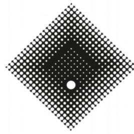

VICTORIA UNIVERSITY
MELBOURNE AUSTRALIA

“I Just Know if I Keep Going, I'll End Up Hating Nursing.” Lived Experiences of Emergency Nurses Three Years Into the Global COVID-19 Pandemic

This is the Published version of the following publication

Simic, Megan R, Porter, Joanne E, Peck, Blake and Mesagno, Christopher (2024) “I Just Know if I Keep Going, I'll End Up Hating Nursing.” Lived Experiences of Emergency Nurses Three Years Into the Global COVID-19 Pandemic. Journal of Emergency Nursing, 50 (3). pp. 425-435. ISSN 0099-1767

The publisher’s official version can be found at
https://www.sciencedirect.com/science/article/pii/S0099176724000187?via%3Dihub
Note that access to this version may require subscription.

Downloaded from VU Research Repository https://vuir.vu.edu.au/48296/

"I Just Know if I Keep Going, I'll End Up Hating Nursing." Lived Experiences of Emergency Nurses Three Years Into the Global COVID-19 Pandemic

Authors: Megan R. Simic, BN (Hons), RN, Joanne E. Porter, PhD, MN, GradDipCC, GradDipHSM, GradCertHeD, BN, RN, Blake Peck, PhD, BN (Hons), RN, and Christopher Mesagno, PhD, MSESS, BS, Churchill and Ballarat, Victoria, Australia

Contribution to Emergency Nursing Practice

- The current literature on emergency nursing during the coronavirus disease 2019 pandemic indicates that nurses are leaving the profession at rapidly increasing rates, with impacts on health and well-being, ultimately leading to increased levels of anxiety, depression, and post-traumatic stress.
- This article contributes knowledge to the Australian emergency nursing experience 3 years into the coronavirus disease 2019 pandemic and after the major 2021/2022 summer virus outbreak. A key strength was the longitudinal contact with the same sample of emergency nurses, resulting in greater depth of findings.
- Key implications for emergency nursing practice include implementation of professional boundaries such as policies on work communications outside of working hours and allowance for staff to take accrued leave entitlements and to provide input into professional practice and culture guidelines within the department, which may enhance role satisfaction and increase intentions to remain in the emergency nursing workforce.

Abstract

Introduction: As the coronavirus disease 2019 pandemic continues globally, the personal and professional pressure on health care workers continues to accumulate. Literature suggests that as the pandemic evolves, nurses are experiencing increased levels of anxiety, depression, and post-traumatic stress, ultimately leading them to voice intentions to leave the profession, if they have not done so already.

Methods: Informed by an interpretive hermeneutic phenomenological approach, this longitudinal study was designed to capture how the lived experiences of 9 emergency nurses evolved over the coronavirus disease 2019 pandemic, highlighting their feelings, attitudes, and perceptions toward working in the emergency department at this time in history. Interviews were undertaken in June 2022 and were analyzed using a thematic analysis approach.

Results: Data analysis resulted in a total of 2 major themes and 8 minor themes. The 2 major themes included "exposed wounds" and "Band-Aid solutions." Levels of burnout increased during the pandemic, with most of the emergency nurse participants dropping their hours, moving roles within the profession, or leaving the profession entirely. Findings elucidate where and

Megan R. Simic, *Member,* International Chapter, is a Research Fellow, Collaborative Evaluation and Research Centre, Federation University, Churchill, Victoria, Australia. **ORCID identifier:** https://orcid.org/0000-0002-6589-1284; **Twitter:** @megsimic.

Joanne E. Porter is a Professor and a Director of Collaborative Evaluation and Research Centre, Federation University, Churchill, Victoria, Australia. **ORCID identifier:** https://orcid.org/0000-0002-1784-3165.

Blake Peck is an Associate Professor, Nursing, Institute of Health and Wellbeing, Federation University, Ballarat, Victoria, Australia. **ORCID identifier:** https://orcid.org/0000-0002-2444-9780.

Christopher Mesagno is a Senior Lecturer, Institute for Health and Sport, Victoria University, Melbourne, Victoria, Australia; and an Adjunct Senior Research Fellow, Exercise and Sports Science, Federation University Australia, Ballarat, Victoria, Australia. **ORCID identifier:** https://orcid.org/0000-0001-9417-4359; **Twitter:** @CMesagno.

For correspondence, write: Megan R. Simic, BN (Hons), RN; E-mail: m.simic@federation.edu.au

J Emerg Nurs 2024;50:425-35.
Available online 18 February 2024
0099-1767

Copyright © 2024 Emergency Nurses Association. Published by Elsevier Inc. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/).

https://doi.org/10.1016/j.jen.2024.01.003

how concerns may arise in clinical practice and holistic well-being among emergency nurses, particularly surrounding professional boundaries and protecting work-life balance and professional identity.

Discussion: As the world moves to managing coronavirus disease 2019 as a recognized common respiratory illness, providing time and space for emergency nurses to voice their concerns, design their well-being interventions, set professional boundaries, and reconnect with their professional passion may see lower attrition rates and higher levels of professional satisfaction in emergency nurses globally.

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

Introduction

As the coronavirus disease 2019 (COVID-19) pandemic continues globally, the personal and professional pressure on health care workers continues to accumulate. As the pandemic evolves, nurses are experiencing increased levels of anxiety, depression, and post-traumatic stress.[1,2] In Turkey, predictors of these experiences included a lack of organizational support, an increase in working hours, and more colleagues being diagnosed as having COVID-19.[1] In 1 study, Putekova et al[3] explored the impact of COVID-19 on 1170 nurses in Slovakia and found that 70% of respondents thought of leaving their jobs due to increased work stress and inadequate salary.

In the United States and Canada, data suggest that trauma experienced by emergency nurses during the pandemic was likened to that of trauma experienced in war or assault.[4,5] These trauma and stress experiences may cause moral injury to emergency nurses, an increasingly recognized phenomena resulting from the pandemic whereby feelings of grief, meaninglessness, and remorse arise from a transgression that violates assumptions and beliefs of what is right and what is wrong.[6] This increase in moral injury may lead to impacts on the emergency nurse's professional identity, subsequently negatively influencing confidence in one's own skills and self.[4] Conversely, when confidence is present within the workplace, empowerment, resilience, and strength in teams and decision making may be present within staff, which subsequently results in patients' perceptions of hospital experience being higher.[7] Furthermore, literature suggests that acknowledging the emergency nurse voice and empowering staff to be involved in decision making about clinical practice and personal healing after COVID-19 induced traumas may assist in maintaining a healthy and resilient workforce.[5,8]

Within Australia and globally, studies exploring the longitudinal lived experiences of emergency nurses throughout the COVID-19 pandemic are limited. To date, there are no comprehensive studies that explore emergency nurse COVID-19 experiences over time. This study forms part of a longitudinal investigation that may bring clarity to identifying the specific feelings, attitudes, and perceptions of emergency nurses during this time, providing a snapshot of what nurses experienced when they were exposed to working in the COVID-19 pandemic. This may elucidate where and how concerns may arise in clinical practice and holistic well-being among the emergency nurse population, allowing implementation of stronger, time-bound, well-being practices and professional boundaries and mitigation of adverse effects in future pandemic or epidemic events. Findings from stage 1 of this study in 2020 demonstrated the uncertainty and fear of contracting COVID-19 among the emergency nurses and fears of taking the virus home to their families.[9] In 2021, the second year of the pandemic within Australia, the emergency nurses voiced that they were feeling the early effects of burnout and frustration with the mounting pressure on them professionally.[10] This present paper will showcase the findings of the third and final stage of data collection in 2022, which aimed to demonstrate the lived experiences of the emergency nurses now 3 years into the COVID-19 pandemic within Australia and how this experience affected their thoughts, feelings, and attitudes personally and professionally.

Methods

AIM

This research aimed to explore the lived experiences of Australian emergency nurses working on the frontline 3 years into the COVID-19 pandemic.

Research questions that were addressed included:

1. What were the lived experiences (eg, feelings, attitudes, and perceptions) of 9 Victorian nurses working in the emergency department in Australia during the third year of the COVID-19 pandemic?

TABLE
Participant characteristics

Participant characteristics	n or mean
Sex	
Male	2
Female	7
Age (y)	40.3 (mean)
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 (mean)
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

2. What perceived impact did 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.[11] By incorporating an emergent, reflexive design in this study, it allowed for study evolution as the pandemic continued.[12] This paper will explore the third and final stage of a 3-stage data collection, which was undertaken in 2020, 2021, and 2022. Findings from 2020 and 2021 have previously been reported.[9,10]

POPULATION

The study population comprised 9 Australian emergency nurses residing in the state of Victoria, Australia, 3 from regional hospitals and 6 from metropolitan hospitals (see Table for participant characteristics). All participants were the same sample of registered nurses interviewed in stage 2 of this research project in 2021, as outlined by Simic et al, 2023.[10] Participants ranged from 23 to 58 years of age and varied from newly graduated nurse 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 Committee granted ethical approval for this project.

DATA COLLECTION PROCEDURE

The sample of 9 emergency nurses were contacted by email to enquire whether they would like to participate in a further interview regarding their COVID-19 experiences. Data collection was undertaken using a semistructured interview approach, allowing robust discussion of thoughts, feelings, and attitudes from participants.[13] Participants were asked 2 open-ended questions, with the objective to let participants share their lived experiences without restriction. Data were collected in line with COVID-19 restrictions, with all interviews conducted virtually via Microsoft Teams (Microsoft Corp, Redmond, WA) and Zoom Video Communications, Inc (San Jose, CA). Data collection was undertaken in June 2022, with interviews ranging from 14 to 36 minutes in duration. During preceding interview sessions with participants, rapport had been gained by deep discussion surrounding COVID-19 lived experiences.[10] This previous rapport building meant that ice-breaking methods at the commencement of interviews were not required; therefore, interviews were shorter in duration for the third stage of data collection than for previous data collection points.

Questions asked of participants included:

- Tell me a bit about your experiences since we last spoke 6 months ago.
- Have there been any changes to your role? What sort of role are you in now?
- We spoke about your experiences with "X" in our last interview; can you tell me about your experiences with that now?

DATA ANALYSIS

Data were analyzed using a Braun and Clarke[14] 6-step thematic analysis approach. Steps 1 and 2 involved transcribing interviews verbatim, replacing participant names with code for the research team to begin drawing out codes independently. Step 3 involved combining research codes for refining and development of initial themes. Steps 4 and 5 involved mapping and refining of themes to develop clear names and outcomes for themes. Finally, step 6 involved appropriate documentation of participant quote excerpts to capture the theme essence.

Within the research team, authors 1 and 2 were involved in steps 1 to 3 of the analysis process, with authors 3 and 4 assisting from step 4 to 6. This combined analysis approach ensured unbiased decision making to occur in the development and reporting of themes.

RIGOR

In qualitative research, demonstrating trustworthiness and rigor of data can be achieved through representing the credibility, dependability, confirmability, transferability, and authenticity of the project and the chosen methods.[15-17] In this study, credibility was achieved by way of the longitudinal study design, with prolonged engagement with the same sample of emergency nurses, allowing for a richer and more nuanced exploration of their experiences. Dependability and confirmability were achieved in the rigorous interview notes, reflections, and COVID-19 process logs kept by the research team, which were shared in peer debriefing sessions to confirm findings and avoid biases. Although specific findings may not be generalizable to other populations within qualitative research, transferability of this study was achieved in the documentation and reporting of all data through process logs, academic publication, and global conference dissemination. Finally, authenticity of the project was achieved by appropriately reporting participant experiences who varied in ethnicity, age, gender, and experiences through quote excerpts.

Results

Data analysis resulted in a total of 2 major themes and 8 minor themes generated from the data. The 2 major themes included "exposed wounds" and "Band-Aid solutions"

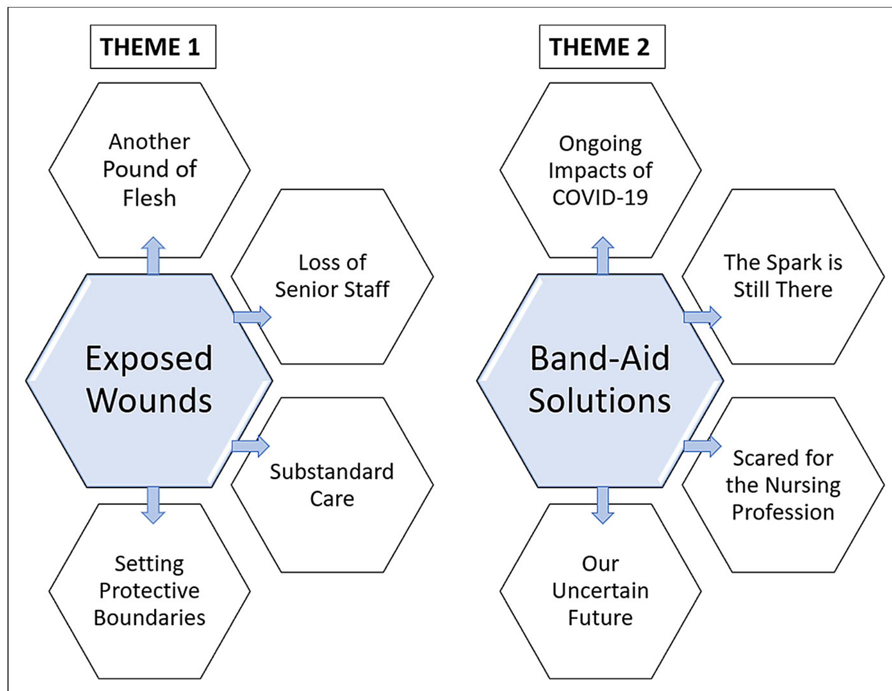

FIGURE
Major theme model.

(Figure). Levels of burnout increased during the pandemic, with most of the emergency nurse participants dropping their hours, moving roles within the profession, or leaving the profession entirely.

EXPOSED WOUNDS

The first major theme, "exposed wounds," explores how the emergency nurses managed the relentless pressures of their roles, while also attempting to manage their own well-being. The emergency nurses described being asked to work well beyond their allocated hours and noted an increase in senior staff leaving the profession, which was beginning to affect the quality and safety of care provided in the department. Dropping hours and making a conscious effort to take time to care for oneself were now occurring as the pandemic continued within Australia.

Another Pound of Flesh

Now 3 years into the COVID-19 pandemic, the emergency nurses described the increasing negative impacts of their role on their mental health and well-being and of being asked to give more of themselves to their employer than what they thought was possible:

> "Sometimes you'll get a message that will say 'there's 2 tubed patients in ED, can anyone come help?' And that just makes you feel really bad because I could go in and help with those patients, but I have a family and I think that's just the guilt." (P6)

The nurses highlighted that "I do feel like there's an element of post-traumatic stress" (P9), and when they entered the emergency department, they could "feel a lot of stress and anxiety coming back" (P9). To manage a workload that required many of the emergency nurses to forgo annual holiday leave and work longer hours, the emergency nurses described how they "pushed down and repressed a lot of my mental health issues" (P4), which ultimately returned with heightened intensity. "It all kind of bubbled up and became quite overwhelming" (P4). The emergency nurses said:

> "I feel absolutely wrecked after these last, I would say, 3 years... I feel absolutely wrecked. There's no holiday on the horizon." (P7)

When discussing the unrelenting pressures of their employment, the emergency nurses talked about "the constant text messages that come, there's like 4 or 5 a day" (P6). To protect their own time and well-being, the nurses would sometimes have to "ignore" (P6) the messages. For some, they had to step away from the profession completely:

> "I just know if I keep going, I'd end up hating nursing or something like that or my mental health would deteriorate worse or my physical health would deteriorate worse. I really struggled to get that fine balance over the last few years with nursing." (P4)

When discussing how they felt now 3 years into the pandemic, the emergency nurses described "I'm passed being burnt out, I'm into another realm. There's like a numbness now, I don't know any more what I feel" (P7). For some, they knew "I want to stay working in the ED and supporting it" (P7), but the pressure from management to work longer hours without reprieve was challenging:

> "I don't think asking people to do doubles and doing overtime is great for people's well-being. Whether or not this has all just come to light because of COVID or this has probably been a long-stemming issue and COVID just highlighted the fact." (P3)

Loss of Senior Staff

The emergency nurses not only had to manage their declining personal physical and mental well-being, but they were also managing senior staff leaving the profession and "loss of leadership" (P3) in the department. The nurses described how "there's been a huge amount of movement, in and out, more than any other time" (P2):

> "From what I can see just so many people have left that there's just not enough senior staff left to actually run the department in a safe manner at all, it's quite scary." (P9)

With the loss of senior staff, there was a loss of "reassurance that people need" (P3) from those in leadership positions in the department; "you'll see things that would have been picked up by a senior nurse much sooner" (P6). With senior staff leaving, the staff with fewer years' experience were concerned about what they were being asked to now do, in particular take on senior leadership positions:

> "I don't feel comfortable, and you can't pressure me into doing something like that. And there was probably a lot of pressure to try and move up the tree a little bit to fill in those gaps… I'm not ready for that sort of thing." (P3)

This increased pressure to step up into more senior roles "puts a greater toll on those that stay because the workforce just becomes so much more junior" (P5). From the senior staff perspective, "I see the senior staff quite desperate…it makes me really anxious… I don't want to leave them like that" (P7). Not only was COVD-19 loss of senior staff affecting colleagues, but it was beginning to affect the level of care that could be provided to patients:

> "A lot of what's happening with patients, it's really quite dangerous when they are looking at a cubicle to be a resuscitation room and you've only got junior staff out on the floor. That's just bloody dangerous." (P7)

Substandard Care

With the loss of senior staff came increasing impact on the care that could be provided to patients. The emergency nurses discussed the "substandard care" (P8) that was being provided and how this went against their nursing values:

> "You can't provide the care the patient deserves because you are short staffed. You want to provide the best care for patients, but unfortunately due to staff shortages, the care for the patients just isn't there." (P3)

The staff shortages were beginning to lead to "very poor outcomes for patients" (P7). The emergency nurses described "3 or 4 incidences in that last 2 or 3 weeks where it's been life threatening, and its due to being short staffed, not having the resources to be across a lot of this" (P7). In addition to staff shortages affecting care provided for patients, the emergency nurses highlighted that "they're [hospital management] still not allowing visitors to come in with patients unless someone is imminently dying or they've had a miscarriage or they need a carer" (P8). With a lack of focus on "person-centered care" (P8) the emergency nurses described:

> "…There is a lack of empathy for patients and compassion and reluctance to have patient advocates come with them. And that's a mixed emotion, and it goes against my ethos of nursing." (P8)

Setting Protective Boundaries

In the midst of the ongoing "frustration" (P8) of the current state of the emergency department, the emergency nurses focused more on setting "boundaries" (P6) between their work and personal life. The current working environment was no longer sustainable:

> "I definitely felt it [was] more of an unsafe environment and I just didn't want to be part of it for my own safety, but also my patients. And I know that's kind of hypocritical as well because I've left [the hospital] which leaves them [the former workplace] even more short staffed, but I guess ultimately, you've got to put yourself first sometimes." (P4)

The nurses found that either dropping hours or sharing their time between other roles was protective for their well-being. It gave the nurses "more time to do activities and keep up just around the home" (P6), which ultimately "makes you feel more in control of your life" (P6):

> "I'm finding that having a mix of roles and being able to sort of have a day or 2, or 2 days a fortnight away from physical patients is a little bit more…it's better for my own work-life balance." (P5)

The emergency nurses voiced that they were doing "the limit of what I can do" (P6). Some acknowledged that they were "taking that break from clinical nursing" (P4) and that "you do need to have a break now and then and listen to how you feel and how you're responding at work" (P4). The emergency nurses discussed how their "coping mechanisms" (P8) included "yoga" (P8), being able to "socialize" (P5), "walking the dog" (P5), and "friendship…within the workplace and outside of the workplace" (P8). Within the workplace, communication was key to feeling heard and valued as an emergency nurse in the department:

> "The staff have more voice now. Whenever staff raise issues, the issues are taken very seriously… So at least there's good communication, or lines of communication between the executives and all the staff, which was not happening before COVID." (P2)

In this first major theme, the emergency nurses highlighted that they could not give any more to their organization without it being at significant detriment to their health and well-being. Seeing colleagues leave the profession due to burnout and the subsequent impact this had on patient care increased moral distress. To protect their own well-being, the emergency nurses implemented boundaries between themselves and their workplace. However, despite implementing these boundaries, there remained a degree of uncertainty regarding their future within the department and the profession.

BAND-AID SOLUTIONS

In the second major theme, "Band-Aid solutions," the emergency nurses highlighted that although they were 3 years into the COVID-19 pandemic, they were still adapting to the many changes to clinical practice and environment. The nurses discussed that despite time passing and lessons learned, issues within the department remained unresolved and only temporary solutions were implemented. Although they continued to have a great passion for emergency nursing, the likelihood of resigning or reducing their fraction of employment was imminent for many. The emergency nurses were concerned that the profession would never recover from the impact of COVID-19.

Ongoing Impacts of COVID-19

The emergency nurses were beginning to adapt to COVID-19 changes to practice and figuring out how to manage the constantly updating virus landscape. "Now that COVID's around for almost 3 years, I think everybody has learnt how to play the game" (P2). When reflecting on how things had changed over this time, the emergency nurses reflected on how they had adapted to the pandemic with "less worry about the unknown" (P10) in the clinical environment:

> "I remember at 1 point we had a COVID positive patient in the department in an open cubicle and he'd taken his mask off for maybe 10 minutes while he was assessed… We had staff furloughed, they shut down the entire department for the day. I sort of look back and laugh at that now!" (P10)

When discussing the impact of the pandemic, the emergency nurses described that "people have developed resilience" (P2), yet COVID-19 was "just ongoing and relentless" (P8). The "strain" and "stress load" (P5) of managing COVID-19 on top of increasing acute care presentations were bringing the ED environment to boiling point:

> "We're bed blocked, we haven't got adequate beds, there's not enough staff, there's staff off sick constantly, we're still required to wear PPE [Personal Protective Equipment]. It's [COVID-19] still affecting so much. It's affecting education free time, it's affecting staff supporting each other, it's affecting staff attrition, it's affecting support for each other." (P8)

The emergency nurses discussed the political impacts of COVID-19 in Australia. Some acknowledged that "COVID has been a blessing in disguise somehow because it brought up a lot of issues that people are just quiet about in the health sector" (P2). For others, not enough had been done to highlight the increasing pressures on staff in the emergency department:

> "We just had a whole election and health care wasn't mentioned at all. And now all of a sudden, this week everyone's saying, 'Ooh, someone waited 12 hours in the emergency department.' And I'm like, yeah so what? People are actually starting to die now because we don't have the ability to do our job and I think no one's talking about that." (P9)

The emergency nurses were doing what they could to maintain their high standard of work, understanding the demands of the environment. "We expect that [ED] to always be short staffed. The workloads, it's onerous, it's busy, it's demanding" (P7). As the pandemic continued, so did the "demand for emergency services" (P2), with emergency nurses describing that "everyone's getting on with their lives but…it's not for nursing and it's not for the health environment. It's still relentless and it's still ongoing" (P8).

The Spark Is Still There

Despite the numerous challenges of the pandemic, many emergency nurses still wanted "longevity" (P5) in their careers. They were "still definitely very passionate about nursing" (P4), describing how nursing was "really a special profession" (P4):

> "I still really enjoy my job. I have bad days, but I still enjoy coming to work in the emergency department. I think that is also about the people that I work with. Hopefully even with the change of staffing, it's still the culture within the workplace that's still 1 that you want to be there for." (P5)

For some staff, they had considered "maybe it's time to step away from [clinical work] for a little while" (P10), whereas others "would prefer to look for another position in the hospital" (P7). The emergency nurses stated "burnout" (P3) and "needing a bit of change" (P3) as some of the biggest reasons to either dropping hours or resigning from their role, in addition to the moral distress of nursing in the current COVID-19 environment:

> "I have thought about seriously just resigning from the role… I haven't but I guess that's why I'm probably picking up less shifts. But I've seriously contemplated that… I love patient care and love working in

that team environment and when you can't provide the care that you want to provide, or even nearly the care, then it goes against all my values of nursing." (P8)

Scared for the Nursing Profession

When asked about what the future may hold for them and their professional practice, the emergency nurses were "scared for the nursing profession future" (P8). They stated that "no one applied for the mid-year post-graduate [certificate/diploma]" (P3). For some, this lack of confidence in the emergency nursing profession was more systemic:

> "I think the health system is broken, fully broken. The staff are not necessarily the people to fix it and I don't know who will fix it. They're [the organization] relying on the kindness of the staff and the ideas of loyalty and solidarity to keep these places going." (P9)

When looking to the future, the emergency nurses were uncertain whether they could maintain their current momentum, stating that "it's really hard to get people to perform at their peak when they're already struggling with showing up to work and worried about what might happen to them" (P10). When attempting to solve COVID-19 issues in their departments, the staff were required to "think way outside the box" (P9), with their organizations having "looked at other opportunities" (P7) to keep staff "rejuvenated" (P7), such as sharing hours across other hospital departments. Others were unsure how COVID-19 issues in the department were going to be resolved:

> "I really don't know what the answer is, if there is an answer to it? Everyone's going to say they want more money to stay, but is that really the answer? Or maybe being recognized? I don't know." (P3)

Despite implementing a range of "ideas" (P9) from reduced hours, shared roles between clinical environments, or stepping away for a break, the emergency nurses were "worried that it [nursing] will never go back to how it should be" (P8):

> "We've still seen a lot of staff leave, a lot of staff reduce their hours as well. And I guess there's no end in sight, there's not going to be, there's no easy fix, and we're all well aware of that. So, I guess long term wise, everyone's like, 'How much longer can we do this for?'" (P5)

Our Uncertain Future

When asked about whether they would stay within the emergency nursing profession, some stated their limit would be "5 years" (P2, P10). From a leadership perspective, some outlined that they were unlikely to remain in senior leadership roles due to it being "a draining role, and it's been extra draining through COVID" (P10). For those who were working toward senior leadership, there was increased motivation to stay:

> "For now, I hope to stay in the emergency department. I am working towards my CNS [Clinical Nurse Specialist], but as to the long long term, I guess, who knows really. I think time will tell as to how long things stay the way they are as to what happens. But for the immediate, short future, I see myself in the ED still." (P5)

There was a strong desire to want to continue practicing nursing in the emergency department and working with colleagues and friends who had been a source of personal and professional support throughout the pandemic. Some gave "credit to the team" for their ability to "function so well" (P10) despite the challenges of COVID-19. Others made the decision to stay in the emergency department for the immediate future because they did not feel comfortable leaving their workmates short another staff member:

> "I just can't bring myself to leave it [the ED]. I can't do it. I know too many people down there. I know what position they're in and I think morally I just can't do it." (P7)

In the second major theme, the emergency nurses reflected on how the pandemic had developed over the last 3 years and that, despite the challenges they had faced, they still had a deep passion for nursing and the emergency department. A level of hopelessness was identified in what the future may hold for the nursing profession, with many leaving and a lack of new interest in the department from students and newly graduated nurses. The future of the profession on an individual level and as a whole remained uncertain as the emergency nurses managed emotions that were at conflict with their own personal and professional identity.

Discussion

This research paper aimed to explore the lived experiences of emergency nursing during the third year of the COVID-19 pandemic within Australia. It was anticipated that by

exploring and reporting on the longitudinal COVID-19 experiences of the 9 emergency nurses, greater understanding of their thoughts, attitudes, and perceptions may be achieved. By understanding this experience over time, greater insight into supportive ED practice and policy recommendations may be developed for future pandemic and epidemic events. To date, the authors are not aware of any other study that has explored emergency nurses' experiences of the COVID-19 pandemic over an extended period.

Emergency nurses in this study highlighted that as the pandemic continued within Australia and the pressure of their role increased, so did the prevalence of mental ill health including anxiety, burnout, and post-traumatic stress. These findings aligned with Zehra and Tugba,[1] where 50% of a nursing population who were caring for COVID-19 positive patients had experienced an increase in anxiety, depression, and post-traumatic stress. Zehra and Tugba[1] demonstrated that the likely reasons for this increase in mental ill health were inadequate organizational support and an increase in working hours.[1] Emergency nurses in this study highlighted similar reasons as to why they believed their levels of burnout had increased, including a lack of professional boundaries and inadequate staffing. The feeling of being “devalued” was supported by Holtz et al,[4] where nurses felt “betrayed” by their organization, feeling as though the organization put their own priorities before the well-being of staff. The emergency nurses in this present study voiced that their organizations would call or text them outside of their rostered hours, sometimes multiple times per day. This left them feeling guilty about not attending work and concerned about the well-being of their colleagues. This fracture to moral values affected professional identity and potentially the ability to remain in a profession that could no longer protect them personally and professionally.[4,6]

Now 3 years into the COVID-19 pandemic in Australia, the emergency nurses in this study voiced that they were more readily saying no, ignoring requests to work additional hours, and spending more time looking after themselves physically and mentally. When exploring the most effective support strategies endorsed by nurses, Quon et al[8] demonstrated that nurses were most interested in self-directed healing strategies. These strategies included focusing more on social and emotional well-being: spending time with family and friends, engaging in healthy eating and exercise, and seeking counseling offered or sponsored by the workplace.[8] Emergency nurse experiences in this study of boundary setting and protective strategies included not answering their phones outside of working hours to avoid contact with their employer, dropping their employment fraction to spend more time with family or work in settings other than the emergency department, and spending time on well-being activities such as exercise and personal development. Global literature congruence with this study indicates that a greater focus on providing nurse autonomy over their personal and professional healing may encourage a more resilient and empowered emergency nursing workforce.[8]

Most emergency nurses in this study voiced that, within the 3 years of COVID-19 in Australia, they had moved roles within the nursing profession, dropped their hours, or had left the nursing profession entirely. This trend of “self-preservation” was supported in global literature by Holtz et al,[4] where perceived “hopelessness” eroded nurses’ sense of identity and Putekova et al,[3] where 70% of their nursing sample voiced intending to leave the profession because of unsustainable workloads and poor salary. Emergency nurses in this study expressed that although they ultimately moved roles, dropped hours, or left the profession, they still had a strong desire to return to the nursing workforce in the future. This key finding demonstrates that although the COVID-19 pandemic has had a profound negative impact on the professional and personal well-being of emergency nurses, they still desire to reenter the workforce after a professional break or change of environment. Limited global literature exists on those emergency nurses who desire to stay in the department and build a positive ED culture after the COVID-19 pandemic. Further research is required into fostering emergency nursing culture to support departments in future pandemic and epidemic events and in retention and recruitment of new staff.

Limitations

A key strength to this study was the contextual understanding the lead author had when interviewing participants and interpreting data. Having worked in the emergency department as a registered nurse, the lead author understood the context being described, having dialogue as a nurse colleague, with the ability to be removed from the clinical environment as a researcher. Another key strength to this study was its longitudinal nature. Documenting the evolution of lived experiences of the emergency nurse participants allowed for robust insight into key moments in the trajectory of COVID-19 and may better inform opportunities for intervention to protect practice and well-being of the nursing workforce.

Although this study had many strengths, such as the rich deep and longitudinal nature of the responses gained

from each participant, it was not without limitations. It was recognized that the ongoing impacts of COVID-19, particularly after the Code Brown emergency response in Victoria implemented to ensure departments did not exceed safe functional capacity, may have affected the nurses' ability to give additional time to research external to their professional roles. Despite the increased load on the emergency nurses, all 9 participants who remained from stage 2 of the study returned for a third interview. In addition, although including an appropriate cross-section of emergency nurses was achieved in this project, findings may not be generalizable to other Australian states or internationally.

Implications for Emergency Nurses

As the COVID-19 pandemic continues to affect the health of populations globally, findings from this study demonstrate that emergency nurses do not wish to accept current practice and protocol as "the new normal." Instead, emergency nurses are making the difficult decision to step away from their profession to protect their mental and physical well-being.

This presents an opportunity for organizations to explore options for the emergency nursing workforce to regain their professional autonomy and design their own professional healing. Nurse well-being in the workplace has been comprehensively documented by National Academies of Sciences,[18] with holistic nurse well-being described and broad clinician well-being frameworks outlined. These frameworks provide a foundation for further development of emergency nursing–specific guidelines for practice and well-being. With reduced staff availability and increasing patient presentation back to emergency departments in the peri-COVID-19 era, this puts added strain on organizations to manage workforce and admission capacity. However, it is also acknowledged that by maintaining the current practice of asking health care workers to go above and beyond their professional and personal capacity, workforce numbers will continue to decline.

Empowering nurses to reduce their working fraction to maintain an appropriate work-life balance, share their employment fraction with other departments or outside of the organization, and engage in other professional development ensures that decision-making autonomy is returned to the individual. Furthermore, implementation of professional boundaries such as policies on contact outside of working hours, allowing staff to take accrued leave entitlements, and permitting staff to provide input into professional practice and culture guidelines within the department may further enhance role satisfaction and increase intentions to remain in the emergency nursing workforce.

Conclusion

The COVID-19 pandemic has had devastating consequences on the personal and professional well-being of emergency nurses. Findings from the third year of the pandemic within Australia demonstrate that the emergency nurses in this study are experiencing high levels of burnout and poor professional satisfaction, and are voicing intentions to leave the profession if they have not done so already. As the world moves to managing COVID-19 as a recognized common respiratory illness, providing time and space for emergency nurses to voice their concerns, design well-being interventions, set professional boundaries, and reconnect with their professional passion may see lower attrition rates and higher levels of professional satisfaction. These findings present an opportunity for hospital management to review current practices within their organization, recognize the impact of the pandemic on emergency nurses, and facilitate a voice for staff to reinvigorate the emergency nursing culture for the future.

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.

Author Disclosures

Conflicts of interest: none to report.

This research was supported by an Australian Government Research Training Program Fee-Offset Scholarship through Federation University Australia. No other grants or funding have been received for this project.

Acknowledgments

The research team acknowledge the time and stories shared by Victorian emergency nurses and express our appreciation for their ongoing work and sacrifice to protect the health of our communities.

REFERENCES

1. Zehra A, Tugba P. Prevalence and associated factors of anxiety, depression and post-traumatic stress among frontline nurses during COVID-19: a

cross-sectional study. *Int J Caring Sci*. 2023;16(1):176-189. https://doi.org/10.1016/j.ijnurstu.2020.103809

2. Lin C-H, Siao S-F, Lin Y-J, Hsin P-H, Shelley M, Lee Y-H. Cognitive appraisals and coping strategies of registered nurses in the emergency department combating COVID-19: a scoping review. *J Nurs Scholarsh*. 2023;55(1):79-96. https://doi.org/10.1111/jnu.12815
3. Putekova S, Martinkova J, Urickova A, et al. The impact of the COVID-19 pandemic on the health and working conditions of nurses and its implications for policies: a cross-sectional study in Slovakia. *BMC Nurs*. 2023;22(1):185. https://doi.org/10.1186/s12912-023-01356-z
4. Holtz HK, Weissinger GM, Swavely D, et al. The long tail of COVID-19: implications for the future of emergency nursing. *J Emerg Nurs*. 2023;49(2):198-209. https://doi.org/10.1016/j.jen.2022.10.006
5. Rana R, Kozak N, Black A. Photovoice exploration of frontline nurses' experiences during the COVID-19 pandemic. *Can J Nurs Res*. 2023;55(1):25-33. https://doi.org/10.1177/08445621211064691
6. Koenig HG, Al Zaben F. Moral injury: an increasingly recognized and widespread syndrome. *J Relig Health*. 2021;60(5):2989-3011. https://doi.org/10.1007/s10943-021-01328-0
7. Owens KM, Keller S. Exploring workforce confidence and patient experiences: a quantitative analysis. *Patient Experience J*. 2018;5(1):97-105. https://doi.org/10.35680/2372-0247.1210
8. Quon AC, Vanderburgh W, Foley A. Emergency nurse consensus on most effective and accessible support strategies during COVID-19: a Delphi study. *J Emerg Nurs*. 2022;48(5):538-546. https://doi.org/10.1016/j.jen.2022.06.003
9. Jackson MR, Porter JE, Peck B, Mesagno C. "If I Can't Do It, Who Will?" lived experiences of Australian emergency nurses during the first year of the COVID-19 pandemic. *J Emerg Nurs*. 2023;49(5):733-743. https://doi.org/10.1016/j.jen.2023.05.004
10. Simic MR, Porter JE, Peck B, Mesagno C. "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. *J Emerg Nurs*. 2023. https://doi.org/10.1016/j.jen.2023.11.011
11. Gadamer HG. *Truth and Method*. Revised ed. Continuum Press; 2003.
12. Polit DF, Beck CT. *Nursing Research : Generating and Assessing Evidence for Nursing Practice*. 10th ed. Wolters Kluwer Health; 2016.
13. Jamshed S. Qualitative research method-interviewing and observation. *J Basic Clin Pharm*. 2014;5(4):87-88. https://doi.org/10.4103/0976-0105.141942
14. Braun V, Clarke V. *Thematic Analysis: A Practical Guide to Understanding and Doing*. Sage Publications Ltd; 2021.
15. Connelly LM. Trustworthiness in qualitative research. *Medsurg Nurs*. 2016;25(6):435-436.
16. Guba EG, Lincoln YS. Epistemological and methodological bases of naturalistic inquiry. *Educ Commun Technol*. 1982;30(4):233-252. https://doi.org/10.1007/BF02765185
17. Guba EG, Lincoln YS. Competing paradigms in qualitative research. In: Denzin NK, Lincol YS, eds. *Handbook of Qualitative Research*. Sage Publications, Inc; 1994:163-194.
18. National Academies of Sciences, Engineering, and Medicine. In: Flaubert JL, Le Menestrel S, Williams DR, Wakefield MK, eds. *National Academy of Medicine; Committee on the Future of Nursing 2020–2030*. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity.