changes with COVID, although it's been a massive change with lots of constant little changes. We're still not at a period of acceptance and getting on with things. (P10)

Emergency nurses recognized that being in this profession, they could be "moved around as required" (P6), if things changed "you'll move with it" (P6); however, this change had been "so ongoing" (P6). Some senior staff highlighted that "structure-wise, things are coming to place, and it looks like the focus is managing this for the long run" (P2). However, this structure was beginning to lose its foundations, with the loss of senior staff:

> We started writing a list of all the names of staff members that have left since the beginning of COVID and we stopped counting at 60 in the last 18 months or so. We've lost over 60 staff and that is both trained and just grade 2's [2nd year registered emergency nurses]. (P5)

Many of the emergency nurses felt that the future was beginning to look uncertain, both for their profession and what was happening beyond the walls of the hospital; they "didn't know what was ahead of us" (P7). When discussing "Freedom Day," a day when lockdown restrictions were lifted in Victoria, Australia, and the public could resume daily life, some felt that "it's a Band-Aid that needs to be ripped off. The time is going to come" (P10) and "just rip it off, let's see what happens. Shit's hit the fan, so let's just let the fan spin" (P9). For others, they felt "nervous" (P5) and "anxious" (P7) about what was to come:

> We still haven't hit the end yet, and I don't know if there will be an end for us. There might be an easy, but I don't think there will ever be an end. So I think that's something we all need to learn to live with. (P3)

Change remained constant in clinical care and how the clinical environment looked and functioned. When managing these changes and the need for more staff, the emergency nurses felt that their organizations were "not bringing them [staff] in quick enough to train them up" (P6). Although the "panic" (P2) may have "subsided" (P2), there was still a long way to go:

> It just feels like the system is broken and it's never going to get any better. And then you add some COVID surge on top of that, and the governments out there, and the news is saying "we're prepared, we've had 18 months, we're all over this," and we're not in any way shape or form "all over it." (P9)

Messages From the Top

As the pandemic continued, emergency nursing staff continued to feel that the "transparency" and "communication" (P6) from the executive level of the hospital were "quite poor" (P6). At times, staff found that if they had "problems," their managers "can't be part of the solution"

(P6) if they were nonclinical. The lack of being "listened to" (P5) was taking a larger toll on the workforce:

> No one was listening much to the nursing staff and how unsafe we were feeling. That was probably one of the main things that we were frustrated about, that we weren't being listened to. (P5)

From a senior management perspective, emergency nurses recognized that it was "open communication" that "really motivates the staff" (P2). For some emergency departments that were able to maintain open communication within their departments and when communication was "considered" (P6), the rewards were realized:

> Effective communication and closing the loop is just the easiest thing we can do, or the cheapest thing we can do, or the most effective thing we can do to keep the team on track and keep people safe. It's been an absolute godsend. (P10)

However, not all communication was beneficial, with the nurses now outlining that their organizations would send "text messages, perhaps 10 times a day" regarding the "short staff" issues (P8). These messages were making the emergency nurses feel "obliged to go in" (P8):

> Everyone is being pushed, most of the time we are being asked to do doubles. So over the past 2 weeks, I've done 2 doubles, so I've done and AM [shift] and a PM [shift] and then did a PM [shift] and a night shift with one day off and then back on an AM [shift]. (P3)

CAN I KEEP GOING?

Within the second major theme, the emergency nurses described the increasing pressure, loneliness, and lack of support that were occurring. There was no reprieve from COVID-19 discussions, with home and social life now mirroring the same conversations as in the workplace. The emergency nurses discussed the positive impact of strong collegial connections, while also highlighting the trauma and anxiety that would resurface with each new wave of the virus. Maladaptive coping strategies were mentioned, with some newer healthy habits implemented to protect well-being.

Never Switching Off From COVID

With the pandemic now a common point of discussion in both the professional and personal lives for the emergency nurses, COVID-19 was "the same topic repeated, you just get sick and tired of it" (P2). They described "not being able to switch everything off from COVID" (P10):

> It's never gone, COVID is a big thing at work, it's in your social life…it also means that the family unit functions differently. (P6)

When discussing the impact on their families, the emergency nurses were more "worried" (P4) of passing it on to others than contracting it themselves. For some who had "2 small kids at home," they were "very, very aware of what I take home and knowing that they're not vaccinated, it's always in the back of my head" (P10):

> I think I'm not too scared of contracting it myself, I'm double vaccinated now. I take all the precautions, I wear my PPE properly. I think I'm more worried of now that things are opening up, of contracting it, being asymptomatic and passing it on to someone. (P4)

Some emergency nurses described how they would not stay with family and that "it wasn't until everyone in the household was double vaxxed that I felt a little bit more comfortable going there" (P5). For others, it was family and friends who were "hesitant" (P4) to see them due to their high-risk work. Emergency nurses outlined how extended family would "minimize their risk of coming and helping us" (P6) and how "that really isolated us as a family" (P6).

We Have Each Other's Backs

Although the emergency nurses continued to be isolated from family and friends, they formed stronger collegial bonds; "the nurses are trying to support each other and I think they're only doing it for each other, not necessarily for the organization" (P8). The nurses described that the hospital environment was "one of the rare places whereby you could still work with people face to face" (P2) rather than online or remotely. It was encouraging that although there was suffering, there was also support; "I always feel so supported" (P4):

> The team I've got I think are a good one and are in it for the long haul, and I'm more invested in them than the role to be honest. It's not necessarily the role that keeps me here, it's the team. (P10)

When discussing formal debriefing opportunities from an organizational level, the emergency nurses described "that there has been still minimal change in the opportunities to debrief" (P4), which was caused by social distancing requirements, and "it just hasn't been a priority"

(P4) and "there's no opportunity" (P8). The nurses found this "really heart breaking" (P4) and "lonely" (P6), having to "go into the tearoom and you're only allowed to go to the tearoom by yourself" (P6). This lack of opportunity to debrief compounded by the heavy workloads, where senior ED management was torn between looking after their staff well-being or covering all positions within the department:

> Encouraging staff to take a break when they can, or to not pick up the extra shift if they don't feel they can, but at the same time begging them to pick up their shifts. (P10)

For some, there was still light at the end of the tunnel during their "harder days" (P10). At times it was "reinvigorating" (P10); "even all the pressures we've had over the last 2 years, I still want to be there" (P5). For others who had been in the profession for many years, they wanted to see it survive and thrive in future:

> We're not going to live forever, but it would be good for me to know that there's some dedicated staff that will stay on and continue to support that department. (P7)

Old Fears and Anxieties Resurface

The emergency nurses began to describe their mixed feelings toward coming into work, now almost 2 years into the pandemic. For some of the nurses, they described how they would "get more anxious as the day goes by… A bit anxious not knowing who I'm working with, what I'm going to face" (P4):

> People are left with, I hate to say it, but a bit of trauma; it just brings back a memory of how uncomfortable you felt last year and that fear, and they're almost back there again. (P6)

Not knowing what they would face on any given shift, the emergency nurses described it feeling like "a tidal wave, we're waiting to see if the tidal wave is going to hit us and it didn't really" (P7). Within Australia, COVID-19 cases became severe toward the end of 2021, with emergency nurses perpetually waiting for what was to come:

> People are all excited about Christmas, but that's when they're saying we're going to get 6000 cases a day or something. I don't think the general population is ready for that. I think they are very ignorant to what happens within the emergency department. (P3)

At this time, regular "disconcerting" (P9) antilockdown protests were common within the streets of Australia, causing ED staff to be "highly anxious" knowing that "there was going to be a surge" (P3) in COVID-19 cases due to increased likelihood of community transmission.

Not Well, but Coping

During times of high stress and pressure for emergency nurses during the COVID-19 pandemic, they outlined beginning to notice maladaptive coping strategies; "I started drinking far too much alcohol" and "I put on a few kilos" (P6). The nurses had also "not been afraid to call in sick if I just can't hack another shift for the week, just out of pure exhaustion" (P4). The nurses could see that "staying in the hospital is going to be hard for a couple more years to come" (P6) and that "I'm actually not enjoying nursing as much in the hospital environment. I didn't think I'd get to that, but I have" (P6):

> I feel quite guilty at the thought of leaving, but I'm also excited at the thought of leaving and not being a part of it anymore I think, I am that fatigued now. (P6)

Conversely, there were some healthier habits that had been implemented by the emergency nurses since the beginning of the pandemic. Habits such as "journaling" (P3), "mindfulness" (P7), "counseling," and "exercise" (P4) were becoming part of their routine:

> I go and see a psychologist and a counselor and everything because there have been a lot of moments, and a lot of patient cases and a lot of family members that have really, I wouldn't say it's caused PTSD, but just caused a lot of anxiety and sadness and it's been definitely a very hard time to nurse through. (P4)

For some, "having a better morning routine, so morning stretches, sitting out in the sun, grounding work" (P3) was helpful, alongside "a lot of meditation and fasting and increasing my exercise, which, it's sort of fallen by the wayside with all of the shift work" (P4).

WHAT'S AROUND THE CORNER?

Within the final major theme, emergency nurses discussed the positive impact the vaccine was having on their patient's morbidity and mortality; however, it had ethical concerns around mandating the vaccine. They discussed the emergence of burnout and how it was beginning to manifest in their work and personal lives. For some, who had begun implementing plans to leave, it meant no longer working in the profession. Others were unsure of what the future

may hold for their careers within the emergency department.

Vaccine Making a Difference

In 2021, treatments and vaccines were becoming available for health care workers and vulnerable populations. The emergency nurses could see that the vaccine was making a difference to patient outcomes:

> Through our own observations I can tell you, the people who are vaccinated are less likely to be as sick as someone who is unvaccinated, so it's those unvaccinated people who we are most fearful for because they are the ones becoming so unwell and so fast. (P3)

The emergency nurses experienced "a lot of sick patients and patients that are younger and deteriorate so quickly…they've all been unvaccinated" (P4). For those severely unwell patients, the nurses spoke about the patient's family "begging" for the vaccine, "explaining to family members that we can't give the vaccination to your family members right now" (P4). The efficacy of the vaccine was 1 factor that made the emergency nurses feel safer both at work and at home; "as soon as the vaccination came on board, I felt better immediately… I just felt so much safer" (P6).

The emergency nurses highlighted that not all elements of the vaccine rollout were positive for them, particularly the vaccine mandates for health care workers; "I don't agree with holding a gun to people's head metaphorically and saying, you must be vaccinated to keep your job" (P6). The nurses saw "quite a few nurses who have resigned because of the mandated vaccination requirements" (P8):

> This is where my values and my ethical dilemma is, as a nurse, I believe that people should not be coerced or be mandated for vaccinations, that no one should be made to put a substance into their body that they don't choose to. In saying that, there's a pandemic, and I want the majority of populations, especially vulnerable populations to be protected, so I'm torn their ethically. (P8)

Quietly Quitting

Discussion of being "burned out" (P3, P5) was a key feature within interviews, where emergency nurses described the factors that had led to their feelings of losing "compassion" (P7). From having "moments of frustration that I never thought I would have" (P10) to having no "attention span" (P7), "I wasn't letting people finish their sentences…no patience at all, nothing, not even for my family" (P7):

> My feelings are, aw f**k, I don't care. I haven't got the capacity to care. Especially now with so many people coming in who are not vaccinated who have got COVID and who just seem like they haven't seen the news for the last 2 years. (P7)

When looking toward the next 12 months, some emergency nurses had made "the decision to leave" (P9). For others who remained in the profession, "some days I go, I don't really wanna go back. I know what I've got in front of me" (P10). For some, the future was uncertain. They could see that "there will be people who will be changed by this" (P3), which may mean "they reconsider their career in nursing" (P3):

> It's day to day. It's different. There are some days that you feel really refreshed and excited to come into work and then there are other days you're like, I just don't want to be here anymore. (P5)

Discussion

This research aimed to continue to explore lived experiences of Australian emergency nurses working on the frontline in the COVID-19 pandemic. These findings present a snapshot in time of the second year of the COVID-19 pandemic within Victoria, Australia, and how this affected emergency nurses physically and psychologically. The second stage of this longitudinal study was to capture how the lived experiences of 9 emergency nurses evolved over the COVID-19 pandemic, highlighting the key moments that affected their feelings, attitudes, and perceptions toward work in the emergency department at this time in history.

Findings from this study demonstrate the ongoing mental and physical impacts of the COVID-19 pandemic on emergency nurse populations. These findings from 2021 in the second year of the pandemic within Australia showed marked differences to experiences in 2020. In stage 1 of this study, the emergency nurses outlined that they experienced a great sense of unknown, fear, and concern surrounding the effects of the COVID-19 pandemic.[14] In this study, the emergency nurses sighted less fear toward the clinical impacts of COVID-19 with the introduction of vaccinations and available treatments. The prominent experience emergency nurses were now outlining was the ongoing relentless nature of their work, with no respite to be realized in the immediate future.

Similar to findings demonstrated by Armstrong et al,[10] despite fluctuating lockdowns, and overall lower caseloads and death rates of COVID-19 in Australia, increasing levels of burnout were realized within the sample of emergency nurses. Although lockdowns were becoming less common and more freedoms were granted for the overall population, the emergency nurses highlighted their levels of overall well-being were decreasing. This may be attributed to evidence of a "compounding effect" of stress on the population. Exposure to greater numbers of stressful events over a long period of time is associated with poorer health outcomes.[22] The effects of chronic stress on the brain become evident when an individual experiences prolonged anticipation and reactivity to events, with a lack of habituation.[23] With repeated exposure to the unknown and a lack of familiarity in the working environment, the emergency nurses were exposed to a chronic stress environment. The emergency nurses in this study were required to shift thinking, practice, and behavior on short notice, with little time to adjust to a new norm. It is not yet known how this chronic state of stress will affect the nursing workforce; however, greater numbers of nurses globally are leaving the workforce.[24] Research reveals that COVID-19 has affected emergency nurses' intentions to leave the profession in the imminent future.[25] Further findings from Armstrong et al[10] demonstrated that with increased age came increased resilience of health care workers. In this study, both newly graduated nurses and nurses in senior leadership roles expressed an intent to leave the profession due to the unrelenting pressure of the role, suggesting that age and experience level may not have affected the outcome. Greater insight and reflective practice discussion was evident in the senior nurses of this study; however, emergency nurses of all experience levels expressed emotional exhaustion, and they desired more support from their workplaces. These findings aligned with global frontline nurse experiences, with staff wanting better working conditions, more regulation of hours, and their workplaces to better understand and acknowledge their work.[12,13]

A key protective factor for emergency nurses' well-being in this study was support from colleagues and comradery. The nurses outlined how it was their colleagues' and their desire to support and protect their colleagues that kept them returning to work. They highlighted that, during lockdowns, their workplace was somewhere they could interact with others, discuss concerns, and share ideas. This sentiment was shared within global COVID-19 literature, with nurses stating a sense of gratitude they felt from their workplace team connections.[26] With comradery comes mutual trust, a sense of family, and pride and passion in work being performed.[27] Globally, comradery, culture, and rituals within nursing and other workplaces are a strong protective factor for staff well-being, requiring more investigation into how this tool can be used in the peri-COVID-19 era.[26,28] This finding offers an opportunity for future research that might take a focused look at the role of comradery and those activities that help create, maintain, and strengthen this untapped human resource.

Limitations

Although this study had many strengths such as the richly deep and longitudinal nature of the responses gained from each participant, it was not without limitations. One of the original 10 participants could no longer continue in the study due to time constraints and personal demands. Due to the timing of second interviews just weeks before the introduction of the Code Brown emergency response in Victoria, Australia, participants voiced their lack of availability in time and capacity for interview. Due to this increased strain placed on health care workers during the subsequent waves of COVID-19 cases in Victoria, nurses may have been reluctant to engage in any further activity such as research outside of working hours. In addition, although an appropriate cross-section of emergency nurses was achieved in this project, findings may not be generalizable to other Australian states or countries.

Implications for Emergency Nurses

Findings from this study highlight the ongoing negative impacts on the personal and professional well-being of emergency nurses. The impact of staff well-being continues to affect the attrition of nurses from the workforce on a global scale.[24] Increasing staff attrition, particularly the loss of senior staff within the emergency department, has the potential to affect the quality and availability of appropriate acute care in the department. By understanding the negative compounding nature of the COVID-19 pandemic on emergency nurses, this may provide insight into specific moments or trigger points where low levels of well-being were irreparable, ultimately leading to their leaving the profession. Understanding how and why these moments occur may allow for a more proactive method of well-being protocol implementation, which may assist in improving worker well-being, improving levels of job satisfaction, and improving comradery among all levels of the emergency nursing workforce. Exploring the power of comradery within the emergency department may provide

insight into the creation of resilient teams. More research is required on the compounding effects of disasters and events that affect well-being and the livelihoods of nursing workforces, exploring mental and physical impacts not in isolation, but collaboratively.

This study presents findings from the second of 3 stages of data collection for the broader longitudinal project, undertaken from 2020 to 2022. Subsequent findings will be made available after analysis.

Conclusion

As the COVID-19 pandemic continued into 2021 and beyond, unrelenting work pressures continued to mount on the emergency nursing workforce. In the second year of this longitudinal study on emergency nurse lived experiences, staff outlined the continued strain of the profession, highlighting their increasing levels of burnout and identifying early stages of trauma response. Unsure whether they could remain in the profession due to the impacts on physical, mental, and social well-being, the emergency nurses were uncertain of what their future may hold. Greater emphasis on staff well-being within the emergency department is required for future maintenance of a resilient and healthy workforce. Without this, lack of support for subsequent nursing cohorts may affect the quality and reliability of care being provided in acute care centers.

Data, Code, and Research Materials Availability

Ethical approval for this project was granted by the Federation University Human Research Ethics Committee, approval number: A20-095.

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Author Disclosures

Conflicts of interest: none to report.

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