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2022-03-14

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## The Lived Experience of Intensive Care Unit Nurses During the COVID-19 Pandemic

### **Background and Significance**

There are many challenges that ICU nurses have faced historically, currently and will encounter in the future due to the COVID-19 pandemic. It is important to explore the lived experiences of the nurses that provided care to ICU patients during this time. Understanding their perspective and lived experiences of being an ICU nurse during a pandemic is needed to inform care and potentially institutional practices. Many nurses are leaving the bedside now and the profession must be informed about what transpired during the COVID-19 pandemic for the bedside ICU nurse. There is a gap in the literature regarding the experience of the ICU nurse providing care during the pandemic. Lumley et al. (2020) discuss that the “unprecedented patient numbers needing ICU” has caused hospitals to increase bed capacity, to utilize staffing models that have not been seen before, and to change medical strategies (p. 203). In an article written by Rose et al. (2020), it was suggested that “visiting restrictions are causing moral injury to intensive care staff for whom in-person emotional support of family members throughout their loved one’s critical illness is integral to professional practice” (p. 1). Videoconferencing tools have been adopted by healthcare staff to communicate with patient’s family members, however utilizing this mode of communication poses its own challenge. Nurses and other healthcare providers resorted to using their own personal devices to facilitate communication with family members. In many cases nurses had to search for the hospital devices spending precious time locating the device and then locating the contact information for the family member to be reached each time a call is to be made (Rose et al., 2020). As Pattinson (2020) writes, “the weeks and months ahead are likely to prove even more challenging and when this pandemic abates, and normal critical care services resume, there must be time built into staffing rotas to regroup, come together as teams, recognize our own grief and have the opportunity to reflect on what has been achieved under extraordinary circumstances” (p. 2). It is important to provide nurses the opportunity to share their experiences in order potentially care for the caregiver as well as potentially improving the care of Covid patients. It is imperative to understand the lived experience of the ICU nurse and to understand the current state of nursing during these difficult times. Understanding how this

pandemic has affected nurses will help not only the current workforce but will allow for better preparation for the possibility of future pandemics.

### **Purpose**

The purpose of this study was to understand the experiences of Intensive Care Unit (ICU) nurses working at the bedside during the COVID-19 pandemic that provided care.

### **Research Question**

The research question for this study was; What is the lived experience of the Intensive Care Unit nurse providing care during the COVID1-19 pandemic?

### **Method**

The method for this qualitative mini-study was a descriptive phenomenological approach. Phenomenology can be described as a method that offers a “descriptive, reflective, interpretive, and engaging mode of inquiry” that the researcher may elicit the core of an experience from (Richards & Morse, p. 67). The approach that was utilized was Hermeneutical phenomenology. With this approach, “knowledge comes into being through language and understanding” (Richards & Morse p. 71). The descriptive method is used to “give a clear picture of what is going on” (Richards & Morse, p. 50).

Data was collected using an open-ended question interview guide designed by the researcher. Data was obtained by conducting individual interviews via Zoom. Consent was obtained prior to the interview via Qualtrics form. Once the Zoom interview began, the researcher went over the purpose of the study with the participant. The participant was given the opportunity to ask any questions at this time. The interview began using the open-ended interview guide. The participant was instructed that there was no limit to the answers to the questions given, and they can answer with as much data as they are comfortable providing. Once all questions had been asked the researcher asked if there is anything else the participant wanted to discuss related to this topic. This gave the participant the opportunity to discuss anything that they wanted included in their interview.

### **Instruments**

Demographic data was obtained via Qualtrics such as gender, age, education level, and years of experience as a nurse. An open-ended interview guide that the researcher created was utilized to gather data regarding the participants experience as an ICU nurse during the COVID-19 pandemic during the interview via Zoom video conference. The first question asked was; can you tell me a little bit about yourself? This question allowed for participants to describe their background in nursing and any personal information that they wanted to share. The second question asked was; I am interested in learning about your experiences as an ICU nurse during the COVID-19 pandemic. Follow up if needed for this question was, what was it like for you, and what have your experiences been? These follow up questions were utilized if the participant had a harder time articulating their experiences and needed assistance with what kind of information they should share. The interview concluded with the last question giving the participants the opportunity to add anything that they felt was not covered in the interview.

### **Sample selection and size**

Inclusion criteria for this study included: participants must be Registered Nurses that are practicing or were practicing at the bedside in the ICU during the COVID-19 pandemic and must be over the age of 18. There was no limitation as to experience level of the nurse or type of ICU that they worked in. Nurses serving in supervisory or in educational roles in the ICU were excluded. Study participants were recruited through a Registered Nurse gatekeeper to start. Snowball sampling or word of mouth was utilized after the first participant was interviewed. A total of three participants were recruited for this mini-study.

### **Collection of data and method of data analysis**

Data was collected in one individual interview with each participant via recorded Zoom meeting. Each interview lasted from thirty minutes to an hour. All Zoom interviews with participants were recorded and transcribed. Transcriptions were then loaded into the data manager. Nvivo 12 was utilized to manage data obtained for data analysis. Data was analyzed using Giorgi's (1997) five basic steps. In the first step, the verbal data was collected via Zoom interviews. Next, the researcher read all obtained transcripts before each new interview to ensure familiarity with any emerging themes and ensure

a strong understanding of the data. This step helped guide each subsequent interview and allowed common themes to be explored. In the third step the data was broken into parts or themes. This was done via coding using Nvivo 12. The fourth step requires organization and expression of the data that has been obtained. In the fifth and final step synthesis and summary of the data is completed for the purposes of sharing with the scholarly community.

## **Findings**

The sample consisted of three ICU Registered Nurses that were previously practicing at the bedside during the COVID-19 pandemic. The nurses were aged 25-44, all three were Caucasian and female. One nurse had an associate degree, the other two had bachelor's degrees and they had between 10-16 years of experience in nursing. All three nurses worked at different hospitals throughout the Dallas area. One of the nurses worked at a large hospital on the southside of Dallas. It is a teaching hospital that serves mostly the underserved population. Another nurse worked at a hospital in a suburb of Dallas that is part of a large hospital system in Texas. The third nurse worked at a hospital north of the Dallas area that is one of the main hospitals for the region.

Initial data resulted in six break in codes. These codes were anger, lack of PPE, poor patient care, sadness, safe environment and unsupported. The data was then further analyzed into 4 organized nursing codes of grief and sadness, lack of organizational support, patient care delivery and safe work environment.

In grief and sadness, they discussed feelings of sadness, anger, depression and feeling traumatized. One nurse had already sought therapy and another nurse cried throughout the interview and stated she knew she needed to seek help with these feelings. The nurses discussed that the organizations took all their support staff away, some were cleaning their own rooms, passing trays, and transporting patients all in the presence of an overwhelmed ICU. They stated that they had unsafe patient assignments and/or nurse to patient ratios. They stated that they felt abandoned by leadership and regulatory organizations such as joint commission. The nurses spoke about poor care delivery due to doctors not wanting to go into rooms and not willing to order tests that normally would be done such as CT scans as

the patients were typically not permitted out of the rooms once they were diagnosed with COVID-19.

They all spoke about the difficulty of not allowing family at bedside to make decisions. One nurse stated that the nurses could have made it work and it really bothered her that family was not allowed in the ICU.

Regarding safe work environment they all spoke about lack of PPE, reusing PPE until points that they knew they were not being protected and feeling scared to go home and possibly expose their family. The nurses spoke about using visibly soiled N95 masks and masks that were leaking air rendering them ineffective. One nurse stayed with a friend at the start of the pandemic and then transitioned back to her home where she quarantined from her family. The other two nurse quarantined from their extended families while working with COVID-19 patients. At the time of the interviews all three nurses interviewed had left the bedside. Two of the three stated that they would not go back to bedside nursing in the ICU. The other nurse did state that she would be hesitant to go back to bedside nursing in the ICU.

## **Discussion**

The findings of the mini-study were consistent with the recent literature regarding COVID-19 and studies related to nurses. A study from the American Journal of Critical Care by Guttormson et al, (2022) was recently published with similar findings. In this study surveys were sent out from October 2020 through early January 2021 through social media and the American Association of Critical-Care Nurses. Three open-ended questions focused on the experiences of ICU nurses during the pandemic. 285 answered the open-ended questions. Nurses reported stress related to a lack of evidence-based treatment, poor patient prognosis, and lack of family presence in the ICU. Nurses perceived inadequate leadership support and inequity within the health care team. Lack of consistent community support to slow the spread of COVID-19 or recognition that COVID-19 was real increased nurses' feelings of isolation. Nurses reported physical and emotional symptoms including exhaustion, anxiety, sleeplessness, and moral distress. Fear of contracting COVID-19 or of infecting family and friends was also prevalent.

## **Conclusions and Implications**

Initial data warrants further study. This mini study only included 3 nurses in the Dallas area. A full phenomenology should be conducted to add to the mini-study data to inform the broader nursing

population about the lived experiences of ICU nurses during the pandemic. This research could have implications to the general well-being of ICU nurses after caring for patients during the COVID-19 pandemic and potentially why they are leaving the bedside.

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