Narratives of Nurses Working in Intensive Care Units During the COVID-19 Pandemic

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Abstract

Rationale and aims: The COVID-19 pandemic is thought to be the greatest challenge the United Kingdom (UK)'s intensive care units (ICUs) have faced. The literature on experiences of nurses working during the COVID-19 pandemic is rapidly evolving. However, there appears to be a scarcity of research on how nurses who worked in ICUs during the pandemic construct their experiences and identities, within social, cultural and political contexts.

Methodology: A qualitative approach, specifically narrative inquiry, was employed to explore the accounts of six nurses, all of whom worked in an ICU during the COVID-19 pandemic. The nurses were both ICU-trained nurses and redeployed nurses from other departments, recruited from a specialist cardiothoracic hospital. Nurses were interviewed individually using a semi-structured format. The content and structure of their narratives were analysed, with attention to performative and contextual aspects and the construction of narrative identity.

Analysis: Nurses constructed rich, multi-layered narratives, enhancing the existing literature. Three broad stories were observed across the accounts: 1. "It came with like a bang", 2. Working in the red zone, and 3. Looking back, looking forward. Nurses faced a multitude of morally challenging situations, including an inability to provide the usual standard of care, lack of adequate personal protective equipment (PPE), and faced the danger of contracting the virus and fears of infecting others. The analysis highlighted that the nurses worked to construct credible narratives that conveyed the difficulties they encountered. This particularly can be seen within the broader contention relating to the existence of the pandemic, despite being depicted as 'heroes' by society, the Government and the media. Clinical implications and future research suggestions are proposed.

Acknowledgements

This is for you, Grace.

And to others who did not live long enough to become storytellers.

With thanks to Dr Wendy Solomons, Dr Melissa Sanchez and Ciara Collins. We got there in the end.

Thank you to my colleague, and now close friend, Emma Wallis. Without our many meetings, WhatsApps and voice notes, this research journey would have been a lonely one. Thank you for keeping me on track.

Thank you to the nurses who shared their stories with me; you made this research possible. It was such a privilege meeting you.

"And then the, the look in the eyes was exactly the same like, gosh, let's hope to get this right. Let's hope to get through this."

'Leia', ICU nurse

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List of Abbreviations

Abbreviation	**Explanation**
BPS	British Psychological Society
COVID-19	Coronavirus Disease (2019)
HCW	Healthcare worker
ICU	Intensive care unit
RCN	Royal College of Nursing
PTG	Post-traumatic growth
PTSD	Post-traumatic stress disorder
SARS	Severe Acute Respiratory Syndrome
UK	United Kingdom
WHO	World Health Organisation

Chapter One: Introduction

1.1 Chapter One: An Overview

This research explored how nurses construct their narratives of working in intensive care units (ICUs) during the COVID-19 pandemic in the National Health Service (NHS) in England during 2020 - 2021. Within this chapter, I situate the research within a particular period of history, considering the broader research the current pandemic and the role of ICUs and healthcare workers (HCWs). Drawing on psychosocial and epistemological frameworks, I set out the relevance of the topic for the profession of clinical psychology and my own relationship to this and I provide a rationale for the particular approach I take in researching the topic now.

1.2 Situating the Research

This research, taking place between March 2020 to June 2021, was developed, conducted, and written amid the COVID-19 pandemic. Nurses were recruited from a cardiothoracic hospital. The hospital began treating patients with COVID-19 disease in April 2020. The project was developed between March and July 2020, during the first wave of the pandemic. Ethical approval was obtained in August 2020 when COVID-19 cases had reduced after the first wave. Recruitment began in October 2020. Interviews took place between December 2020 and February 2021, during the resurgence of the second wave.

1.3 Epistemological Position

Epistemology is concerned with the nature of knowledge, how it is acquired and how certain we can be about its validity (Willig, 2019). The epistemological stance

adopted for this project is social constructionism, which states that our understanding of the world is constructed through language (Burr & Dick, 2017). The approach assumes that knowledge is "made rather than found" (Rorty, 1989), for particular purposes (Chamberlain, 2015), and therefore endorses a critical stance towards "taken for granted" knowledge (Burr, 2015). It favours the view that knowledge should be viewed within the complex historical, cultural and political contexts through which it is generated (Burr & Dick, 2017). This research, therefore, does not seek to discover 'truth' but rather explores how nurses who worked in an ICU during the COVID-19 pandemic construct their narratives within a particular time and context.

I write in the first person, in line with my epistemological position to the project: that knowledge is contextually and interactionally constructed, and therefore, it is not possible to disentangle myself from the topic (Hinchman & Hinchman, 1997).

1.4 Identity

How identity is defined is dependent on one's epistemological lens. As this research takes a social constructionist stance, it is assumed that individuals have multiple, co-existing identities that are perpetually constructed in and through language (Bamberg et al., 2011; Bruner, 2003). Occupational choice is one such aspect of identity. Cowin et al. (2013) noted that for nurses, a strong professional identity is important for optimal job performance.

Telling stories about ourselves is often referred to as a narrative identity (McAdams, 2011). It is proposed that narrative identities draw on broader social and cultural narratives, through interaction for the purposes of themselves and others (Cho, 2018). This also relates to the work of Neimeyer (2006) who writes that our

identities are established through the stories we tell of ourselves and others tell about us.

1.4 Conceptualising Distress and Use of Language

In exploring emotional responses to a pandemic, and witnessing severe illness and death, it is expected that many will experience distress and traumatic reactions. Although the term post-traumatic stress disorder (PTSD) prevails in both the literature and society, how emotional distress is conceptualised continues to be a moot point.

Psychological and psychiatric perspectives construct PTSD as purportedly resulting from disorganised or incomplete processing of emotions and cognitions from the traumatic event(s) (Priya, 2015). This classification, however, evades layers of context (Zur, 1996). In addition to classifications such as PTSD, trauma can be viewed as an understandable, human response to a distressing situation. The Division of Clinical Psychology (2015) adopts this view, and therefore favours the terms 'emotional distress' or 'distress response'

In line with the project's constructionist stance, it is important to question or deconstruct how knowledge and understanding take their form (Georgaca, 2013). A constructionist framework for trauma opens up space for alternative understandings for distress, and within their social, cultural, and historical contexts (Gergen, 2009) - which may or may not include dominant concepts such as PTSD symptoms (Priya, 2015; Zur, 1996). In this thesis, trauma will be defined as 'difficult events that overwhelm our usual ways of coping' (Johnstone, 2020a). This definition has been chosen because it frames suffering as understandable responses to socio-political, cultural, and relational contexts.

Whilst I critique some dominant language, I also use others. Specifically, this research holds a critical awareness to certain discourses and metaphors related to the COVID-19 pandemic. This includes metaphors of war, HCWs as 'heroes' and 'saints', and the virus itself as a natural disaster such as a tsunami. However, I use other wartime language such as 'redeployed' and 'waves' of the pandemic. These will be used in order to easily convey a shared understanding.

1.6 Situating Myself as the Researcher

In early 2020, COVID-19 had reached the shores of the United Kingdom (UK), I was finalising my ethical approval for my original thesis. This was going to be on narratives of individuals living with a heart transplant.

I never anticipated that my original research project would collapse, and I certainly did not think it would be due to a global pandemic. The hospital I had planned to recruit from, as a specialist cardiothoracic centre with an ICU, began preparing for the influx of patients with severe disease caused by COVID-19. I soon learnt that research unrelated to the COVID-19 pandemic would not be granted NHS ethical approval. My original topic had a great amount of personal significance to me, and the realisation that this would no longer be possible was a loss. However, it could be said that, at this moment, my new thesis began. It soon became a topic that I would dedicate myself to for the next 15 months.

I have felt connected to the ICU context since my childhood. Growing up, I spent time in ICUs when my youngest sister, Grace, had multiple surgeries for a congenital heart condition. I remember spending time around Grace's bed in the ICU, fascinated watching the nurses work. Grace never left the ICU, but if she had lived, she would have gone on to need further surgery, likely a heart transplant, and would

have spent more time in ICUs throughout her life. Perhaps I feel that by listening to nurses' stories of a difficult time, I am sustaining them in some way. Maybe, then, in another world where Grace had gone on to live, they would help sustain her.

1.7 Background Literature: Situating the Topic

1.7.1 Pandemics and impact on health care workers.

The World Health Organisation (WHO) (2010) define a pandemic as a global spread of a new disease. Key features of a pandemic include a wide geographic area, disease movement, multiple cases appearing in a short period, minimal population immunity, novelty, infectiousness, and disease severity (Morens et al., 2009). As the world has become increasingly connected through human mobility and global travel, infectious diseases can spread both faster and further from their origin (WHO, 2018).

Healthcare systems have played a critical role in previous infectious disease outbreaks (WHO, n.d.), however, research has shown such work can have an impact on HCWs. Research on the psychological impact of the 2003 severe acute respiratory syndrome (SARS) pandemic report that HCWs experience stress (Bai et al., 2004), social stigmatisation (Bai et al., 2004; Koh et al., 2005), burnout (Maunder et al., 2006) and trauma (Styra et al., 2008).

1.7.2 Faster, further and with more repercussions: The COVID-19 pandemic.

COVID-19 disease, caused by the virus SARS-CoV-2, is regarded as the first pandemic in a time of true globalisation (Yacoub & El-Zomor, 2020). Declared as a worldwide pandemic by the WHO on 11 March 2020 (WHO, 2020a), the COVID-19

pandemic has placed strain on many countries, exposing public health gaps and perpetuating inequities (Lal et al., 2020).

1.7.3 ICUs.

ICUs, also known as critical care (CC) or intensive treatment units (ITUs) are wards within hospitals that provide specialist treatment for critically ill patients. They emerged as a speciality in Copenhagen in 1952 which allowed the most unwell patients to be separated to allow for intense nursing support (Carter & Notter, 2020). Globally, the number of ICU beds per million population varies significantly, with 292 in Germany to one in Uganda (Schell et al., 2018). Patients may be treated in an ICU to support recovery following surgery if they are having difficulties with one or more organs, or if there is a high risk of medical complications (NHS, 2019). These patients often require close monitoring and support for vital physiological functions. ICU teams encompass a diverse range of highly skilled specialist professionals (King's Fund, 2020a), including doctors, nurses, physiotherapists, surgeons, clinical pharmacists, speech and language therapists, occupational therapists, and psychologists. Despite the reward of helping unwell people recover (Alameddine et al., 2009), ICU work brings many challenges including facing complex and novel situations, critical decisions related to patient mortality, and ethical dilemmas within time-critical circumstances (Laurent et al., 2017).

1.7.4 The role of the ICU nurse.

According to the World Federation of Critical Care Nurses (2019), an ICU nurse is a 'registered practitioner who enhances the delivery of comprehensive patient care, for acutely ill patients who require complex interventions in a highly technical

environment'. ICU nursing is a highly specialised area of nursing requiring additional training beyond a nursing qualification (Credland, 2020) and an understanding of the complex needs of each patient (Carter & Notter, 2020). Typically nursed on a one to ratio, although sometimes greater (Williams et al., 2006), nurses play a core and vital part in ICU care (Lord et al., 2021).

1.7.5 Working in an ICU: The emotional toll.

Outside of a pandemic, the challenges that come with ICU work has an emotional impact on nurses (Mealer et al., 2007). It is perhaps not surprising that quantitative studies have highlighted that ICU nurses report high levels of burnout (Poncet et al. 2007) and reported PTSD when compared with general nurses (Mealer et al., 2007). This has both a personal cost to the individual, and an organisational cost (Intensive Care Unit Society, 2020).

1.7.6 Existing ICU nursing shortages.

The most challenging element in the provision of safe and high-quality ICU services internationally is the workforce (Williams et al., 2015). There have long been a shortage of nursing staff in the NHS (Finlayson et al., 2002; Meadows et al., 2000). In 2018, one in 10 nursing posts across the NHS nursing workforce in England remained unfilled (King's Fund, 2021). It is well documented that the recruitment and retention of ICU nurses is a difficulty. Factors include further training requirements due to technology advancements (Cortese, 2012), working conditions (Stone et al., 2006), work pressure (van Dam et al., 2013), traumatic experiences (Khan et al., 2018) and seeking out jobs which are less stressful (Hussain et al., 2012). Staff shortages of NHS ICU nurses have a negative impact on the wellbeing of nurses, and

the subsequent standards of care they deliver (Faculty of Intensive Care Medicine, 2018). Ulrich et al. (2010) state that supporting the retention of nurses is preferable, due to the costs and resources involved in recruitment.

1.7.7 The COVID-19 pandemic and ICUs.

At the time of writing, it is understood that current variants of the COVID-19 virus mostly cause mild to moderate illness in otherwise healthy individuals (WHO, 2021). However, in the UK, approximately two-thirds of patients who required ICU treatment were given mechanical ventilatory support within 24 hours of admission (Mahase, 2020). A meta-analysis of international studies reported that from the start of the pandemic until 31 May 2020 the mortality rate for ICU patients with COVID-19 was 41.6 percent (Armstrong et al., 2020).

Although UK ICU teams often face complex and novel situations, the COVID-19 crisis has presented the greatest challenge to date (Carter & Notter, 2020). In early 2020, existing ICU staffing models were deemed unsustainable given the increased demand posed by COVID-related illness (King's Fund, 2020a), therefore, staffing models were adapted. The Royal College of Nursing (RCN) (2021a) highlights that this included the upskilling and redeployment of non-ICU nurses and HCWs with transferrable skills into ICUs. Nurse-to-patient ratios were also temporarily changed from one-to-one to one-to-six (King's Fund, 2020a). As Kherbache et al. (2021) state, this left many nurses 'practising on the edge of or beyond their competencies'. Further, an Austrian survey-based study (Hoedl et al., 2020) of nurses reported a significant association between nurses' working hours and their reported stress levels.

Nurses have been faced with many challenges during the COVID-19 (Lord et al., 2021). Research has highlighted that nurses who work in high-risk contexts such as ICUs during the COVID-19 pandemic, reported high levels of psychological distress (Sayilan et al., 2020; Chen et al., 2020). It has also been proposed that the challenges nurses encounter in the current pandemic include work long hours and high workload (Morgantini et al., 2020), challenges of wearing PPE (Kisely et al., 2020), inadequate PPE (Hignett et al., 2020; Rodriguez et al., 2020; Sharma et al., 2020), and the discrepancy between patient needs and ability to meet those needs (Greenberg et al., 2020). As nurses have more frequent and longer patient contact time, they themselves have greater potential exposure to COVID-19 pandemic (Bowdle & Munoz-Price, 2020), therefore fears of becoming infected and then infecting others are also reported to be a significant source of distress (Kang et al., 2020; McConnell, 2020; Rodriguez et al., 2020; Sharma et al., 2020). Further, a qualitative study based in Ireland (Feeley et al., 2020) that explored experiences of paediatric and adult ICU staff during the COVID-19 pandemic, discussed that uncertainty around the trajectory of the pandemic, and not knowing when 'normality' will resume, is also a source of distress.

The role of ICU nurses at the recruiting hospital site for this study includes management of medication, ventilation, cardiovascular and renal support, attending to personal care, communicating with family and friends of the patient via telephone call and videocalls, end of life care and supporting redeployed nurses. Manoeuvring patients into a proned position, where patients lie on their front to improve the patient's blood oxygen levels - and therefore survival - also became a standard of care during the pandemic (Koeckerling et al., 2020; Paul et al., 2020). Although this has been a well-known treatment for acute respiratory distress

syndrome for decades (Paul et al., 2020), the COVID-19 pandemic led to a sharp increase in patients requiring proning (Sarma & Calfee, 2020). The intervention is labour intensive, requiring five to seven members of staff (Royal College of Nursing Magazines, 2021). A literature review has highlighted that proning patients can place staff at risk of both musculoskeletal injury and greater exposure to the virus (Wiggerman et al., 2020). As the minimum suggested duration of prone position is 12 hours a day (Ghelichkhani & Esmaeili, 2020), it can become difficult to perform usual nursing care, which can lead to patients developing pressure sores (Moore et al., 2020), facial bruising and swelling (Ghelichkhani & Esmaeili, 2020). It is also known that wearing full PPE makes the ability to prone a patient increasingly difficult (Houston et al., 2020). At the time of writing, there appears to be little to no literature on the emotional impact on nursing when caring for patient who is in a faced down (prone) position.

The pressures on NHS nurses will continue long after the pandemic has ended. (Carr et al., 2021; Bhangu et al., 2020; NHS, 2021). As of February 2021, there has been a 153-fold increase of patients who are waiting more than a year for treatment within the NHS, compared to November 2019 (Carr et al., 2021). Recently, the NHS (2021) announced an increased £160 million to support the backlog of non-COVID-19 care.

1.7.8 PPE.

At the time of this research, the COVID-19 virus is understood to be transmitted through close contact, respiratory droplets, in poorly ventilated indoor settings, and through contaminated surfaces (WHO, 2020b). Close contact with infectious patients, along with the addition of respiratory droplet transmission during

procedures, lead to HCWs being at an increased and repeated risk of infection (Carter & Notter, 2020). Wearing PPE became essential for all HCWs during the pandemic (WHO, 2020c). It is recommended that HCWs wear masks, gloves, gowns, goggles, and visors when treating a patient with known or suspected of COVID-19 (Centers for Disease Control and Prevention, 2020)

In a qualitative, UK-based study (Hoernke et al., 2021), some HCWs who treated COVID-19 positive patients, reported inadequate PPE supplies, exhaustion, and a detrimental impact on communication impacted on stress. Hoernke et al. (2021) also noted that due to the gaps in PPE training and guidance, HCWs developed their own informal ways of sharing information, trained each other, and bought their own PPE. It was also discussed that breaks were often not taken due to high workload and guilt over wasting PPE (Hoernke et a., 2021). Other studies report that PPE can impact breathlessness and dizziness (Cui et al., 2020), reduce work efficiency (Cui et al. 2020), and impacts communication with patients (Fernández-Castillo et al., 2021; Goh et al., 2020).

1.7.9 COVID-19 guidance on wellbeing needs for HCWs.

In March 2020, the British Psychological Society (BPS) COVID-19 Staff Wellbeing Group (2020) developed guidance, adapted from an NHS England and NHS Improvement document (Wallbank, n.d.) for managers and leaders when considering the wellbeing needs of HCWs during the pandemic. This guidance proposes three psychological response phases ('preparation stage', 'active phase', and 'recovery phase'), although it is acknowledged that these stages may not be sequential. The first phase, the 'preparation phase' involves anticipatory anxiety and feelings of unpreparedness. Within the 'active phase' are two subphases. The first, 'heroics and surge to

solution', includes teamwork, rising to the challenge, witnessing things not seen before, and trying to adapt quickly. The proposed second aspect of the active phase, is 'disillusionment and exhaustion' - the period of highest psychological risk. This component proposes that this is where HCWs may experience sudden exhaustion and perceive that their wellbeing is not a priority. It is at this point that moral distress (discussed later) may become a risk. The final phase, the 'recovery phase' is proposed to be where HCWs may have time to reflect and may experience post-traumatic growth (PTG) (discussed later). Here, it is proposed that some HCWs may experience difficult emotions such as shame or guilt and dissonance with prevalent narratives such as the 'HCWs as heroes' narrative (BPS COVID-19 Staff Wellbeing Group, 2020).

1.8 Overview of Theoretical and Conceptual Frameworks

1.8.1 Conceptual frameworks for occupational stress.

The demand-control-support (DCS) model (Karasek & Theorell, 1990) has been influential regarding research in occupational stress. It asserts that wellbeing is low when workers are faced with high work demands and low control over their work. A qualitative study on ICU staff during the COVID-19 pandemic (Feeley et al., 2020), discuss that high workload and low control was highest in staff redeployed to ICU, and more junior ICU staff.

A conceptual criticism of the DCS model is its oversimplicity (Bakker et al., 2010) and that it omits important factors such as the role of social support from colleagues or managers (Johnson & Hall, 1988). The model also appears to focus on workload as the main contributor to stress, rather than factors that may come into play in a pandemic such as compassion fatigue, uncertainty, or perceived threat of infection.

Therefore, although the DCS model is likely to be useful for the current study, where nurses have high workloads and demands, it may not capture a range of other factors.

In response to the criticisms of the DCS above, the job demands-resources (JD-R) model was developed (Demerouti et al., 2001). This model suggests that work stress is a response to the imbalance between the individual's demands and their resource to meet these demands (Bakker & Demerouti, 2007; 2017). Demands are defined as aspects of work that can drain energy such as workload, complex tasks, emotionally demanding conversations, and conflict. Resources may include aspects such as social support, optimism, control, and positive feedback (Schaufeli, 2017). The model proposes that when demands are persistently high and not compensated by the motivational impact of resources, physical and psychological fatigue, poorer job satisfaction, and poor job performance occur (Cho et al., 2020).

Frequently applied in healthcare settings (Britt et al., 2021), the JD-R model has been used to explore demands and stress in HCWs during the COVID-19 pandemic, particularly in the context of novel demands and reduced resources. HCWs' emotional wellbeing is proposed to be impacted by an imbalance of increased novel demands (both work and personal) and reduced resources (Britt et al., 2021). The authors also state that during this pandemic, HCWs have been working long hours and personal resources are not available as they usually are, such as support from friends and family (Britt et al., 2021).

The person-environment fit (P-E fit) model (Caplan, 1987) is similar to the JD-R model, but asserts a more reciprocal relationship between an individual and their environment. It highlights that worker's individual characteristics, such as personality, abilities, and values need to be matched with their job and work context for wellbeing

(Edwards & Cooper, 2013). The dissonance between these factors will subsequently impact one's physical and psychological wellbeing. Applying this model to the current pandemic, Feeley et al. (2020) suggested that this imbalance was particularly reported in HCWs who were redeployed to ICUs.

1.8.2 Perceived threat of infection.

In addition to resources and demands, it is documented that for HCWs, perceived threat of infection predicts emotional distress during infectious outbreaks. A questionnaire-based study during the SARS pandemic in Hong Kong (Tam et al., 2004) proposed that 70 percent of HCWs reported that the most distressing aspect of working during SARS was the fear of becoming infected, rather than direct exposure to infected patients. This was hampered by HCWs' reported perception of having poor physical health, and therefore increased perceived vulnerability (Tam et al., 2020).

This was also discussed by García and Calvo (2021), notably that the perceived threat of contracting COVID-19, as measured quantitatively, along with high workload, contributed to reported burnout in nurses. Puci et al. (2020) conducted a web-based quantitative survey exploring Italian HCWs' worries and risk perception during the first wave of the COVID-19 pandemic. Physicians and nurses reported significantly higher perceived risk compared to other HCWs, due to frequent and longer patient contact time. Hoernke (2021) also delineates that actual and perceived shortages of PPE contributed to HCWs' stress. Furthermore, Ganz et al. (2019) concluded from a quantitative questionnaire study that that perceived threat of infection may give rise to an inherent tension of morals, such as a conflict between providing patient care or increased risk of contracting the virus.

For many HCWs, this perceived threat became a reality. Studies report that HCWs who worked during the current pandemic were at increased risk of infection compared with the general community, as reported on self-reported data from COVID-19 testing or a prediction of infection based on symptoms (Nguyen et al., 2020).

1.8.3 Moral distress.

Existing, pre-pandemic research proposes that HCWs most likely to experience moral distress are those who work in ICUs, palliative care units and emergency wards (Dodek et al., 2016; Whitehead et al., 2015). This can be defined as distress that occurs from actions, or lack of them, which violates one's ethical code and can contribute to emotions such as depression, guilt, shame, and anger (Litz et al., 2009). Pre-pandemic, HCWs usually act within their professional standards (Nursing and Midwifery Council, n.d) which includes to 'protect anyone you have management responsibility for from any harm'. Yet, with the arrival of the pandemic, and the high work load and reduced resources, this was required to shift (Kherbache et al., 2021).

In a pandemic context, nurses may find themselves in situations where they do not have adequate experience or training to treat the patient (Greenberg, 2020; Watson et al., 2020) or if normative expectations are breached due to systemic constraints such as inadequate supplies of PPE (Shale, 2020). Kok et al. (2020) state that due to the demand placed on ICUs in the COVID-19 pandemic, ICU staff reported disorientation, worry, and at times, feeling unable to help the patients and their families. Kherbache et al. (2021) propose that when HCWs experience moral distress, this can undermine ethical integrity, contributing to poorer job satisfaction and quality of patient care. Burston and Tucket (2012) propose internal factors, site

factors and external factors contribute to moral distress. Cacchione (2020) applied this to HCWs in the COVID-19 pandemic, proposing that internal factors include role perception, perceived skill level to manage a pandemic, and ability to care for each other. Site factors involve adequate PPE supplies and medical equipment, whilst broader external factors include national policies. Therefore, as a result of the tension between one's professional duty of care to patients and personal duties of protecting their own health also appears to contribute to moral distress (Kherbache et al., 2021; Stovall et al., 2020). An Australian based study (Lord et al., 2021) report that 90 percent of ICU nurses were concerned about spreading COVID-19 to their family. This distress is reported to intensify when working in health systems with frequently changing guidelines (Cacchione, 2020) and those unfamiliar to working in conditions of severely limited resources (Kherbache et al., 2021).

1.8.4 Growth, meaning-making, and culturally preferred stories.

Post-traumatic growth (PTG) (Tedeschi & Calhoun, 1995) is a concept that suggests that struggles with highly challenging life events can lead to positive change. This may include an increased appreciation for life, emotional resilience, deepened spirituality, a change in life priorities, and greater connection with others (Tedeschi & Calhoun, 1995; 2004). McAdams (1993) discusses how trauma offers opportunities for individuals to modify their narrative identities in positive ways. It is also thought that traumatic responses and PTG are independent of each other and can co-exist (Ragger et al., 2019). However, similar to the construct of PTSD, it can be argued that PTG also avoids context (Zur, 1996). A meta-analysis by Wu et al. (2019) reported that approximately 50 percent of individuals who experienced trauma experience some PTG. Regarding the impact of SARS on HCWs, 86 percent

reported a new appreciation for the meaning and importance of their profession (Tam et al., 2004).

However, when people relate the stories or 'journeys' of their experiences over time, particularly those that may include traumatic experiences, there are social conventions and imperatives that come into play, affecting what can acceptably be told, and how. For example, in relating stories of personal experience of illness, Frank (1995), writing in the United States, notes cultural expectations for certain forms of story. Culturally preferred narratives are when one presents themselves as fully 'recovered' from their experience of illness (a narrative of 'restitution') or of the 'quest', which is also similar to PTG (Tedeschi & Calhoun, 1995). Frank also notes that 'chaotic' narratives – which highlight the unpredictability and uncontrollability of traumatic events – are emotionally hard and uncomfortable for listeners to hear. It is argued that there may be social pressure on people to tell stories of quest or PTG rather than leaving listeners with the burden of knowing that life – a pandemic, for example – is simply cruel, unpredictable, and unresolvable. It is also of interest that cultural expectations may vary over time and place, something particularly pertinent to a global pandemic.

1.8.5 The COVID-19 Pandemic and Wartime Language

'Going to war or going to work?'

Naughton-Doe (2020)

Wartime language has remained a constant linguistic tool throughout the COVID-19 pandemic: the virus as an 'enemy', and HCWs as 'heroes' on 'the front line'.

Whilst this rhetoric may have a certain appeal in that it may mobilise a 'fight' against a common threat (Chiang and Duann, 2007) and provide hope of 'conquering the enemy' (Jetly et al., 2020), it may have other consequences (Brencio, 2020). War language may invite questions regarding the impact it can have on HCWs' perception: that they must keep going, stay strong, keep their emotions at bay – which can increase pressure further (Brencio, 2020). Freshwater (2020), a mental health nurse and Chair of the RCN Mental Health Forum, in a commentary for the Nursing Standard, states that the COVID-19 response 'calls for collaboration, not confrontation'.

The hero narrative appeared to be endorsed through the Clap for Carers was later renamed to Clap for Heroes to include all keyworkers (BBC News, 2021a). The public stood on their doorsteps to applaud and show appreciation to keyworkers from March to May 2020 (McAllister et al., 2020).

1.9 Summary

At the time of writing, as the pandemic continues globally, the COVID-19 pandemic marks the worst international health crisis for a century (Singer, 2020). ICU nurses are faced with many challenges (Lord et al., 2021), which sits against a backdrop of the already known stress of such work (Mealer et al., 2007).

While there has been a recent growth in literature into the COVID-19 pandemic, there is a need to take stock and critically appraise current understanding of the experiences of nurses working during the COVID-19 pandemic. To address this, the following chapter explored the existing literature on this topic.

Chapter Two: Systematic Literature Review

2.1 Chapter Overview

This chapter outlines how I systematically identified, synthesised, and critically reviewed the relevant literature. The systematic review aimed to answer the question *'what is known about the experiences of nurses working in ICUs during the COVID-19 pandemic?'*. A separate quality evaluation of the literature will follow, before presenting the rationale for the current research.

2.2 Literature Search Strategy

This systematic review was first undertaken in July 2020 and then, due to the pace of the literature published on the topic during the pandemic, updated in January 2021. In July 2020, the research was largely quantitative in design. By January 2021, the literature, including qualitative studies, was becoming increasingly vast. At the time of writing, the area continues to rapidly evolve, and it is acknowledged that further reviews will be needed over the coming years.

Databases PubMed, Scopus, Internurse, and Google Scholar were used. This first ranged from a generic search using key terms, in addition to more specific searches including variations on 'COVID-19', 'nurse', 'psychological impact' and 'qualitative'. Boolean operators (AND, OR) were used and relevant search terms were truncated (*) to ensure the inclusion of variations on specific words (Table 1). As the volume of the published literature grew, it became feasible to focus in on qualitative literature involving nurses, rather than HCWs generally. To further narrow down the results, I also limited studies to those only qualitative in design in order to capture the lived experience and limited papers to those published in 2020 onwards.

The search term 'intensive care unit' was removed because this narrowed down results too far.

In total, 1770 papers were initially identified. Using the search strategy detailed in Table 1 and the inclusion in and exclusion criteria in Table 2, this was narrowed down to 12 papers for full text review and critical evaluation. Figure 1 shows the process of study selection. Table 3 shows a summary of the results.

Table 1

Systematic Literature Review: Search Terms

COVID-19	Nurses	Psychological impact	Qualitative
*Coronavirus; Covid**	*Nurse**	*Psychological adjustment; Psychological wellbeing; Emotional wellbeing; Emotional impact; Coping; Resilience.*	*Qualitative*

Table 2

Systematic Literature Review: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
1) *Written in English, or available English translation* 2) *Focus on experience of working as a nurse/psychological wellbeing during the COVID-19 pandemic* 3) *Qualitative* 4) *Published from 2020 onwards*	1. *English translation is not available* 2. *Review papers* 3. *Quantitative or mixed methods* 4. *Published before 2020* 5. *Focus on health care workers generally* 6. *Focus on management / organisational issues*

Figure 1

Process of Study Selection

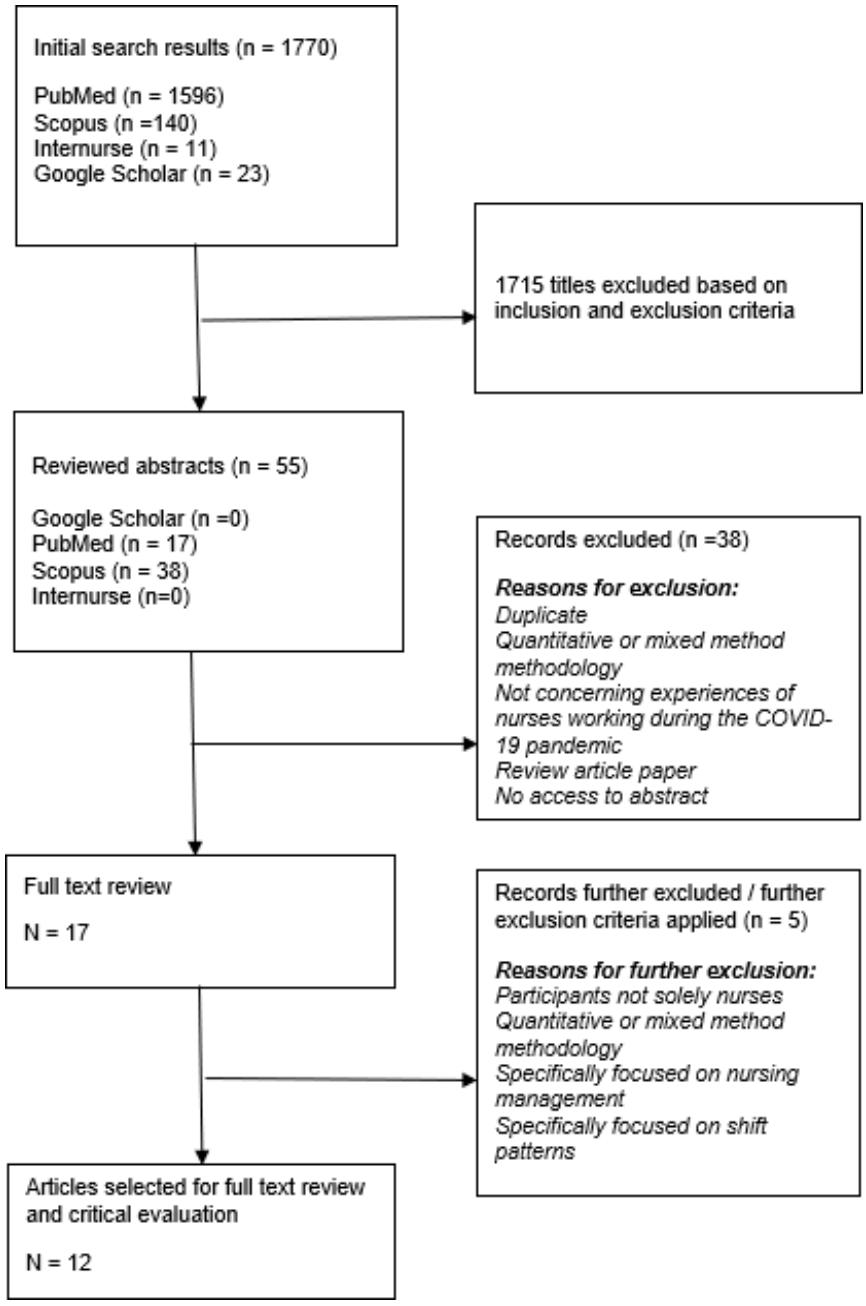

Table 3

Systematic Literature Review: Summary

Paper	Aim	Country, date	Participants	Method	Findings
Cui et al. (2020) *Experiences & psychological adjustments of nurses who voluntarily supported COVID-19 patients in Hubei Province, China*	To explore the experiences & psychological adjustments of nurses who voluntarily travelled to Hubei to provide support during COVID-19	Hubei, China. April - May 2020	Nurses who volunteered to work in Hubei. N=12 Mean age: 34.67 Female: 100 Mean experience in years: 13.58	Content analysis Individual, face-to-face interviews, structured interview, 30-50 minutes	Motivations; Challenges; Psychological experiences; Adjustments; Growth.
Tan et al. (2020) *Experiences of clinical first-line nurses treating patients with COVID-19: A qualitative study*	To explore the work experience of nurses treating patients with COVID-19.	Wuhan, China January – February 2020.	Nurses who worked for 3 weeks COVID-19 experience. N=30 24 females, 6 males. Mean age: 31.23 Varying roles of responsibility & education.	Content analysis Individual interviews (in person, telephone, voice recording, We Chat), semi-structed interview, 30-50 minutes	Psychological experiences; Difficulties faced; Needs of clinical first line work; Impact on professional attitudes.
Kackin et al. (2020) *Experiences & psychosocial problems of nurses caring for patients diagnosed with COVID-*	To determine the experiences & psychosocial problems of nurses caring for patients diagnosed with COVID-19.	Istanbul, Turkey. May 2020.	N = 10. Gender = female: 8, male: 2.	Descriptive phenomenological analysis Individual video interviews, semi-structured.	Effects; Short term coping strategies; Needs.

Paper	Aim	Country, date	Participants	Method	Findings
19 in Turkey: A qualitative study					
Lee & Lee (2020) *South Korean nurses' experiences with patient care at a COVID-19-designated hospital: Growth after the frontline battle against an infectious disease pandemic*	To explore the experiences of COVID-19-designated hospital nurses.	South Korea. June/July – September 2020.	Nurses working in designated COVID-19 hospitals Minimum one year of patient care experience & minimum two months COVID-19 experience. N=18 Female 100 percent Mean COVID-19 patient care experience – 5.33 months	Phenomenological analysis Individual telephone interviews	Pushed into the battlefield without preparation; Struggling on the frontline; Altered daily life; Low morale; Unexpectedly long war; Ambivalence towards patients; Forces that keep me going; Giving meaning to my work; Taking another step in one's growth.
Galehdar et al. (2020) *Exploring nurses' perception about the care needs of patients with COVID-19: a qualitative study*	To explore nurses' experiences of psychological distress during care of patients with COVID-19.	Lorestan, Iran. March – April 2020.	Nurses working in public hospitals, minimum 2 weeks COVID-19 experience. N=20 Women 75 percent, men 25 percent Mean work experience: 7.25 years Average age 31.95	Content analysis 1:1 telephone interviews.	Death anxiety; Anxiety due to nature of the disease; Anxiety caused by corpse burial; Fear of infecting the family; Distress about time wasting; Emotional distress of delivering bad news; Fear of being contaminated; The emergence of obsessive thoughts; The bad feeling of wearing PPE; Conflict between fear & conscience; Public ignorance of preventive measures.

Paper	Aim	Country, date	Participants	Method	Findings
Lapum et al. (2021) *"'Goodbye … Through a Glass Door": Emotional Experiences of Working in COVID-19 Acute Care Hospital Environments*	To explore how nurses are emotionally affected working in COVID-19 acute care hospital environments.	Greater Toronto, Canada.	N=20.	Narrative analysis 1:1 video interviews, semi-structured	The emotional experience; Agency of emotions; How emotions shape nursing & practice.
Zhang et al. (2020) *The Psychological Change Process of Frontline Nurses Caring for Patients with COVID-19 during Its Outbreak*	To identify the psychological change process of the nurses who worked in the epicentre of the COVID-19 outbreak.	Wuhan, China. February – March 2020.	Volunteered to provide COVID-19 care. N=23 Average age 31.5 years Average work experience 7.58 years	Phenomenological analysis 1:1 semi-structured video interview	Ambivalence; Emotional exhaustion; Energy renewal
Goh et al. (2020) *The Impact of COVID-19 on nurses working in a University Health System in Singapore: A qualitativ*	To explore nurses' experiences of working in tertiary hospitals during COVID-19	Singapore. March – June 2020.	Nurses working across tertiary hospitals, community hospitals, speciality care centres & community centres. N=17 Mean age 32.6 Female =11, male = 6 Chinese (n=14), Indian (n=1), Malay (n=1).	Thematic analysis 1:1 semi-structured video interviews	Challenging moments; Professional role as a nurse; Support for nurses.

Paper	Aim	Country, date	Participants	Method	Findings
e descriptive study					
Sheng et al. (2020) *The influence of experiences of involvement in the COVID-19 rescue task on the professional identity among Chinese nurses: A qualitative study*	To explore the experiences of involvement in the COVID-19 on professional identity among Chinese nurses.	Wuhan, China. March – May 2020	Volunteered to care for COVID-19 >7 days N= 14. 11 female, 3 males. Average age: 32 years. Years' experience 1 – 23 years.	Phenomenological analysis. Qualitative arm of a mixed-methods study. Semi-structured video interviews	Impression of exhaustion & fear; Perceiving incompetence in rescue task; Feeling of unfairness; Unexpected professional benefits.
Jia et al. (2021) *Nurses' ethical challenges caring for people with COVID-19: A qualitative study*	To examine the ethical challenges encountered by nurses caring for patients with COVID-19 & to provide suggestions mental health support for nurses.	Wuhan, China. February – March 2020.	Nurses who worked on designated COVID-19 units. N=18 Female 13, male 5 Age range: 24-43 Nursing experience 3-22 years Profession ranged from outpatient, internal medicine, surgery, emergency & ICU	Content analysis 1:1 video or voice interview, 60-120 minutes	Ethical challenges; Coping styles; Impacts on career.
Fernández-Castillo et al. (2021) *Intensive care nurses' experiences during the COVID-19 pandemi*	Qualitative. To explore & describe the experiences & perceptions of nurses working in an ICU during COVID-19.	Spain. April 2020.	Working in ICU treating COVID-19 patients from March 2020. N= 17 Female – 11 Male - 6 Aged 31-54	Content analysis 1:1 semi-structured video interview, 22-45 minutes	Providing nursing care; Psychosocial aspects & emotional lability; Resources management & safety; Professional relationships fellowship.

Paper	Aim	Country, date	Participants	Method	Findings
c: A qualitative study					
Sun et al. (2020) *Qualitative study: Experienced of caregivers during Covid-19*	Qualitative. To explore the psychology of nurses caring for COVID-19 patients.	China. January – February 2020.	Nurses caring for patients with COVID-19. N=20 Male = 3 Female =17 Age range 25-49 Average age 30.60 Work experience range – 1-28 years Average work experience 5.85 17 general nurses, 3 head nurses	Phenomenological analysis In person interviews, 2 interviews per nurse, 40-60 minutes.	Significant amount of negative emotions in the early stage; Coping & self-care styles; Growth under pressure; Positive emotions occurred simultaneously or progressively with negative emotions.

2.3 Systematic Literature Review: Critical Evaluation

Below, each study will be discussed in turn to explore the question: What is known about the experiences of nurses treating patients with COVID-19 disease?

Cui et al (2020) interviewed nurses who voluntarily travelled to Hubei, the Chinese province which includes Wuhan, the epicentre of the pandemic and the focus of national and international attention. The authors noted five themes in nurses' accounts (motivations; challenges faced; psychological experiences, psychological adjustments; personal and professional growth). 'Motivations' involved a professional commitment and responsibility prompted by media publicity. The authors reported that nurses' described an awareness of the value of their role which they reportedly integrated this into a 'stronger professional identity'. The authors proposed that this highlighted the strong sense of duty and dedication.

Similarly, Zhang et al. (2020) explored the experiences of nurses who voluntarily travelled to Wuhan, China. Focusing on the 'psychological change processes' of

nurses, they argued that nurses experienced three stages in coping with their work (ambivalence; emotional exhaustion; energy renewal) which, they proposed, occurred after working in the isolation unit for a month. Similar to Cui et al. (2020), Zhang et al. (2020) discuss how nationalism during the pandemic played a key part in nurses' sense of duty and responsibility. However, it appears that there was more cognitive dissonance for the nurses, and some reported this to be an 'obligation' (Zhang et al., 2020). They reported feeling excitement and pride alongside fear, reportedly due to the contagious nature of the virus and the dearth of knowledge. It is interesting to consider that it may be that those with less nursing experience may have played a part in this ambivalence, as 65.2 percent of the participants had between two to five years' experience (Zhang et al., 2020). By contrast, in the study by Cui et al. (2020), 33 percent of nurses had six to 10 years' experience, whilst another 33 percent had 11 to 15 years' experience. Although the findings in the study by Zhang et al. (2020) are presented in three distinct categories, it may not capture possible nuances within the data. However, given the paucity of participant quotations presented in the paper, this is hard to decipher. Further, Chinese cultural values of family and community and collectivism may have also played a part in the reported sense of duty and responsibility, which may not be generalisable to other countries.

A sense of duty was also reported strongly in the South Korean study (Lee & Lee., 2020), however, similar to Zhang et al. (2020), this was also reported as an 'obligation' and an 'unavoidable duty'. So too, both Lee and Lee (2020) and Zhang et al. (2020) also note that nurses reported fear, particularly at the start of the pandemic. Lee and Lee (2020) reported that this stemmed from a lack of PPE training and knowledge about the route of transmission. Zhang et al. (2020),

however, discussed that the nurses worried about their family's safety, which was intensified by HCWs dying from COVID-19. Although the nurses reported struggles, they also reported positive changes when they reflected on the meaning of their experience (Lee & Lee, 2020). This alludes to the idea that PTG can occur when faced with challenges during a pandemic. It is of note that Lee and Lee (2020) heavily use wartime language in the several themes (pushed onto the battlefield without any preparation; struggling on the frontline; unexpectedly long war). This is disproportionate to the amount of war language apparent in the participant excerpts.

The Singapore-based project (Goh et al., 2020) discussed three themes (challenging moments; professional role; support for nurses). For some nurses in this sample, the reported sense of duty was stronger in that they felt a responsibility to circulate correct COVID-19 information to the public, as well as publicly adhering to preventative measures. Across the papers, the reported sense of duty appears to have difference nuances, from a pride and a professional commitment (Cui et al., 2020; Goh et al., 2020), to an obligation (Lee & Lee, 2020; Zhang et al., 2020). The authors refer to self-determination theory (Ryan & Deci, 2000), which is concerned with the motivation contributing to an individual's decision. Goh et al. (2020) state that nurses are intrinsically rather than extrinsically motivated to explain why they may have felt pride in contributing to the pandemic. Viewing nurses' experiences through this framework, however, may be over-simplistic. Indeed, relying on the assumption that nurses are intrinsically motivated could be problematic particularly in the context of nurses who have been working in high-risk situations, long working hours, and with relatively low pay. It also ignores the role of broader military and hero discourses.

Tan et al. (2020) collected their data from nurses working in one of the main COVID-19 designated hospitals in Wuhan. They reported that difficulties encountered by nurses included heavy workload and pressure, fear and anxiety, helplessness and frustration, shortage of staff and PPE, and lack of knowledge about COVID-19. Conducted between January to February 2020 at the epicentre of the pandemic, these conclusions are perhaps unsurprising. The authors also explored reports of positive experiences (as did Zhang et al. 2020) and noted that nurses reported an improved sense of responsibility and professional identity. Notably, the authors framed the theme of 'most nurses did not complain' as a 'positive professional value', which may be perceived differently in other cultures.

Galehdar et al.'s (2020) Iran-based study specifically explored nurses' psychological distress. This contrasts with the other reviewed studies which contain aspects of positive experiences and growth, although to different degrees. There are different ways to view this. The absence of reported positive growth may be a reflection of their methodology (this was not a question asked in the interview). Therefore, this does not consider whether growth and distress can co-exist (Ragger et al., 2019). It is also important to consider that perhaps by the nurses not having been asked about growth, there may have been less of a social pressure for this type of talk (Frank, 1995).

Galehdar et al. (2020) also discuss the 'multidimensional construct' of death anxiety, including not feeling prepared to communicate with dying patients and their families and observing the death of patients. Nurses reported that many patients may have contracted COVID-19, despite adherence to preventative measures, and that patients were 'victims of others' carelessness and authorities' poor decisions'. This narrative reportedly led to the death of patients being even more

difficult for the nurses, which perhaps reflected nurses' compassion towards patients, but also how they may not have felt supported by the authorities and the public. This contrasts with Lee and Lee's (2020) findings, who noted that some nurses 'lacked sympathy' for patients and 'did not want to understand the patients' situation because they had not followed the basic prevention'. Both these aspects of these studies (Galehdar et al., 2020; Lee & Lee, 2020) may speak to a similar point, regarding frustration at those not adhering to preventive measures to contain the spread of the virus. Another theme discussed by Galehdar et al. (2020) was fear of infecting the family. This is in line with conclusions from other reviewed studies (Sheng et al., 2020; Zhang et al., 2020).

Similar to the other studies, Lapum et al. (2021), described that, in Canada, nurses' accounts were emotionally charged, with fear, uncertainty, helplessness, and anger prominent. However, Lapum et al. (2021) discuss how these emotional experiences are complex and enmeshed. The authors add an additional layer to the literature by discussing the agency of emotion and how this impacts nursing practice. For example, some nurses described how staff shortages, exhaustion, and the need to become task-orientated reduced capacity for empathy. Additionally, nurses found new ways to enhance the humanistic aspects of their role, resulting in a strengthened professional identity. This highlights the importance of identity and self-concept, especially in times of increased and novel work demands. However, the authors' lack of transparency in the paper, including the vague description of their methodology and analysis, means that the findings should be viewed cautiously.

Sheng et al. (2020) add a new angle to the literature as they specifically focus on exploring the professional identity of nurses who volunteered to work in hospitals in Wuhan. Alongside themes such as exhaustion and fear and perceived

incompetence, they also discuss the theme of unexpected professional benefits. Within this, nurses described the experience as a learning opportunity, specifically in that they developed skills in intensive care of infectious diseases, wearing PPE, and improved communication. The authors also discuss social identity theory (Tajfel & Turner, 1986), where they state that nurses' identities are tied to societal images and are strengthened when nurses perceive they are being portrayed positively, for example, such as nurses as 'heroes' and 'soldiers'.

Sheng et al. (2020) also report 'feelings of unfairness'. As nurses were required to have closer and longer patient contact compared with other staff, there was a greater risk of infection. This was reported to be hampered by nurses' medical colleagues being given a greater financial reward, despite nurses having increased and longer patient contact time. Reportedly, the nurses felt their contributions went unrecognised by the hospital and wider society. This appears to be one of the few studies, along with Jia et al. (2021), to discuss inequality and unfairness perceived by nurses. It appears that nurses' perception of how they were perceived by society plays a core part in their experiences and offers suggestions for mangers on organisational justice. This offers an alternative view to some of the other studies, where although nurses reported fear (Cui et al., 2020; Lee & Lee, 2020; Tan et al., 2020), frustration and unfairness were not discussed. This may also tie into the strong sense of professional duty and responsibility reported by Cui et al. (2020).

Jia et al. (2021), another Chinese study, took a different approach and focused on exploring nurses' encounters with ethical challenges. Due to the limited medical resources in Wuhan, nurses were required to neglect patient rights at times. Notably, the nurses reported that patients did not participate in their plan for treatment (due to being too unwell to talk and not being allowed because of pressures the Unit was

under). The nurses also reported feeling distressed if patients were not receiving a good standard of care, particularly if other staff were slow to support patients in order to avoid contracting the virus from the patient. There are several similarities between Jia et al. (2021) and Sheng et al. (2020) in terms of their conclusions. Both discuss the experience leading to a positive impact on professional identity and the development of nursing and management skills.

Sun et al. (2020) discussed how despite the challenges, growth emerged under pressure - a key finding reported in other studies (Cui et al., 2020; Jia et al., 2021; Lapum et al., 2021; Lee & Lee, 2020; Sheng et al., 2020; Tan et al., 2020; Zhang et al., 2020). Unlike these other studies, however, Sun et al. (2020) propose that positive emotions can co-exist alongside distress, which fits the literature on PTG (Ragger et al., 2019). By contrast, Zhang et al. (2020) propose a 'change process', although this is arguably rigid. The exception is Lapum et al. (2021), who suggested emotions are enmeshed. This type of framework, rather than a stepwise, sequential model is more likely to capture the complexity of human emotion.

Kackin et al. (2020) also highlighted the psychological and social impact on nurses and working conditions. They propose that nurses have robust coping strategies existing before the pandemic. These strategies include normalisation, refusing to dwell on experiences, avoidance, expression of feelings, and distraction. Coping strategies were also discussed by Sun et al. (2020) where the nurses reported using journaling, deep breathing, and mindfulness practice. Aspects of coping strategies were discussed in the other studies. This included an appreciation from patients and concerns from family/friends (Lee & Lee, 2020), containing and releasing emotions (Lapum et al., 2021), social support, counselling, and diary writing (Cui et al., 2020) and planning, and staying focused (Jia et al., 2021).

Fernández-Castillo et al. (2021), another Spanish study, was the only reviewed study to discuss the role of the media. Nurses reported that it was difficult to 'disconnect' which led to feeling a lack of control. This highlights the implications of a pandemic in a world where the internet and media are rife. It also points to how misinformation and information overload can impact experiences.

Fernández-Castillo et al. (2021) also noted that ICU nurses who worked with redeployed nurses reported increased levels of anxiety - a finding not noted in the other reviewed studies. A key theme that also sets this study apart is the theme of 'resources management and safety' which discusses the management of the correct provision of PPE, adequate staffing and nurse-to-patient ratios. This study takes a broader, more systemic lens when considering factors contributing to distress and burnout in nurses, which offers implications for leaders within healthcare systems.

Although not a research question for any of the studies, and therefore not a focus, many allude to the nurses' identities. For example, across the studies the nurses appeared to construct identities of responsible, professional nurses with a duty to work during the pandemic (Cui et al., 2020; Goh et al., 2020; Lee & Lee, 2020; Sun et al, 2020; Zhang et al., 2020). Despite this, the studies lack a fuller exploration of these identities.

2.4 Quality evaluation

Quality evaluation tools appraise the methodological quality and rigour of research (Elliott et al., 1999; Hammersley, 2008). I selected the guidelines set out by Tracy (2010) because it is an established quality standard that expands on previous work. It is also applicable to many forms of qualitative research. To reflect a more nuanced

rating scale, rather than a binary 'yes' and 'no' approach, I employed a three-tiered rating system of 'criteria met', 'criteria not met' or 'partially met'. Studies were given a 'high' rating if they met five or more of the criteria and a 'low' rating' if they met four or less (Appendix A).

Worthy topic: This refers to whether the research is novel, timely, significant, and interesting. All the papers met this, which is perhaps unsurprising given that the topic is so current. Studies were novel and interesting based on the country the project was based, the methodology employed, the date it was conducted, or taking a specific angle in terms of their aims. Specifically, some Chinese studies interviewed nurses who volunteered to travel to Hubei (Cui et al., 2020; Sheng et al., 2020; Tan et al., 2020; Zhang et al., 2020). Some studies were conducted early on in the pandemic, such as January to February 2020 (Tan et al., 2002) and April to May 2020 (Cui et al., 2020). Zhang et al. (2020), however, explicitly focused on the 'psychological change process' nurses go through, whilst Jia et al. (2021) explored specifically ethical challenges.

Rich rigour: Rigorous research relates to appropriate participants, methodology, and analysis. Studies had poor rigour if they did not state the participant demographic details, if interviews were short in length, if the interview format was inappropriate, vague description of the recruitment strategy or did not use field notes or a lack of transparency about the methodology (Cui et al., 2020; Galehdar et al, 2020; Lapum et al., 2021; Tan et al., 2020). Some studies were deemed to have sound rigour (Goh et al., 2020; Jia et al., 2021; Kackin et al., 2020; Lee and Lee., 2020; Sheng et al., 2020; Sun et al., 2020 & Zhang et al., 2020). Most of the papers provided much information about their sample, including the nurses' work position, work experience, and qualifications. Goh et al (2020) went further and recorded

ethnicity and religion (Goh et al., 2020). However, these details were often not referred back to in the context of the findings.

Sincerity: Researchers should state their epistemological and theoretical orientation to the topic, and be reflexive throughout. None of the papers shared their epistemology. However, two papers met this criterion as they stated their values, beliefs, and thoughts throughout (Goh et al., 2020; Sheng et al., 2020). Fernández-Castillo et al. (2021) did not provide details of the research team and what they may have brought to the research, nor did they show any hint of reflexivity. Kackin et al. (2020) attempted to show sincerity by providing details about the research team such as their training and qualifications, however, there was limited evidence of reflexivity.

Credibility: Research high in credibility will include triangulation, member checking with participants, and offers rich detail within the paper. All but two of the studies (Cui et al., 2020; Lapum et al., 2021) meet this. No credibility checks were employed by Lapum et al. (2021), and the authors also do not state their epistemological or theoretical lens, it is difficult to know whether this is deliberate or not (for example, if member checking does not fit with their epistemology). Lapum et al. (2021) provided only a brief description of their methodology with only two examples of interview questions. Cui et al. (2020) used member checking, but details on this are vague. There were no details on how a consensus was reached in the analysis or indeed how the interview guide was developed or concrete details on how the data was analysed. Some papers stated how they used established quality criteria such as that by Lincoln and Guba (1985) (Galehdar et al. 2020; Kackin et al., 2020; Lee & Lee, 2020). Other studies developed their interview guide by consulting the literature and 'experts' (Sun et al., 2020).

Resonance: This takes into account whether the research impacts the reader, and how it is presented. It also considers 'generalisability', although research adopting a social constructionist lens - which views knowledge as dependent on context - would not seek to easily 'generalise' to other populations. Given none of the papers shared their epistemology, this is hard to assess. Lapum et al. (2021) had low resonance as it lacked details such as the date for when the study was conducted, leaving the reader unclear as to at what point in the pandemic it was conducted, which is likely to heavily impact the data. However, Lapum et al. (2021) document the metaphors the participants used such as "so the baggage is, not only are you carrying whatever you had, but also trying to bottle it in" which helps the reader resonate. Zhang et al. (2020) used language such as 'sacred mission' without any critical evaluation, which may not resonate with readers.

Significant contribution: This refers to the impact of the research, including theoretically, practically or methodologically. Nine of the reviewed studies met this (Cui et al., 2020; Galehdar et al., 2020; Fernández-Castillo et al., 2021; Jia et al., 2021; Tan et al., 2020; Lapum et al., 2021; Lee & Lee, 2020; Sheng et al., 2020; Sun et al., 2020; Zhang et al., 2020). Tan et al.'s (2020) study, conducted in January and February 2020, was one of the first qualitative studies to explore the experiences of nurses who worked in Wuhan. Galehdar et al. (2020) refer to death anxiety and discussed how this may impact communication with patients reaching the end of life. However, the authors do not offer specific practical recommendations. Further, although brief, the authors discuss their findings to previous epidemics and pandemics (Galehdar et al., 2020). Two studies partially met this criterion (Goh et al., 2020; Kackin et al., 2020). The findings presented by Goh et al. (2020) are not new

perhaps in part due to the methodology employed, thematic analysis, which lacks in-depth exploration and does not explore patterns within accounts.

Ethical: This considers whether the research has been conducted ethically. This component proved difficult to assess as many of the studies lacked details in this regard. Only two studies made specific reference to how they would manage potential participant distress (Sheng et al., 2020; Sun et al., 2020). Sheng et al., (2020), however, stated that when the participant showed signs of distress they would pause or 'change the topic'. More detail on this is needed, as this could be perceived as closing down emotion and therefore more distress. Sun et al. (2020) met this criterion; they discussed employing certain therapeutic techniques such as acceptance and active listening. Further, the interview had a large focus on coping strategies, and the topic is likely to not be problem-saturated. None of the papers discussed whether they gave participants contacts for further support following the interviews.

Meaningful coherence: This assesses whether the study appropriately achieves its aims and whether the paper is meaningfully connected. Some papers did not meet this if their sample lacked generalisability and therefore does not achieve its aims. Lee and Lee (2020) only interviewed those who only volunteered to care for patients with COVID-19 patients, and they also note that some of the nurses in the sample had 'extremely limited nursing experience' in caring for patients with COVID-19. Galehdar et al. (2020) also did not meet this as some aspects of the discussion lack coherence with the findings, in addition to methodological limitations in having short telephone interviews.

2.5 Rationale

Although the literature on experiences of nurses working during the COVID-19 pandemic is already a rapidly evolving area, this review highlights the scarcity of research exploring how nurses construct their narratives, particularly within a UK NHS context. There also appears to be a dearth of research that explores situated and contextualised understandings of accounts, for example, the power of discourse on narratives and identities. This is important given that the COVID-19 is the first large scale crisis in over a century, and given the existing shortages of NHS nurses. Whilst several of the reviewed studies allude to an impact of the professional identities of nurses, they did not explore how this was told. Furthermore, much of the literature employed inclusion criteria that nurses were required to have a minimum amount of experience working during the pandemic. The redeployment of nurses is a distinct feature of nursing during a pandemic; excluding redeployed nurses may miss important aspects of experiences. It is also important to note that many of the reviewed studies were rated 'low' in the quality assessment and therefore care should be taken when inferring too much from the findings of these studies. These limitations in quality of these studies also provides a further rationale for the current project. In summary, the literature on how nurses construct their experiences and the self within local and broader socio-cultural contexts remains sparse. To meet this need, narrative inquiry is an appropriate methodology.

2.6 Research Aims

This study explores the following questions:

1. *How do NHS nurses' construct their narratives of working in ICUs during the COVID-19 pandemic?*
2. *What identities are constructed in their narratives?*

Chapter Three: Methodology

3.1 Chapter Overview

Within this chapter, I outline the design, procedure and how I addressed ethical considerations. I will close this chapter by outlining how I have ensured quality throughout, and maintained a reflexive position.

3.2 Design

This research is a cross-sectional study, using retrospective individual interviews. Employing narrative inquiry, it aimed to gain an in-depth, rich understanding of how nurses construct their experience of working in an ICU during the COVID-19 pandemic.

3.2.1 So, why stories?

We are born into a world of stories (Bruner, 2003; Fisher, 1984; Murray & Sools, 2015). Stories are how we come to know our world and our place in it (Oliver, 1998; Squire, 2008). Attempts to understand experiences in social science took a 'narrative turn' in the 1980s (Pinnegar & Daynes, 2007), which considered how events and identities are constructed within particular contexts, how they unfold over time (Caine et al., 2013), and the impact of certain versions of stories over others. As such, narrative inquiry considers stories as a tool for constructing meaning, ordering experience, and constructing reality in an ever-changing and often chaotic world (Bruner, 1986).

Narrative inquiry allows the researcher to make sense of stories at various levels, including structurally, contextually and performatively (Esin et al., 2014). Narrative also considers the multiple contexts, including the interview context itself (Wells,

2011), and the broader social, historical, political, cultural and institutional contexts. These broader contexts often draw on wider societal discourses that inform narratives and the discursive resources available to the narrators. *When* a narrative can be told, or indeed whether it can be told at all, may relate to who is considered 'entitled' to tell that story or whether it resists dominant societal discourses in some way (Bamberg & Andrews, 2004). For example, over the last century in Western culture, sharing stories of emotional distress would have resulted in different consequences at different times, which may have led to these being told in secret or silenced.

Although there are some overlaps between narrative inquiry and other qualitative approaches, narratives preserve temporality and analyse individual accounts as a whole (Haydon & van der Riet, 2017; Riessman, 2008; 2010). This is useful with regards to considering transformation or change in stories of adversity (Squire, 2008).

A constructionist narrative analysis was used, which is consistent with the epistemological stance for the project. This views narratives as co-constructions, and recognises that individual identities are shaped through language. I also drew on aspects of discursive psychology to consider how identities may emerge from positioning in relation to societal discourses (Harré, 2012).

It is important to briefly comment on the potential links with the term 'story' and something being 'made up'. Although the approach for this research views narratives as socially constructed, and therefore focuses of meaning over 'truth', this is not to say 'stories' are fictional accounts.

3.2.2 Consultation.

Consultation can positively influence the research at all stages. It offers opportunities for feedback and advice on the design of the study (Morrow et al., 2010) and can help inform methodological reflexivity (Treharne & Riggs, 2015). I was fortunate to have a senior matron at the hospital as the research consultant to the project. Consultation impacted the design from the outset, including recruitment, guidance on changing the interview guide and ways of managing potential emotional distress.

3.3 Procedure

3.3.1 Recruitment.

I recruited nurses who worked in the ICU at specialist cardiothoracic hospital during the COVID-19 pandemic (Table 4). Purposive sampling was employed, which is in line with the project's aims and methodological approach (Ames et al., 2019).

Table 4

Sample Inclusion and Exclusion Criteria

	Criteria	Further comments
Inclusion criteria	Aged 18 or above at the time of recruitment;	
	Worked on the ICU at the hospital during the COVID-19 pandemic;	This includes those who usually work in the ICU and those who were voluntarily redeployed from other hospital departments. A minimum length of time that participants needed to work in ICU during the pandemic for was not implemented, as the stories of those nurses who were unfamiliar with an ICU context is a unique feature of nursing during a pandemic.

	Band 5 and 6 nurses	The role of the Band 7 nurse involves a greater degree of responsibility, therefore only Band 5 and 6 nurses were recruited.
	Speaks sufficiently fluent English	With narrative inquiry's emphasis on the nuances of language, and how this is both used and performed, it is not possible to complete interviews in languages other than English. This is not possible by my own limitations in only speaking English. This is also in line with the recommendations from Miczo (2003).
	Nurses must have access to a computer and internet access.	
Exclusion criteria	Those with a significant history of mental health difficulties.	It was assumed that those who have been cleared by Occupational Health to work in an emotionally charged environment will not have existing significant emotional difficulties. Low mood and anxiety will not be an exclusion criterion as these emotions are understandable and expected given the topic.
	Band 7 nurses	

There were three methods of recruitment led by the external supervisor for the project. The research consultant also advertised the study through email groups, WhatsApp groups, and displaying the participant information sheet in the ICU staff rooms. Recruitment was further supported by nursing managers from other departments in the hospital.

3.3.2 Participants.

Six nurses were recruited and interviewed, which is sufficient given the level of analysis involved in narrative inquiry (Wells, 2011). All participants who came

forward were female and there was a diversity of participants' reported ethnic background (Table 5). The nurses' ethnicities and age were assumed to be representative (gender is slightly less representative) of the nurses at the hospital.

Changing or removing identifiable information was discussed with each of the participants. Whilst some details have been changed and removed for confidentiality purposes, some information has been kept in where it is important when understanding broader stories. Further communication with some of the nurses following the interviews was sought to clarify their consent for this, despite the risk of potentially identifying themselves.

Table 5

Participant Details

Pseudonym	Rose	Amelia	Leia	Anna	Jane	Ellie
Age	28	56	30	41	26	29
Gender	Female	Female	Female	Female	Female	Female
Ethnicity	White British	Asian	White Italian	Asian	White British	White British
Length of experience as a nurse (years)	7	13	6	21	4.5	3.5
Dept. usually works in outside of COVID-19	ICU	Another dept (redeployed)	Another dept (redeployed but a trained ICU nurse)	Another dept (redeployed)	ICU	ICU
Length of experience as an ICU nurse	5 years	3 days	6 years	4 days	3 years	7 months
Health condition that puts them at greater risk	No	Yes	No	No	No	No

of COVID-19?						
Other details	Worked across two sites during the pandemic. (redeployed to work several shifts at a ward in another hospital that was not connected to the hospital site recruited from).		An experienced ICU nurse but was working in another department before and after the pandemic			Was on a planned rotational post to ICU delayed by several months due to pandemic

3.4 Ethical Approval

As recruitment took place through an NHS hospital, with NHS staff as participants, ethical approval was required from NHS Health Research Authority (HRA). IRAS project ID: 284812 (see Appendix B).

The process of obtaining ethical approval involved considering solutions to anticipated ethical issues. Regarding NHS HRA ethics approval, for COVID-19 related research, a fast-track system was in place. The approval, whereby the project was deemed ethically sound, was provided within several days. I received requests for five amendments and for further information to be provided (Appendix C-E).

Following this, I sought research registration from the Hospital Trust's Research and Development (R&D) Department (Appendix F-G). Once this was approved, I requested full sponsorship from the University of Hertfordshire's Ethics Board. Protocol number: LMS/PGT/UH/04269 (Appendix H-I)

3.4.1 Addressing ethical considerations.

Ethical considerations were paramount to hold in mind through all stages of this research. These are informed consent, confidentiality, and potential participant distress. I also discuss the ethical issues that relate to conducting research during a pandemic.

3.4.1.1 Informed consent.

Informed consent is at the very core of ethical considerations in all psychological research. To assist the nurses in making an informed decision about participation, they were provided with the Participant Information Sheet (Appendix J), which provided clear and detailed information about the study's aims, what participation involves, potential risks, and confidentiality including its limits. It also stated that the interviews will be video and audio recorded in line with both the University's and Hospital Trust's policies. The research team's contact details were provided, if potential participants wished to seek further information.

The nurses were also asked to complete the Expression of Interest form (Appendix K). Once I received this, I added their details to a secure, confidential database where I checked that they met the inclusion criteria. Following this, they were emailed the Consent Form (Appendix L) to complete and return to me electronically before the interview. During the first part of the interview, I asked each the nurses whether they had any questions or concerns regarding any of the items on the Consent Form.

3.4.1.2 Confidentiality.

Care was taken to ensure confidentiality and was maintained throughout the process. At the end of each interview, I discussed with each participant which information they would like me to change or remove, for example, demographic details or if they had a unique role that could mean they may be easily identifiable. Participants were invited to choose their own pseudonyms, which were used for sending the audio recording to an independent transcription company and in the write-up of this thesis. Electronic data was kept secure by using password protection and then stored on an encrypted USB stick. The dictaphone was secured with the use of a pin code. When using the transcription company, a non-disclosure agreement was used (Appendix M).

3.4.1.3 Potential emotional distress.

Stories can help sustain people, even in challenging times (Bennett et al., 2020; Clandinin et al., 2018; Miczo, 2003). Yet, whilst the interview offers a discursive space, it remains paramount to consider that participants may be sharing these accounts whilst in a state of ongoing threat. Notably, not only are nurses telling their stories at a time of the ongoing physical threat of the virus, but also at a time of emotional threat. Sharing stories may be uncomfortable, and distressing for the participants, and therefore anticipating and preparing for this was essential. Advice was sought from a highly experienced clinical psychologist in the field of trauma at the University, who provided advice on shaping the interview structure to reduce the chance of additional distress. Below, I detail the strategies employed to mitigate additional distress:

- The recruitment strategy was designed to encourage individuals to have time and space to consider participation before expressing their interest.

- During the interview, participants were reminded that they could take breaks and that they can withdraw at any point during the interview.

- As with any research into sensitive topics, the establishment of rapport and helping participants feel comfortable is key (Dickson-Swift et al., 2009; Kleinman & Copp, 1993; Miczo, 2003). As a clinician with experience working therapeutically, I was well-placed to manage such situations. I maintained sensitivity to signs of distress from participants, specifically using a validating stance and not closing down signs of distress. This included advice on reminding participants that they only need to talk about what they feel able and willing to talk about, and at a level of detail that they feel comfortable with.
- I avoided probing questions regarding more detail about specific events that appear to be distressing for the participant.
- Narrative inquiry gives the agency to the participant, allowing them to be in control of the pace, length, structure, and content covered.
- It was anticipated that individuals may wish to seek out further emotional support following the interview. Therefore, each participant was emailed contact details of further support (Appendix N).

Awareness of the emotional safety of the researcher, particularly trainee researchers in qualitative research, is increasingly recognised (Bowtell et al., 2013). It was important to consider the importance of the potential impact on my wellbeing. Regular supervision with the research team, peer supervision, use of a reflective journal and self-care strategies were helpful.

3.4.1.4 The screen between us: Ethical issues relating to COVID-19.

From the very start of this project, it was uncertain whether the interviews would be conducted in person or remotely. In line with this, my ethical applications stated

that the interview setting will be subject to and in line with advice set out by the Government, NHS Trust, and the University of Hertfordshire at that point in time. Due to the ongoing COVID-19 restrictions, all interviews were conducted remotely. Further consideration around confidentiality was necessary such as asking the nurse whether they were somewhere where they would not be disturbed. I also informed them I was in a place where I would not be disturbed.

I noticed I felt apprehensive about conducting the interviews remotely. I wondered if the capacity to reflect, or emotional expression would be influenced by certain contexts, particularly in terms of what storylines or discourses are 'authorised'. The literature, however, highlights that video interviews were emerging as a way to conduct interviews, even outside of a world in a pandemic (Coomber, 1997; Seitz, 2015; Sullivan, 2012). Other benefits of video calls include personal convenience (Heath et al., 2018) and being at an emotionally safe distance, whilst also being face to face with the researcher (Dodds & Hess, 2020; Heath et al., 2018). I followed the Division of Clinical Psychology's guidelines on conducting remote therapy to help establish rapport (British Psychological Society, 2020).

3.5 The Interview Structure

At the start of the interview, I stated that the interview is anticipated to be approximately 90 minutes, although it can be shorter or longer than this. The Participant Information Sheet was reviewed, including reminders about the interview being video and audio recorded, and confidentiality.

The interview guide was pre-developed in collaboration with the relevant literature, the epistemological underpinnings, and discussions with the research team, peers and the research consultant. In line with the stance that narratives are

co-constructed, my role will both limit and shape the story told (Mishler, 1986; Seidman, 2006) - the interviews were loosely structured and gently guided (Squire, 2013). I began the interview with:

> *"I am interested in hearing about your experience of working in ICU during the COVID-19 pandemic. I will ask you to tell me your story; there are no rights or wrongs, I would just like to hear your story in your own words. So I will give you time and space to tell me about this as fully as you want to, or feel able to. I will sit back and listen, but I do have some areas that I would like cover"*

To promote narrative production, I incorporated questions relating to chronology and time (Appendix O). For example, *"Starting from the beginning, it would be good to know about you, growing up, did you always see yourself being a nurse?", "What was the turning point?", "What led to that?" and "Looking ahead, how do you see you future as a nurse?".* All interviews closed with an opportunity for participants to add anything they thought was important and to reflect on how the interview had been for them.

3.6 Analysing Stories

3.6.1 Transcription.

The process of turning talk into text is not a neutral task (Lyons, 2015), however, the time limitations for the project meant it was only possible for me to transcribe one of the six interviews. An independent transcription company was used to support the initial stages of verbatim transcription of content.

As immersing oneself in the data is paramount, I read each transcript in turn whilst listening back to the audio recording which allowed me to check accuracy and make necessary amendments. For all of the interviews, I further transcribed by listening to the audio and adding in communication that goes beyond words such as pauses, emphasis, tone, overlapping speech and changes in volume. This was adapted and simplified from Jefferson (2004) (Appendix P).

3.6.2 Analysing stories.

There is no one singular method for narrative analysis (Riessman, 1993) and summarising formal guidance is no straight-forward task. However, Riessman (2008) refers to three broad components to narrative analysis outline which considers content, structure and performative aspects of narrative. This is summarised below (Table 6), informed by the work of Benwell and Stokoe (2006), Riessman (2003; 2008), Murray and Sools (2015), and Wells (2011). Whilst the components below are presented in terms of discrete components, they were applied synergistically and flexibly to inform a broad analysis.

Table 6

Analysis Components

Analysis component	What this component explores
Content	• What is said, including identifying any themes/patterns

Structure	• How the narrative is told, including how it was organised • How stories began and ended • Storylines frequently drawn on • How stories within the narrative were woven together • Why certain storylines emerged at that point in the account • Use of discursive devices (i.e. mimicry, active voicing, repetition)
Performance	• How my position may have informed the narrative • Wider social, cultural and societal and institutional discourses that may be drawn on or resisted • How the nurse position *themselves* and others • How the narrative considers meaning-making and identities • The power dynamics which may be at play, what and who may be silenced or not feel entitled to make certain claims • Other ways the storylines may be interpreted

To immerse myself in the accounts, each narrative was first analysed as a whole. I listened to the audio whilst reading the transcript, which helped prompt my memory of the tone of the interview. I then repeatedly read each narrative to consider the components outlined above. Once I had listened to and read the accounts several times, I wrote a narrative impression for each account. The qualitative data analysis software, NVivo and Microsoft Word were used as a tool to manage, organise and assist in analysis. I then considered all accounts collectively, exploring similarities and differences across accounts. Here, I focused on specific events and identities

that appear to be privileged, with a focus on the performative and discursive aspects of narrative. See Appendix Q for the analysis process.

3.7 Ensuring Quality

Benchmarks of rigour and credibility in qualitative research can be ensured through quality criteria. These often consider concepts including transparency, reflexivity, and transferability of findings (Treharne & Riggs, 2015). Specific to narrative inquiry, and in line with a constructionist lens, the notion 'trustworthiness' over 'truth' is more appropriate (Riessman, 1993). The transcripts or analysis were not shared with the participants which is also in line with the constructionist stance. Moreover, there have been concerns about the impact of member checking on the emotional wellbeing of participants (Wells, 2011), particularly when the topic is potentially emotive. Therefore, as member checking was not appropriate for the current study, it was necessary to consider other approaches to support the credibility of my analysis. I used the quality criteria set out by Tracy (2010)[1] (discussed in the Chapter Five).

3.8 The Reflexive Researcher

Committing to the role of the reflexive researcher is imperative in high-quality, credible qualitative research (Treharne & Riggs, 2015). In the ensuing section, I describe how I employed both personal reflexivity and epistemological reflexivity throughout the research process.

Personal reflexivity involves the researcher attending to the multitude of lenses through which the data is viewed (Bowtell et al., 2013). It is a research tool that

[1] Reasons for the selection of this quality assessment were outlined in Chapter Two.

considers what is attended to, and what is not, involving an ongoing process of explicitly locating their experiences, assumptions, facets of identity, and values that influence the research. These are inevitably shaped by the socio-cultural context which, in turn, contextualises the interpretation of the data. It is necessary to be aware of how my methodological decision-making encourages the participant to construct certain identities and meanings, for example, the use of narrative analysis, and certain questions and prompts.

Using my research diary helped hone my reflexive thinking throughout (Appendix R-S). This included reflecting on what surprised me, emotions I experienced, language I was drawn to, and roles I found myself acting into or resisting (the therapist; the researcher; white, female, healthy, young, someone who did not have clinical contact with patients with COVID-19, and someone with health anxieties around contracting COVID-19). I also used my research diary to record 'unplanned' reflections that occurred outside of my dedicated research time.

Chapter Four: Analysis and Discussion

4.1 Chapter Overview

In this chapter, I address the research questions:

1. *How do NHS nurses construct their narratives of working in ICUs during the COVID-19 pandemic?*
2. *What identities are constructed in their narratives?*

In keeping with a constructionist narrative analysis, I provide a summary of each account, considering the main storylines. I consider content, structure and to some extent performance. I then consider the collective storylines across all six accounts. Here, I attend to the common and distinct threads, and relate these to performative, discursive and contextual aspects within different local and broader socio-political contexts. I also integrate a discussion of the stories in relation to the existing literature, exploring how the nurses' narratives speak to and beyond the existing discourse.

All interviews took place between December 2020 and February 2021. The interviews lasted between 60 minutes and 111 minutes. As previously noted, pseudonyms have been used and some identifiable information has been changed for anonymity purposes. Some of the nurses stated that they were happy for identifiable information to be kept in, and so this has been done where certain information is important in understanding broader stories. In keeping with the constructionist stance to the project, I continue to write in the first person; this is based on the understanding that the analyses are co-constructions from my

perspective of participant accounts, with the meanings both fluid and contextual (Earthy & Cronin, 2008).

4.2 Summary of Individual Stories

4.2.1 Rose's story.

Rose is a 28-year-old, White British woman with seven years' nursing experience and five years' ICU experience. This account was different to the others, in that in she worked across two sites during the pandemic. In addition to working at the hospital site, Rose was voluntarily redeployed to another hospital ward for several shifts.

Rose struck me as a compelling narrator. For the most part, her account followed a coherent and chronological sequence. Imbued with calmness, the account evolved gradually, which helped me develop a clear sense of time and place. She told me how in February 2020 *"word was getting around about coronavirus"* but that *"nobody ever really thought it was going to happen, but when the surrounding hospitals was so overwhelmed, we couldn't not*." Rose used vivid descriptions, for example she spoke of *"putting two patients in one-bed space"* and *"putting extra oxygen ports on the wall".* Woven into Rose's description was the use of technical, medical language (*"learning about how these patients behave"; "septic"; "200 systolic to about 60"; "mucus bugs*"), which appeared to highlight her knowledgeable position in keeping with the highly specialised and technical but somewhat impersonal ICU setting.

When talking of the impact of the pandemic, Rose spoke about how initially she thought it was *"just people scaremongering" and that she "underestimated it massively".* This was a phrase she repeated *("completely underestimated it")* but

soon after moved on to her talk about other, and more positively evaluated aspects of her experience, that it was *"nice to be part of"* something that would *"go down in history".*

A turning point in the account occurred when Rose spoke of the hospital she was redeployed to during the pandemic. This appeared to provide Rose, and me through the construction of her story, with a contrast between the two sites. Speaking of the hospital she was redeployed to, she narrated that the "*standard of care*" was lower. Rose also spoke about how her role changed when she was working at the other hospital, and this talk helped position herself professionally. She narrated how she had to support nurses who, unlike her, lacked previous ICU experience: "*they saw me as the ITU nurse any time anyone had any problems*" and that she was *"really pleased that they felt they could come to me".* She described that it was not just *"patients you were having to look after, it was all the staff as well".* This talk appeared to construct how Rose, despite being an experienced and specialised ICU nurse, was pushed beyond her comfort zone.

The narrative of 'quest' (Frank, 1995) emerges towards the end of the account when Rose narrated how her experience during the pandemic had led her to want to *"have some sort of management experience"* but also that *"covid has sort of accentuated the fact that I want to remain by the bedside".*

4.2.2 Amelia's story.

Amelia is a 56-year-old Asian woman. Though with 13 years' experience as a nurse in another department in the hospital, Amelia had no ICU experience before volunteering (her *"duty"*) to work for three days in the ICU during the pandemic. Amelia was at the hospital when the interview took place, and there were several

interruptions by her colleagues, something that may have contributed to the interrupted 'flow' and tone of the account.

Unlike Rose, Amelia did not 'set the scene' (Labov, 1972). Although English was not Amelia's first language, I had the impression that it was difficult for her to tell her story, as indicated by the structure of her talk. For example, she marked her account in three distinct days in a list-style format and made temporal jumps between these days (*"so, the first day, I thought, so much fear, one thing is covid, because (2) but only thing I'm encouraged the:: because the precautions help, so that's a strength for me to do, the work"* which was soon followed by *"and then second one, then the, erm, the night shift, I have done only three days. But it's first day, I'm totally confused like that because it's new environment").* With the absence of narrative detail, I felt distant from the narrative.

Telling me why she volunteered, Amelia referred to her *"duty"* to make her *"contribution"* and she is *"a little bit strong actually, even though fear"* in ways that resonate with broader societal narratives about nursing as a vocation and responsibility. Amelia then told me that she has a health condition that may have put her at further risk of more serious COVID-19 illness *("it's risky but, I did the risk also, thank god nothing happened"),* which supports her earlier story of *"strength".*

Like Rose, Amelia also constructed an identity as a competent nurse, while simultaneously stressing the difficulties of this period (*"its ↑challenging period actually, very challenging"*). A plot that appeared important for Amelia to convey was that she managed (*"I am just helping, but I manage a lot of things"; "even though difficulties, because I learn something and then next I can face without fear cos my fear↑ gone").* Yet woven into these stories were also talk of *"fears"*, such as feeling *"scared to breathe"* near her husband, swiftly followed by expressing her trust for the

PPE, describing it as a "*strength for me to do, the work"*. Amelia's talk appeared to combine a sense of personal threat with organisational protection.

Amelia discussed how many of the patients with COVID-19 that needed ICU care were of Asian ethnicity, and how this perpetuated *"more fear".* She spoke of needing to be *"more careful"* and that her *"guard need to be strong".* Amelia also discussed how her Buddhist faith and belief in karma played a part in her volunteering to work in the ICU, stating that she believed she was part of the wider organisation (*"helping for good things").*

4.2.3 Leia's story.

Leia, aged 30, is a White Italian woman and was at the hospital when the interview took place. With six years' experience as an ICU nurse prior to the pandemic, she had been specialising in another department within the hospital at the time. Leia returned to the ICU for six months during the height of the first wave of COVID-19 in April to September 2020. Leia spoke fast and switched between short stories quickly. For example, she moved from talking about anxiety about the patients with COVID-19 to talking about concerns about PPE *("the patients were totally different, so there was quite a lot of anxiety about, am I doing the ↑right thing. Um, I wasn't sure that the PPE are protecting us").*

Although working in another department in the hospital before the pandemic started, she positioned herself as a *"critical care nurse"* from early on. Throughout her narrative, Leia made relevant her values of compassionate and family-centred care. She told me how the hospital *"took the overflow"* from surrounding hospitals, *"very often families were not even aware that their loved one was with us"* and spoke of how it was *"very stressful and worrying"* for the patient's family. She discussed

how she was required to have *"difficult conversations over the phone".* Leia then spoke of having particularly struggled with *"not having the control" or* seeing *"how that person reacted to my words"* and *"not being able to offer them a drink",* highlighting the way that usual ICU working was so dramatically different under conditions of infection control restrictions. But during a period of time in which news reports of the pandemic's devastating impact in Italy, Leia also stressed wanting to treat *"my people" "back home"* in Italy, which, similar to Rose and Amelia, pointed to a sense of duty.

Leia ended her narrative by talk of having realised the importance of *"communicating with people that you love and make them know that you love them, share with them*
what's important to you". Yet this narrative soon comes to a halt, as if to remind us both that the pandemic is not over yet, and further constructs a sense of professional duty: *"if the pandemic takes over, I'm ready to go back to critical care".*

4.2.4 Anna's story

Anna, aged 41, is an Asian woman with 21 years' experience as a nurse. She usually works in another department within the hospital but volunteered to be redeployed to ICU for four days during the first wave of the pandemic. The interview took place when Anna was at work.

Many of Anna's stories showed her wanting to put others before herself , and in volunteering to work in the ICU during the pandemic, for example *("to help out").* Like the other nurses, this pointed to a sense of duty. This was also constructed by her telling me why she wanted to participate in the interview *("I want to help you with your research"),* despite initially expressing feeling *"worried"* about taking part in the interview.

Structurally, Anna began with brief answers to my questions, leading to a somewhat question-and-answer style format. Anna's answers became longer, however, when she told of the challenges of juggling work and childcare, and the difficult decision to send her children to school during the first national lockdown (*"we:: are sending you to school, not because we don't love you, we are sending you to school because mummy and daddy has to go to work").* Positions of 'good parent' and 'good nurse' were therefore apparent in the dilemma, as her 'hesitant' decision was narratively dismissed: *"we don't have a choice".*

Unlike Rose and Leia, the content and performance aspects of Anna's talk drew attention to the emotionality vulnerability of nurses during the pandemic. For example, when talking about working during the pandemic she said *"it's so hard to work in there because I am easily get attached to:: a patient"*. I noticed I felt moved by how distressed Anna was, and provided more validation than I did in other interviews. My response may have had an impact (or even disrupted) the depth of Anna's stories because at this stage the account moved briskly onto say *"but we get through it. That's what they say, we're in this together"* and that she adopted a practical approach (*"but you have to get on with it").* This may also point to not wanting to show 'too much' emotion and uphold 'professionality'. Anna's talk appeared to show a movement over time, away from the emotional vulnerability, when she storied *"I will volunteer to ITU again".* Ending her interview, she affirmed *"I think the future will be good"* and looks forward to 2021 *"whatever it brings. I think we are stronger"*. Anna's shifting between personal and collective pronouns (*"I"* and *"we"*) points to a corroboration with others, suggesting that a collective identity appeared to be protecting her somehow.

4.2.5 Jane's story.

Jane, aged 26, is a White British woman with four and a half years' nursing experience and three years' in ICU. The interview took place when Jane was at home. Although at the start, Jane told me her memory was a *"bit of a blur",* she appeared to retell stories as they came into her mind during the interview. I had the sense that this was a narrative not told until now.

Jane spoke of how she was not given a choice on whether to work during the pandemic *("we were just told to")*. Like Amelia, Jane highlighted the tension between a professional duty and duty towards the health of themselves and their families *("we're scared for ourselves, our families"; "you just do worry about passing it back onto your family")* – the use of *"we"* constructing an understandable collective concern of professionals, rather than a personal weakness.

Jane described how *"some nurses got to kind of rotate a bit and go to recovery or the ward",* but that this was not the case for her as *"every single shift I was in that covid area"),* yet *"didn't feel like I could (2) voice my opinion".* Jane also made relevant her position within the hierarchy when she told me *"you're just a band 5 on the ward who: you just get told what to do effectively (2) from your seniors (1) and you've just got to trust that (1) obviously, it's come from somewhere higher up".* This may draw on broader discourses of lack of agency within a broader hierarchical system, and/or professional responsibility, but an awareness that *"higher up"* were responsible for decision making. Another key thread within her account was the clear shift away from normal ICU patient care and nursing practice. Jane then spoke about struggling with the *"dignity side and the care side of things"* and how nurses were being required to perform duties *"we didn't have training on".* Yet, despite this, Jane

narrated *"it's kind of::: adapting to the times but still feeling (1) cautious and I guess like (1) worried about doing the wrong thing".*

The narrative shifted when Jane narrated how she used social media *"it was just a way of offloading"*. This suggests Jane was gradually feeling able to speak of her experiences - albeit in a virtual capacity - pointing to the veneer and distance of social media creating a safer space to share stories.

Towards the end of the account, Jane constructed the pandemic as a disruption to her career progression as an ICU nurse. She told me how the next module for her ICU training was *"postponed again because of covid"* which, she said, *"is a bit frustrating".* However, the tone shifted when Jane spoke feeling *"more confident"* and that she has placed *"less pressure"* on herself. Jane initially told me how she questioned her role as an ICU nurse: *"during the first wave"* she *"honestly thought:: I was going to give it up"* but – as with many of these nurses' accounts – concluded with a more hopeful note that *"things will eventually go back to some normality"* and that she now *"definitely"* wants to stay in ICU.

4.2.6 Ellie's story.

Ellie is a 31-year-old, White British woman with four years' experience as a nurse and one years' experience in ICU. During the first wave of the pandemic, she was working in another department within the hospital. Ellie's rotational post to ICU was delayed for several months due to the pandemic *("because they didn't want to move staff and start like retraining them in the middle of the pandemic").* Therefore, Ellie began working in ICU at the hospital site during the second wave. She was at home for the interview.

As she had previously worked in a different department, Ellie first spoke about the shift to ICU work generally. She told me that one of the things she initially *"really struggled with"* was that *"ITU itself is a whole different world of nursing"* which, she said, was *"strange to get my head around".* Ellie described how as people were *"sedated and ventilated", "they're a body in a bed, which like obviously, they're not, like people know they're a person"* – highlighting the challenges of moving to work in ITU, even without a pandemic.

Ellie explained that during the first wave of the pandemic when *"it was all kicking off",* she had some annual leave and volunteered to work at another hospital to care for those with COVID-19. She spoke of how *"it was probably the worst week of my entire life".* Ellie recalled a story of measuring a patient's oxygen saturation and having *"never seen oxygen levels like it"* , *"trying a different finger and I was like, maybe the reading is not right".* She spoke too about worry for the patients in other wards where she worked: *"I was so like scared of them covid getting on to that Unit and it would, from what I'd seen, I was like it would just wipe out the Unit"*. Of note is that Ellie initially spoke more about fears for the patients who were *"very complex"* and *"so vulnerable",* rather than worries for herself. It was only later in Ellie's account that she spoke about the worries she had for herself. She discussed realising she had COVID-19 antibodies and that this led her to feel *"much safer".*

Ellie recalled the difficulties she faced when she received emails asking her about working extra shifts. Her talk pointed to a tension between an organisational duty and self-care: *"finding that balance"* between wanting *"to go in and help"* but recognising that by continually working she could *"end up going off sick anyway",* and so she decided to *"pull back"* from extra shifts. Ellie then negotiated her position on language propagated by the media, such as the use of the 'hero' narrative,

wartime language: *"we didn't sign up to go to war, we signed up to be nurses and have been dragged into this"* and *"we didn't sign up for a suicide mission".*

Ellie concluded *"we are privileged compared to some other, how some other people have had it".* I wondered whether this was speaking to the protection that may have come with being a tertiary care centre, or pointing to a strong collective ICU identity narrated across the accounts.

4.3 Collective Stories

In considering the accounts collectively, I explore commonalities and differences between storylines, performance and discursive aspects, and draw on the contexts in which the narratives were produced. I also present this alongside existing literature. I weave in the nurses' quotations. For the longer quotations, time markers will be included for clarity regarding at what point in the interview the talk occurred. Table 7 summarises the main stories and substories.

Table 7

Stories and Substories

Story	Substory
"It came with like a bang"	• *"Nobody ever really thought it was going to happen": Tales of the unexpected* • *"We'd been red-zoned": Stepping up as a professional*
Working in the red zone	• *"You deserve so much more than this": Moral distress about standards of care* • *""An extra pair of hands": Redeployed nurses to ICU*

	• *"You were wearing a plastic bag while trying to do your job": The physical, psychological and social challenges of PPE* • *"Nurses just sit around playing on their phones all day": The impact of public misconceptions* • *"If we call them heroes then that will fix everything": Grappling with discourses of war and heroes* • *"No one's had a break": Unrelenting work and exhaustion*
Looking back, looking forward	• *"It's shown me how strong I am": Stories of growth* • *"There was this whole talk of the second wave…": An ending out of reach*

4.3.1 "It came with like a bang"

4.3.1.1 "Nobody ever really thought it was going to happen": Tales of the unexpected.

Across the accounts, although differing in level of detail, the arrival of the COVID-19 pandemic was depicted as a sudden disruption. All but two of the nurses (Amelia and Leia) 'set the scene' (Labov, 1972):

> *"It was just- it was just normal* [hospital site]. *Um, yeah, it was just all very normal and what we were used to. Um, and then around about sort of February time (1) um, sort of word was getting around about coronavirus and nobody ever really thought it was going to happen, or we were gunna- it was gunna-, you know, have much of an impact on us. But then, in a matter of weeks, we'd been red-zoned."*
>
> *Rose (10m)*

Rose's scripted a 'what could possibly go wrong?' plot familiar to the beginning of many stories ("*it was just normal* [hospital site]). Rose's talk of *"nobody ever really thought it was going to happen"* speaks to the work of Wooffitt (1992). Specifically, how constructing scenes of normality – and thus the narrator themselves as 'normal' and 'credible' - are important for those who begin to tell stories of extraordinary experiences. Rose then said *"but then, in a matter of weeks, we'd been red-zoned"*, which constructed the arrival of the pandemic as an abrupt departure from the scene of normality told moments before.

> *"I remember hearing, I really vividly remember like, there was a consultant in, um, and this was when covid was kind of that thing on the news happening in Italy that no one really believed would happen here, and there was a consultant that had a friend working in Italy. It was in the doctor's room talking to her colleagues, it was like, yeah, the, the hospitals in Italy are like running out of oxygen and it just sounded like this, this nuts thing".*
>
> *Ellie (17m)*

Ellie also sets the scene, narrating how she remembered *"really vividly"* the start of the pandemic. As in Wooffitt's (1992) previous analyses of people talking about events that others may struggle to understand or even believe, Rose and Ellie's accounts combine the hard-to-understand ("*this nuts thing"* events that "*no-one really believed would happen*") with discursive devices such as detailed description and reminders to the listeners that the narrator remembers this *"really vividly"* (Ellie). This was then juxtaposed with *"it kind of came then quite suddenly, it came with like a bang").* Again, with the use of onomatopoeia, highlights a departure from the norm

and the shock that came with this. Though incredible, these are first-hand, witness accounts that must be taken seriously (Edwards, 2005; 2007).

> *"the first thing I remember actually, was, um, when the matron came round with (2) I can't remember who it was, but someone very senior in the hospital and told the patients' relatives that they were going to have to start cutting down to only one visitor. Um, so this was before, you know, lockdown, social distancing. But I think government had given guidance that, you know, we were going to have to start (2) maybe potentially locking down, um, and trying to stop (1) the spread".*
>
> *Jane (19m)*

Jane also painted a vivid picture of how the arrival of the pandemic presented an interruption to the usual ICU activities. She also brought in the voice of someone higher in the hierarchy (*"someone very senior"*) to convey how from early on, difficult decisions were being made ("*cutting down to only one visitor")*. Again, the use of detailed description and narrative flow are widely understood by listeners as demonstrating plausible accounts of real events in constructing 'authentic' accounts (Edwards & Potter, 2001).

Jane's words chime with the recent accounts of ICU nurses in Spain (Fernández-Castillo et al. (2021), stressing the difficulty of patient isolation, and how this impacted on the nurses emotionally. Notably, the nurses in this study reported that reducing patient contact impacted their workload and their stress levels (Fernández-Castillo et al., 2021). Other studies discuss how the changes and ambiguities in protocols and guidelines around patient isolation led to reported confusion and

anxiety in nurses (Goh et al., 2020; Lee & Lee, 2020), although this did not feature in the nurses' accounts in the present study.

4.3.1.2 "We'd been red-zoned": Stepping up as a professional.

A strong theme across all of the nurses' narratives was of their professional commitment as nurses, and the sometimes-contradictory impacts of their professional identities. The nurses described wanting to help but at times narrated that they did not have a choice (due to their position in staff hierarchy, and feeling that they had a moral or professional obligation). This points to broader professional and cultural discourses as nursing as a vocation, and the dilemmas of this such as being torn between commitments to be a 'good nurse' and a 'good mother' (Anna).

For Amelia, Anna, and Leia, who were working in other departments when the pandemic started, the professional commitment was more explicit. Anna narrated how, despite ICU work being *"a really different area",* she wanted to help the ICU nurses ("*ITU nurses already have enough, you know, and then they need help. That's why I volunteer"),* which draws on broader professional nursing narratives about helping others in times of need.

Rose volunteered to work several shifts at another hospital in April 2020. Similar to Anna, Rose constructed a sense of professional duty and that she had skills to offer. Through her talk of surprise that more nurses did not *"jump at the opportunity*" to work at another hospital, Rose positioned herself as someone who was enthusiastic, despite the unknown. Rose further strengthened this when she explicitly narrated *"part of me was kind of excited (1) I know that sounds really awful".* Here, she expressed awareness of how I may be perceiving her, and perhaps

a taken-for-granted assumption of experiencing only distressing emotions at the pandemic. This chimes with research that working in novel and risky contexts has reported to increase the motivation of HCWs, as reported from a quantitative study from the 2009 H1N1 pandemic (Imai et al., 2010).

Leia, who was working in another department when the pandemic started, presented a story of concern for her colleagues working in the ICU. Leia pointed to a collective identity and sense of duty when she spoke of how she had *"really struggled"* with not being with her *"mates"* in ICU and that she *"knew from the beginning"* that she *"had to go back to help",* adding *"it just felt right".* Similar to Rose, Leia's talk spoke to a nursing as a vocation narrative. A sense of duty was apparent and strong, which may have stemmed not only from identity as an experienced and skilled ICU nurse but also as a friend. This echoes other recently emerging literature whereby nurses have reported a strong sense of duty and professional commitment to work during the pandemic (Cui et al., 2020; Goh et al., 2020). Zhang et al. (2020), however, propose that the sense of duty is more complex in that nurses reported a 'responsibility' to the 'sacred mission', yet also an 'obligation' to work during the pandemic due to fears contagious nature of the virus.

Jane, however, narrated how she was not given a choice:

> *"↓No:, it was never discussed. We, uh, we were just told to:: Well, it was just one day, "right, it's going to be a red zone" and that was it. You just had to, you just had to go in and, and um, you know, I ↓think maybe if you voiced concerns there would have been some support."*
>
> *Jane (48m)*

> *"I think I would have felt guilty not having a health problem and: being one of the younger members of the team, um, you know (1) if I'd have said, "oh no, I don't feel safe, I don't want to go in." Because at the end of the day, someone has to look after these patients. They're someone's family and:: I wouldn't, I think I, yeah, I wouldn't have felt right"*
>
> *Jane (49m)*

Jane constructed a sense of doing what she was told by those more senior *("we were just told to::")*. Here, she drew on her position with the staff hierarchy, and that this happened suddenly *("it was just one day"; "and that was it").* Jane reported that she worried about *"passing it back onto your family",* which echoes the COVID-19 literature that nurses encountered tension between one's professional duty to patients, and to one's own health and that of their family (Kherbache et al., 2021; Lord et al., 2021). Jane also drew on a combination of traditionally held nursing values of compassion (*"they're someone's family*") and professional responsibility when she said that she *"would have felt guilty"* not to work during the pandemic, with reference to her age and health status as protective factors.

It is of note that a sense of duty appears to have different nuances within the COVID-19 literature. Cui et al. (2020) and Zhang et al (2020) report the sense of duty as a 'badge of honour', showing allegiance to both the profession and country – this also fits with the intrinsic motivation aspect within self-determination theory (Ryan & Deci, 2000). However, the present study highlights how the over reliance on nurses being either intrinsically or extrinsically motivated is too dichotomous and oversimplistic. Indeed, this framework is likely to not take into account the very real dangers that come with being a nurse during a pandemic, particularly in the context

of long working hours, broader narratives that deny the existence of the pandemic, and celebration of nurses, yet lack of appropriate pay for their skill.

By contrast, the South-Korean study (Lee & Lee, 2020) describe a sense of duty as 'unavoidable' and an 'obligation', perhaps in fears of repercussions of *not* showing duty. The present study, by employing narrative analysis - and its focus on discursive elements and identity work – adds to the existing literature, notably the role of power within staff hierarchies and the juggling of competing identities ('good nurse', 'good mother').

It is also interesting to consider how able nurses may have felt to say they did not want to work, particularly as broader narratives of HCWs as 'saints' and 'heroes' was prevalent from the start of the pandemic. These narratives may have encouraged a sense of needing to 'rise to the challenge', despite anxieties. McDougall et al. (2021) discuss that although HCW's 'obligation' to care for patients is central to the running of healthcare systems, working during such crises raises questions about duty of care, due to the risks involved. As Ellie stated, *"we didn't sign up for a suicide mission".*

4.3.2 Working in the red zone.

4.3.2.1 "You deserve so much more than this": Moral distress about standards of care.

Given the demand placed on the ICU capacity, all of the nurses reported encountering fraught and deeply challenging situations relating to patient care. These included not being able to provide the usual standard of care in order to prioritise life-saving treatment, and witnessing the death of many patients.

Rose talked of how her expectations of the pandemic were very different from the reality (*"I underestimated it massively")* and that she *"didn't believe it at first".* Rose then explained:

> *"but it wasn't until we started receiving these patients and seeing how sick they really were, I was like, oh my God, and this is just (2) and there were thousands of them all over the country. Just very weird (2) very weird".*
>
> *Rose (15m)*

Rose appears to draw on a 'normalising device' (Jefferson, 1991) where speakers often initially say 'at first I thought X, then I realised Y…' to convey that their assumption is similar to others ("*didn't believe it at first*"), presenting themselves as a credible narrator. Rose then moved on to narrate the reality of the situation ("*seeing how sick they really were")* and repetition of "*very weird (2) very weird".* This too constructed a persuasive, first-hand witness account.

Later, Rose went on to speak about the difference in standard of care at the other hospital she was redeployed to:

> *"patients were like getting pressure sores and they didn't have mouth care equipment, so you couldn't give patients mouth care. So they, they didn't even have a supply of running, hot water. Um, so you were basically having to just baby wipe patients down, which I thought was just disgusting".*
>
> *Rose (48m)*

Rose then drew on nursing values of compassion when she narrated how she felt *"really, really sad"* and *"I just thought, 'my God, you* [the patients] *deserve so much*

more than this'". This speaks to what Chan et al. (2013) calls an 'atrocity story' where one affirms their disapproval of such a situation to reinforce their views and boundaries, which, therefore, draws the listener in. This talk reflected how Rose faced a tension between her identity a skilled ICU nurse within a specialist hospital, and, due to lack of resources, a stark encounter with being unable to deliver patient care at the hospital she was redeployed to. Rose's talk points to an impossible moral dilemma: in the face of so many unwell patients and low resources, the standards of care were not good enough.

Jane spoke of how she struggled with the *"dignity side and the care side"* of patient care. For example, she recounted how patients were required to be transferred around the hospital with a *"drape over their beds"* to stop *"aerosols or things spreading".* Jane then told me how this was *"slightly undignified, you would never do that normally with a patient".* Jane also narrated *"we-we never really <u>proned</u> patients, it was kind of last resort"* but *"nearly every patient was being proned".* Jane then moved on to talk about the shift in patient care and tasks, "*we were never kind of <u>told</u> what you do if some, if someone goes to the toilet and they're lying on their front".* Jane's talk, again with continued vivid description (Edwards, 2005; 2007), helped to construct the scene as a clear departure from the usual activities.

Jane reported feeling unable to do provide the care she usually would *("I love(2) being able to wash my patients' <u>hair</u>, play with, you know, <u>play</u> with their <u>hair</u>, hold their <u>hand</u>, things like that")* in fear of becoming infected. A key concern for Jane was passing the virus on to her family (*"you just <u>do</u> <u>wo</u>rry about passing it back onto your family").* Jane's talk speaks to how nurses were faced with the complex tension between professional duty and personal duties to protect themselves and their family (Ganz et al., 2019; Kherbache et al., 2021; Lord et al., 2021), further highlighting

juggling demands of competing identities. This also highlights how the pandemic marked a crisis that undermined nurses' capacity to treat patients whilst maintaining their own safety (Anders, 2020).

Leia spoke of *"working with bodies rather than, rather than patients"* and that *"it didn't feel for a nurse that we were really nursing them. We were: (2) doing really our best but (1) we were not looking after them the way we would have done if we had the resources".* Leia then narrated how although usually *"we like to get to know our patients"* but *"we had to choose to provide the, the life-saving treatment".* This points to the inability to protect patient's dignity at all times, in keeping with the normal order of care, was distressing for the nurses, which aligns with the literature on moral distress (Greenberg et al., 2020). This echoes the reported finding that ethical challenges related to patient care were a key source of distress for nurses (Fernández-Castillo et al., 2001; Galehdar et al., 2020; Jia et al., 2021; Tan et al., 2020).

> *"you would have suddenly:: in a week, three, four deaths, one after the other, and then:: being always a bit worried, is there enough space in the ↑mortuary. Would we have to move bodies somewhere else? And then, when you, when you had someone dying, we were very conscious that we were the last, the last ones to see that person, because once the body bag was sealed, there was no, no way that that could have been reopened. So the families were not able to do any visit and we were very conscious that that was us, the last, the last people that saw that, the poor person that died".*
>
> *Leia (12m)*

Above, Leia highlighted how, in addition to trying to keep as many patients as possible alive, there were practical implications of the high number of patient deaths ("*one after the other"),* such as mortuary space. Leia then narrated how this was something she had *"not prepared for",* again highlighting how patient deaths were not being handled in the way they usually would.

Mortuary space is not discussed in the reviewed studies, however, the NHS England (2020) stated that the pandemic placed increased demand on mortuary services nationally. Furthermore, Horton (2020) in a commentary in The Lancet, reported that during the first wave of the pandemic in some UK hospitals, emergency mortuary space was created in car parks, where bodies were moved at night to avoid attention from the media.

Ellie was working at another hospital when the pandemic started (before moving to ICU at the recruiting hospital site). She told me:

> *"they knew that they were going to run out of intensive care beds, so they made a lot of people not for resus or not for intensive care and I had one shift where I just had like three, or like two or three patients in a row just deteriorate, deteriorate, deteriorate and like talking to the doctors who were really busy and I was like, "can, you know, this guy, he's got, his oxygen levels are like in his boots", like can he come and see him and they were like "he's not for resus." and that was the answer, and I was like, "need to come and see them" and they were like, "yeah, they're not for resus.""*
>
> *Ellie (17m)*

Ellie's active voicing (Wooffitt, 1992) to bring in the voice of *"the doctors"* and repetition (*"he's not for resus"*), help construct the drama and reality of this scene.

Her sense of powerlessness is conveyed as she continued: *"but from your perspective as a nurse, when you're just watching that and you're like, what are we doing, like (2) this is mad*". Ellie's position in the hierarchy (nurse rather than *"the doctors":* removed from decisions that others *("they")* make and passive positioning *"just watching")* convey a sense of powerlessness in the face of such events. Ellie needing to adopt a bystander position chimes with nurses' reportings in the Canadian study (Lapum et al., 2021). Ellie's switches of pronoun also suggest a collective, shared experience amoung nurses, and an ongoing struggle to make sense of this. Wider narratives from Ellie and others highlight the significant pressure on ICUs and the need to make difficult decisions, which prevent them fulfilling roles as they usually would.

> *"I had friends on the unit who, you know, one, she had to sit with the webcam on like while the patient was dying for the fam<u>ily</u> to like watch the patient die, basically."*
>
> *Jane (68m)*

This is echoed in the COVID-19 literature, which highlights that nurses faced a multitude of morally challenging situations during the current pandemic (Jia et al., 2021; Lapum et al., 2021; Tan et al, 2020), including patients dying without their loved ones present (Cui et al., 2020; Fernández-Castillo et al., 2021; Galehdar et al., 2020; Lapum et al. 2021). As the nurses in the current study reported, much of this distress came from being unable to provide the usual standard of care, or having no choice but to take a passive, rather than an active role (Kok et al., 2020). Cui et al. (2020) discuss that nurses reported they were labelled as 'carriers of the virus' by the public, which contributed to moral distress. The existing ICU, pre-COVID-19

literature highlights how end of life care, and preparation for this, is a 'moral imperative' for ICU nurses (Peden-McAlpine et al., 2015), thus the COVID-19 pandemic marked another clear disruption from the norm for the nurses.

4.3.2.2 "An extra pair of hands": Redeployed nurses to ICU.

Amelia, a nurse redeployed from another department in the hospital, spoke about the initial challenges of working in ICU. Jane and Leia (with ICU experience) and Ellie (without ICU experience) recounted the experience of working with nurses who were redeployed to ICU, and all framed this as challenging. Rose, by contrast, was also redeployed to another hospital. However, unlike other nurses at the other hospital, Rose also supported other redeployed nurses from *"non-essential services":*

> *"most of the registered nurses that were there, they'd been redeployed from sort of (1) non-essential services such as, um, ophthalmology, sexual health. So most of these nurses who were there, the-they hadn't really been working in the clinical area for years, um, so we were suddenly thrust back into this environment. Not only was it clinical they were being expected to look after, you know, one or two ITU patients, without any training um:: it must have been a lot worse for them than it was for me, but because:: I have to say they were amazing".*
>
> *Rose (32m)*

Rose used perspective-taking and empathy to construct her account of what it may have been like for the nurses who were redeployed. She also used the pronoun *"we",* aligning herself with the redeployed nurses, which draws on broader

professional nursing narratives of not only supporting patients but also her colleagues. Rose then narrated how, as an experienced ICU nurse, she was required to take a leadership role. This too points to Rose's sense of 'duty' not only to patients but, as a skilled ICU nurse, as a duty to support the other nurses. Below, Rose spoke of doing the *"ITU-y"* stuff, which speaks to how ICU nurses are more familiar with performing technical procedures (Credland, 2021) and treating the most unwell patients (Park, 2020):

> *"I was kind of overseeing all six patients and all the staff, um (2) just to make sure that all the sort of most important things were being done. Um, yeah (2) so they were kind of bedside nursing, but I was sort of doing the more ITU-y stuff".*
>
> *Rose (32m)*

Jane also narrated what it was like to work with redeployed nurses, but with a different perspective:

> *"I actually think it (2) I know this sounds horrible because (1) of course, they wanted to do their bit and help out and like I'm super grateful for that but I honestly think it added to our stress, um, instead of having an extra pair of hands to help, it was, it was kind of trying to, trying to teach them at the same time while trying to look after a patient, and you're not even familiar with this, um, illness."*
>
> *Jane (57m)*

Structurally, Jane preceded her story by saying *"I know this sounds horrible"* and *"I'm super grateful"* – perhaps a hedge (Weatherall, 2011). Here, Jane appeared to

be putting in work to not be seen as a 'complainer' or 'unprofessional' at a time when there is broader controversy about the COVID-19 pandemic. This speaks to the dilemma that nurses were faced with – between upholding professionality, whilst still communicating the challenges she faced. Indeed, this is within a context of broader counter-narratives propagated by both the media and the government, which may undermine nurses' stories in terms of *what* they say, and *how* - including narratives that deny the existence of the pandemic. As such, the use of this hedge may speak to the nurses guarding against the risk of being seen as a complainer. Yet, despite this, Jane clearly conveyed the difficulties that came with working with redeployed staff. Her talk may also speak to the impact of there being newcomers at a time when a collective identity appeared to be protective, and supports the literature regarding the importance of a sense of belonging during a crisis (King's Fund, 2020b).

Ellie also recounted the difficulties of working with redeployed staff. Although she reminded me that she was *"a new ITU nurse as well",* the content and performance aspects of her talk positioned her otherwise (*"like you've got an extra pair of <u>hands</u> but then actually in other ways, then you're also trying to teach, which takes so much longer").* Ellie then discussed the time pressures the unit was under: *"there wasn't time to do that like nicey-nicey like this is, you know, welcome to intensive care like, you know, this is how this works and this is how this works".* This supports the literature around how a task-orientated approach can encourage silo working and the slipping of the usual niceties (BPS COVID-19 Staff Wellbeing Group, 2020). Ellie also described how the experience presented a disruption to her professional identity as a nurse *("I became then quite like directive, which you don't like")*. Ellie's shift in pronouns from *"I"* to *"you"*, may also signal something that was beyond her control.

> *"So there was also this burden for us with the critical care experience to be named a nurse A to supervise the nurse B who's a nurse that doesn't have ICU experience. And they were very scared and for them, it was so difficult. They, they would be crying every day and having really difficult times, um, but also for us as being experienced nurse, very often you would (2) find yourself the only one experienced nurse with six very sick, sick patients to look after the patients and the nurses. It was very tough."*
>
> *Leia (9m)*

Leia's story had similarities with Ellie's in that she narrated the difficulty of working with redeployed nurses due to the many other challenges they faced, however, also has similarities with Rose's by conveying empathy for the redeployed nurses.

As a redeployed nurse from another department within the hospital, Amelia narrated her experience of working in ICU for three days:

> *"First day, good supporter, I think I didn't get good supporter first day, cos itu were so busy, that's the main thing you know, I had to familiarise their computers, their places, you know (2) new place, I had to familiarise myself a little bit. I know I go there, come back, but I didn't work like, I feel like (2) if I saw the sea, but the sea I didn't go and swim, but I have swim before, but I haven't:: you know, background:: everything together, that's why. I am not happy for the first day cos totally my mind not very good, because fear also, and workload also, and the people not (2), I think I got a bit new girl."*
>
> *Amelia (24m)*

The two stories above, from Leia (ICU-trained) and Amelia (redeployed), highlights the emotional impact for redeployed nurses from different perspectives. Supporting Ellie's

story, Amelia too points to the pressures on staff led to difficulties for the induction of redeployed staff ("*I think I didn't get good supporter first day, cos ITU were so busy").* Amelia then spoke of the emotional experience *("fear"* and *"my mind not very good")* and draws on a school metaphor (*"I think I got a bit new girl")*, which may speak to the collective ICU identity of the ICU team. A systematic review of HCWs redeployed to ICUs during the COVID-19 pandemic reported high levels of anxiety and stress and this was largely attributed to a lack of adequate support (Juan et al., 2021). Further, in an online international study HCWs redeployed to ICU during the current pandemic reported higher levels of depression, and noted that they were dissatisfied with the quantity and quality of training they received (Khajuria et al., 2021). The challenges of working with redeployed staff echoes a theme in the study by Fernández-Castillo et al. (2021). Other studies stated they required participants to have a minimum experience of working directly with COVID-19 positive patients such as two weeks (Galehdar et al., 2020) or seven days (Sheng et al., 2020). Despite the inclusion of redeployed nurses in their sample, however, neither explicitly discuss the experiences of the redeployment from nurses. Not only is this present study different in terms of the variation of length of time nurses worked in ICU for, but also offers stories from these different positions.

The redeployment of nurses to ICU during the current pandemic – for both ICU nurses and those redeployed – highlights how working conditions influence psychological distress, and therefore overlaps with the models of occupational stress. The P-E Fit model (Caplan,1987) highlights that dissonance between a worker's individual characteristics with work context impacts wellbeing, whereas the DCS model (Karasek & Theorell, 1990) proposes that wellbeing is most impacted when workers are faced with high demands and perceived low control. This is also supported by a qualitative study (Feeley et al., 2020) from the COVID-19 pandemic,

where redeployed staff reported a greater disruption of the balance between the worker and the environment and higher levels of stress.

4.3.2.3 "You were wearing a plastic bag while trying to do your job": The physical, psychological and social challenges of PPE.

With the exception of Anna, stories of PPE featured across the narratives. This included stories of depleting PPE supplies, concerns about whether the PPE would sufficiently protect them, the physical and psychological impact of wearing PPE, interwoven with stories of feeling let down by the system.

Rose narrated how, during the first wave of the pandemic, she felt *"a bit angry"* about not having *"↑simple thing as to not having proper PPE"*. The use of "*simple thing"* points to feeling let down by the system, and adequate PPE being something they should have but did not, without explicitly attributing blame. This is further constructed through her talk of feeling *"a bit"* angry –pointing to how she does not hope to be viewed as a 'complainer'. She then spoke about how the senior nurses resorted to making their own PPE:

> *"all the band 7s, they just literally went to Hobby Craft, got some like clear plastic and made their own visors they bought some plastic, they bought some foam (1) like (2) fixed some elastic around the, around the, around the headpiece, so we just had these hand - these homemade visors".*
>
> *Rose (26m)*

This reflects a wider issue of the shortage of adequate PPE both nationally (Dean, 2020; Campbell, 2020; Mason, 2020) and internationally (Triggle, 2020; WHO, 2020), particularly during the early stages of the pandemic. Although this shortage was also echoed by some of the reviewed studies (Fernández-Castillo et al., 2021; Lapum et al., 2021; Tan et al., 2020), none of them discuss having to resort to making their own PPE, as was necessary in the UK (Ford, 2020; Marsh,

2020). Further, the discursive elements of the analysis in the present study also points to feeling let down by the system

Jia et al. (2021), however, report that due to insufficient PPE, such as splash-proof respirators, some of the medical staff reduced the frequency of exposing themselves to reduce the chance of transmission. They also reported that some of the medics worked slowly to avoid aerosols and becoming infected (Jia et al., 2021).

Jane narrated how *they "had gowns at one point that we were joking, they look like shrouds, like they were just plastic like nighties"* as this was *"whatever we could get".* Jane then narrated how *"It was like you were wearing a plastic bag whiletrying to do your job."* Although Jane told this story through light tone and humour - and she is not strongly 'complaining' - the description and content of her talk allowed me to get a good grasp of what this may have been like for the nurses. The use of *"we were joking",* with collective pronouns pointed to a shared identity, and an 'inside joke' with others. Jane then narrated a story of how it was only when *"someone higher up"* would not wear the existing PPE due to fears it was not sufficiently protective, that new PPE supplies were delivered:

> *"we had one night where we had to: (1) we were running like really, really short in PPE and they had to call in, they had to call some site manager or I honestly don't know who it was, but someone higher up. And the man came in, saw the PPE and was like, "I'm not going on the ward in that. Like that wouldn't protect me." And so he then, within half an hour, we suddenly had loads of new PPE delivered, and for us, I think it's outrageous that they're happy for nurses to, to put themselves on that, and doctors that, that were on the ward, wear that PPE for however long but the second someone higher up comes in and says, "no, that's not good enough," suddenly more PPE arrives and I just think it's, it's*

actually quite disgusting that we're not treated in the same way that they want to be treated effectively".

Jane (79m)

Jane's story further built on Rose's, that nurses were let down by the system at times. However, Jane's account takes a different turn. Whereas Rose's story pointed to the initial depleted PPE supplies, Jane highlighted how there *was* adequate PPE, but only when *"someone higher up"* requests better PPE, was this actioned. These stories illustrate a point not referenced in the existing literature, notably the broader narratives about nurses not being valued or heard (Catton, 2020; McIlroy, 2020), whilst being depicted as heroes in the media (BBC news, 2021a; Clarke, 2021). As of January 2021, at least 850 UK HCWs are reported to have died due to known COVID-19 infection between March and December 2020 (Berger, 2021). Further, in July 2020, Ford (2020) reported that England and Wales had the second highest death rate of HCWs due to known COVID-19 infection globally.

Both Jane and Ellie narrated the practical difficulties of wearing PPE. They discussed their worries about drinking too much water and needing the toilet, thus the 'donning' and 'doffing' of PPE again. This is consistent with other research that many HCWs reported feeling guilty about 'wasting' PPE (Hoernke et al., 2021; Vindrola-Padros et al., 2020). It also appeared that Jane and Ellie constructed a sense of 'taken-for-granted' understanding that I am not expecting them to talk of the challenges of PPE. For example, Jane said she remembered PPE "more *than the care of the patients"*. This is also suggested in Ellie's account when she frequently uses the word *"actually"* interspersed with laughter:

"losing that freedom of like actually, I want to drink water and then be able to go to the toilet when I need to, haha it's like (2) it sounds like a silly thing but actually, that's actually one of the biggest things that I've found really difficult haha".

Ellie (29m)

However, unlike the other narratives, Amelia spoke of how her *"trust"* for the protections were a *"strength"* for her to work:

"So, the first day, I thought, so much fear, one thing is covid, because (2) but only thing I'm encouraged the:: because the precautions help, so that's a strength for me to do, the work, starting, without fear for the covid spreading like that, like, cos we are, too much erm:: like, like a trust for the protections".

Amelia (8m)

Concerns over whether the nurses were adequately protected by PPE and the physical challenges of wearing it was discussed in several studies in the literature (Cui et al., 2020; Galehdar et al., 2020; Goh et al., 2020; Lee & Lee, 2020; Sheng et al., 2020; Zhang et al., 2020). Leia's talk was also in line with this. She first narrated that she was unsure whether the PPE was going to protect her (*"I wasn't sure that the PPE are protecting us").* She then moved on to talk about the impact physically (*"causing pressure sores"; "you can't breathe with your nose, you have to breathe with your mouth").* Leia briefly interwove the psychological impact of wearing PPE within her talk of the physical discomfort ("*I'm a bit claustrophobic*"), however, this was immediately followed by turning attention to the patients ("*just look after the patients in front of you (1) patients that are super sick and they are alone and, uh, you always feel like you're not doing, um, ↑enough*"). This highlights how, despite the

clear challenges that came with PPE, both physically and psychologically, it appeared important for Leia to maintain 'professionality' by drawing on broader nursing narratives and relating her story back to patient care.

Despite the difficulties of wearing PPE, when asked about whether there were any positive aspects of working during the pandemic, Leia also discussed how the PPE led to communication barriers disappearing *("the barrier is no longer there").* She told me how all the staff were dressed the same, it was easier to speak to others who were more senior (*"we (2) were all scared and we looked at each other and we, we all felt the same.").* Leia's talk pointed to PPE adding to the collective identity of the staff team in a positive way, and is an alternative to earlier stories of the prevalent hierarchies, as narrated by Jane. This storyline is novel, and not discussed in the reviewed literature.

4.3.2.4 "Nurses just sit around playing on their phones all day": The impact of public misconceptions.

Stories of public misconceptions were woven throughout some of the accounts, particularly Jane's, Ellie's, Rose's, and Leia's. Jane narrated how she used social media to *"just having a bit of moan, basically",* yet, this was met with *"quite a lot of negative comments"* from the public. Jane explained how she was told *"hospital wards are empty, just like (2), stop lying and like get over yourself", "you signed up for this" and "nurses just sit around playing on their phones all day".* Jane then narrated how *"I don't know what they think what we're doing because they think it's empty* [the hospitals] *(2) and that it doesn't exist"* [the virus].

This chimes with the contention in the media about 'covid deniers' (BBC News, 2021b; Giles, 2021), a storyline that Jane developed through her account. Jane then used a reflexive comment - or a 'concession' (Mulholland, 1994): *"I like to think I'm an understanding person"* and that *"it must be hard for people to understand something that they're not seeing".* Jane showing awareness of 'all sides' and empathy, and continuing to uphold 'professionality', further strengthened her account. This is often used 'in the face of resistance' (Mueller & Whittle, 2011) - or specific to the pandemic - other narratives which undermine the credibility of nurses' accounts.

Jane and Leia narrated feeling unsatisfied with the documentaries that were made about the pandemic: *"even some of the documentaries that were made, they just don't give th- the real experience"* and *"you can't really film like raw footage of actual patients dying or like having their bowels open in prone position"* (Jane) and *"what the media has covered probably is not what I would have expected, what I would have wanted"* (Leia).

Rose referred to the media surrounding the hospital she was redeployed to as a *"media circus"* and a *"publicity stunt"* and how it had not shown *"how things really were".* Rose then went on to say:

> *"the way that things have been portrayed to the public, was just completely inaccurate and I don't think it- it had really shown how things really were. Um, I'm not saying (1) yeah, I guess, it was (3) I- I don't know. Um, but, but then, from what I've sort of read from other sections of the media, from the people who worked there, they've, you know, have praised the* [other hospital], *said*

that it's amazing. You've had such a great time here, but I just couldn't help but think, but what were we at the same place?"

Rose (57m)

Ellie, however, spoke about how the pandemic has prompted a shift in public awareness of the NHS:

"I think for a long time the NHS has been completely unappreciated or just taken for granted by (1) people and the public, generally. Um, for, yeah, for like a long, long time and then this happened and people, I don't know, suddenly seem to realise like actually, I think the NHS is the best thing about this country and it's like people (2) yeah, will work and also, you know, put themselves at risk"

Ellie (47m)

"this is great that people are appreciating it but I just think as a profession as well, it's not paid well enough or some of the (3) like, yeah, benefits of being in it (1) aren't enough. And it was like, ah, the clapping stopped and then they (1) what they didn't give, they gave a lot of the other public sector a pay rise and not nursing and I was like, that hurts haha"

Ellie (48m)

Ellie's talk highlighted how although the pandemic has prompted awareness of the NHS, there is a sense of this appreciation being 'too little too late', particularly given *"people"* (assumed to be nurses) do not get paid enough and *"will put themselves at risk"* – possibly linked to a sense of duty and commitment to patient care. The use of laughter could be managing what may be perceived as an

'overreaction' (again, in the face of broader counter-narratives), which Edwards (2005) proposes can strengthen a 'complaint's' basis, or perhaps making an uncomfortable story easier to narrate.

In contrast with the reviewed studies, this research discussed the role of public misconceptions related to 'covid deniers'. Whilst two of the reviewed studies discussed the role of the public (Galehdar et al., 2020; Lee & Lee, 2020), these were different themes to the ones in the current study. For example, Galehdar et al. (2020) discuss that nurses reported 'public ignorance' of the preventative measures, and nurses reported that this led to anxiety. The nurses in this study reported wanting media footage to "scare" the public into adhering to measures (Galehdar et al., 2020). Lee and Lee (2020), however, state that nurses were met with criticism when they became diagnosed with COVID-19, questioning whether they correctly removed their PPE, or criticism re whether HCWs could go to places such as restaurants or the gym.

Of note is that storylines of frustration about the media coverage did not arise in Anna or Amelia's accounts. It may be relevant that Anna and Amelia were the two redeployed, non-ICU trained nurses who, at the time of the interview, had worked several days in ICU. Although they both reported facing many challenges during their time on the ICU, it is likely that they were not required to sustain the level of work over several months. Furthermore, it may be relevant to consider, due to being redeployed, whether or not they feel 'entitled' or 'credible' to make claims about public misconceptions and the role of the media.

4.3.2.5 "If we call them heroes then that will fix everything": Grappling with discourses of war and heroes.

Another thread throughout the accounts was a negotiation of positions on the media discourses, such as the 'health care workers as heroes' narratives and war metaphors. Whilst Rose and Jane drew on these metaphors in their talk, *("it was just honestly like a war zone"* – Rose) and *("you're walking into the enemy effectively but then it's a person that needs your care"* - Jane), Leia and Ellie grappled with their position in this regard.

Although Leia first described that when people *"look at you with admiration"* it felt *"good",* this shifted as her narrative developed. In addition to the challenges reported, Leia's talk pointed to social isolation. Using active voicing (Wooffitt, 1992), she told a story of being in a supermarket that told NHS workers *"'whatever you touch, you need to buy, because you may be contagious'".* She then went on to say *"they're saying that we're heroes but actually, they're looking at us now like we're the ones spreading the disease".* This is consistent with Lee and Lee (2020), where nurses reported discrimination in their daily lives and that others were avoiding them. This speaks to the broader narratives at the time around the public perception of HCWs, which are particularly important in a pandemic where community-centred care is reported to be necessary over the patient-centered care model which dominates in Western healthcare systems (Nacoti et al., 2020). A mixed methods study (Dye et al., 2020) noted that HCWs reported experiencing COVID-19 related stigma in relation to being perceived as 'carriers' of the virus. Leia then offered an alternative to the hero narrative: *"ideally, I would like us, all of us, to be recognised as professionals, highly skilled professionals more than heroes".* Here,

the use of *"ideally"* constructed a sense that she does not currently feel valued at work or by society. Soon after, Leia discussed the media's use of military discourse:

> *"people say they do the comparison with being at, at war with covid or being at war, with a real war that we had with the veterans and stuff, but no, it's not the same. It's a totally different scenario, it's a very tricky situation. But now, personally, I don't like to be called a hero, uh, at all. I, I like to be recognised as a professional with lots of skills and the ability to look after and care for these patients. All they would like is that we would be recognised and, uh, and valued for that more than just being celebrated, uh:: with clapping. Also, the NHS discount everywhere. Yes, it's nice or when I just skipping the queue at the supermarket. I've, I've never felt comfortable doing it".*
>
> *Leia (29m)*

Ellie narrated a similar story:

> *"They used a lot of the like war language and it was like, even, you know, like the heroes in the frontline and I don't know, there was a lot of links to like the war. But it did just feel as well it was like(1) or, you know, a lot like, quite a lot of NHS staff died and then it was kind of, yeah, like linking back to a war and I was like, this is different though, like people didn't sign up to this."*
>
> *Ellie (50m)*
>
> *Ellie: "I'm glad that then the NHS and nursing staff and like have that maybe newfound kind of respect, but actually calling people heroes doesn't fix anything if you're not then going to give them PPE, and (2) I don't know. So I guess tinged as well with there was kind of like, oh, but, you know, they, they're just nurses, so actually, if we call them heroes then that will fix everything?, and*

> *it's like, no actually, you still need to provide the PPE and give people adequate breaks and decent like working conditions"*
>
> *Ellie (51m)*

Leia and Ellie's stories speak to the broader issue of how nurses were showed gratitude yet continued not to be valued. As Leia stated, she hoped to be "*valued for that more than just being celebrated*". This relates to the work of Cox (2020) who writes that the 'HCWs as heroes' narrative is inappropriate as a nurses' duty to treat is not limitless, and therefore proposes that a clumsy use of this rhetoric can stifle discussion on what this limit *is*. Further, Cox (2020) also states that heroism involves voluntary action and a degree of some sort of risk (Cox, 2020; Urmson, 1958) – something which Ellie explicitly countered *("people didn't sign up to this"*). This too was echoed by Jane *("we didn't sign up to fight a pandemic, like I signed up to be an ITU nurse").* Mathers and Kitchen (2020) write how the hero narrative, endorsed by the Government, deflects responsibility of how the pandemic was handled. These stories continue to build on narratives previously told, particularly by Jane and Rose, related to how during the pandemic, nurses had been forgotten (Bettiza, 2020; Slavitt, 2020), silenced and exploited (Daly et al., 2020). A recent discourse analysis (Mohammed et al., 2021) states the hero discourse is not a neutral expression of recognition of gratitude, but rather a politically, culturally and socially convenient device employed to normalise the dangers nurses were exposed to, in spite of low pay (Clarke, 2021; Gunawan, 2020; Munn, 2020). Mohamed et al. (2021) also propose that the hero rhetoric positions nurses to make 'necessary sacrifices' without sufficient recognition of the emotional, physical and ethical challenges.

By contrast, Lee and Lee (2020) argue that public support was a strong motivator for the nurses. However, the author's heavy use of war language for the title of the proposed themes such as *'pushed onto the battlefield without any preparation'* and *'unexpectedly long war'* is disproportionate to the amount of war language apparent in the participant excerpts, suggesting less contention related to this rhetoric. The storyline (and counter-narrative) in the present study, that nurses contended with the military and heroes discourses, adds a novel layer to the existing literature.

4.3.2.6 "No one's had a break": Unrelenting work and exhaustion.

For the nurses, during the COVID-19 pandemic there was a relentlessness to the work as the nation embarked on the second wave. This was a particularly prominent story in the accounts of the ICU-trained nurse who sustained the level of work for many months. Exhaustion due to the intensity of the work was hampered not only by the repeated cancellation of annual leave, but also the restoration of 'routine' hospital activities due to the earlier cancellation of 'routine' work while COVID-19 treatment needed to be prioritised.

Jane narrated how she felt *"angry"* as *"annual leave was being cancelled"* and that "*no one's had a break",* she then explained:

> *"people are having time off because they're sick, probably because they're burnt out, they're, you know, run down. Um, and you just think, well, what (2) I don't know, ↓not- not forgotten but I think at the beginning everyone, you know, it was sort of the claps for the nurses and, or clap for carers, then (2) you know, all the donations and stuff and then suddenly, you're still working through it, through a pandemic and I think people forget almost and, um, and I'm not saying we've had it harder than other people (1) at all, but you do just think,*

> *actually, "do people realise like how long this has gone on for us" and (2) we've actually not had a break and, and we've, you know, have, have we (3) been asked if we are OK?"*
>
> *Jane (50m)*

Although Jane began this story by narrating how she did not think the nurses were forgotten ("*not forgotten")* and how at the start there were *"the claps for the nurses"* and *"all the donations and stuff",* this then shifted: *"you're still working through it, through a pandemic and I think people forget"*, pointing toher fatigue and weariness. Jane then narrated "*I'm not saying we've had it harder than other people",* which is similar to Rose's talk (*"I don't really like to moan*"; *"nobody really had a- cared about us, really" and "we were just expected to get on with it").* Jane initially saying *"not forgotten"* and Rose's "*I don't really like to moan"* may function as an another 'hedge' (Weatherall, 2011*),* suggesting one is not fully committed to what follows in their talk. This points to the management of the anticipation of potential criticism (Edwards, 2005), particularly within the broader context of contention such as 'covid deniers' and 'anti-science rhetoric' (Miller, 2020) which may potentially undermine nurses' accounts (Oliver, 2021a; 2021b). Jane and Rose both constructed identities of professionals who do not 'complain', yet make a clear point: nurses are tired and need a break.

In line with the demand-control support (DCS) model (Karasek & Theorell, 1990) and the job demands-resources (JD-R) model (Demerouti et al. 2001) which propose that high work demands contribute to stress, Ellie discussed the relentlessness of the work: *"everyone is just going to burnout"*. This also mirrors that not having sufficient relaxation time can impact nurses' health (Khan et al., 2018). Ellie also

highlighted how nurses were asked whether they wanted to work extra shifts for payment, which *"was nice",* but led to many *"working an insane amount of hours" and this could be a* "*dangerous, slippery slope".* Not only does Ellie's story make relevant the high workload and low resources, but also her awareness of the impact the quantity and intensity of work were likely to have on nurses' wellbeing.

Heavy workload is echoed by much of the literature on nurses' experiences during the COVID-19 pandemic (Cui et al., 2020; Fernández-Castillo et al., 2021; Goh et al., 2020; Lee & Lee, 2020; Sun et al., 2020; Tan et al., 2020). Notably, Sun et al. (2020) report that working hours increased up to two times normal work hours and workloads. Further, Britt et al. (2021) discusses how with social distancing restrictions in place, not only do nurses work longer working hours but personal resources, such as social support, were not as available as they usually would be, which further contributed to distress (Britt et al., 2021). This is also in line with the JD-R model, which proposes that social support helps an individual manage stress. Fernández-Castillo et al. (2021) discuss that nurses reported a particularly high increase in workload compared to other HCWs, such as doctors and nursing assistants, due to their training and ability to perform a broader range of tasks. This also speaks to Jane's earlier comment about nurses acting beyond their competency in terms of relatively unfamiliar tasks such as proning.

Rose also talked about the unrelenting work that the nurses faced, which continued even after discharging the last COVID-19 patient:

> *"Everything has kind of gone back to normal. But if anything, I think people are now, they're so knackered, um, because when I was saying about when we discharged our last covid patient sort of back in July, um (2) when we had that*

weekend to deep clean the unit, on the Monday, they then just restarted all of the normal activities, um, but if anything, more intensely so."

"so, yeah, we are already knackered from like covid and then just:: ugh. Going back to what we normally do, but it was just a lot more intense because they were all operating on more patients that were just much more sick. Um, yes, there was, there was just no reprieve and, and a lot of people have left, actually. Um, which was to be expected, you know."

Rose (80m)

Rose's 'agentless' (Hardt-Mautner, 1995) talk: *"everything has kind of gone back to normal")* de-emphasises her's and others control, reflecting the broader fatigue following the intensity of the work. Rose also highlighted the impact the pandemic has had on the restoration of 'routine' treatment in the NHS - that patients are "*just much more sick"* – a national issue (Carr et al., 2021; Bhangu et al., 2020; NHS, 2021). This has led to reduced activity in light of continuing infection control measures (Edwards, 2020; British Medical Association, 2021), poor outcomes for patients and significant financial repercussions (Macdonald et al., 2020) in a chronically underfunded health system (Catton, 2020).

Perhaps surprisingly, the psychological impact on nurses of returning to usual activities post-pandemic is not discussed in any of the reviewed studies. This may be linked to the time point at which many of the studies were conducted – all between January 2020 and September 2020 - likely in the 'active phase' of the pandemic (as proposed by the BPS COVID-19 Staff Wellbeing Group, 2020) where perhaps the nurses focus was more focused on managing pandemic itself.

By contrast, stories of the unrelenting nature of the work do not feature in the accounts of Amelia and Anna. This may be related to how, at the point of interview, they had worked several days in ICU during the pandemic, compared to the other nurses who were required to sustain this level of work for longer.

4.4.3 Looking back, looking forward.

4.4.3.1 "It's shown me how strong I am": Stories of growth.

To questions about whether anything positive came from the working the pandemic, and how they see themselves looking into the future, some of the nurses painted a picture of the experience as a turning point: one with many challenges, but also with growth. Rose and Anna discussed their professional identities:

> *"I feel like anything can happen and I'm sure I'll be able to deal with it. Because I feel like throughout covid, there were so many (1) you know, things that happened suddenly and unexpectedly that we just had to deal with. Um, so in that way, I feel like I'm much better equipped to sort of deal with emergency situations. Um, so I guess it's, um, you know, I've become a better nurse because of it. Um, um, and because I had to look after so many people at the* [other hospital] *and* [hospital site], *um, I guess my management skills are a lot better. Um, I feel much more comfortable in terms of like mentoring sort of junior nurses, um, because I had experience of doing it during covid."*
>
> *Rose (87m)*

"this time it's kind of like more closer because when someone gets sick, someone we know that's being isolated, someone we know being::, um- um, infected by this covid, we kind of like text them like, "how are you?" or call them if we have a chance and, um, you kind of wanted to help them out, bring food or, you know, deliver the groceries or whatever. So I think this covid give (1) most of us a sense of, um, like caring, you know, not only because we work together, we kinda::: It's like a kind of, a different kind of family, I would say"

Anna (55m)

Anna also narrated valuing health and family over material things:

"material things now is nothing, you know, because you can't get, you can get out now to where you are very expensive things, but(1) yeah, health is number one and everyone in the family is OK, so 'yeah'".

Anna (57m)

Jane and Leia discussed a shift in life priorities and an appreciation for life:

"I feel like proud that I've been part of it and I've- I have learnt from it 100 percent, and I think it's shown me how strong I am, like, um, to be able to get through this, um, and I guess just like an appreciation for life".

Jane (97m)

"definitely to appreciate more that you are healthy and that you are not going through covid, em, being more conscious about:: wh-what, what are your priorities, what is really important in life for you. Um, so something material comes last, don't care much about having designer outfits or something that I

would have asked for Christmas before, for example haha. Um, I don't care about having the last iPhones or the last iPads. Uh, but if you-you focus a bit more about, on your, on the people, the person that are important for you in your life."

Leia (46m)

"If, if we were to disappear in a couple a weeks time or a couple of months, would we be happy with our lives? So that's being brave to have those conversation, and also asking the other, the people they, that are important for me if they're happy and if they're not happy, OK, what can we do?".

Leia (57m)

Amelia narrated that she felt pride in being able to contribute to the pandemic:

"I think I proud actually because its been long time and I: one thing I'm proud, one thing I'm happy cos I can contribute my something like that, I feel…satisfaction, so I am not like negative feelings, If I do. I don't know I get a positive feeling, I'm satisfied (3) that's why. Yeah."

Amelia (65m)

By contrast, Ellie's response was different in that she appeared more unsure. To my question as to whether working in the pandemic has brought positive change, she initially answered *"no, I don't, I don't think so".* However, this was followed by "*I guess sometimes you don't like, you don't really know how you're going to cope with stuff or like, I don't know, do stuff until you're forced to".* A briefer and vaguer answer than the others, my question may have been a difficult one to answer, given the ongoing nature of the pandemic.

The stories above reflect 'quest narratives' (Frank, 1995), which is consistent with the literature on PTG (Tedeschi & Calhoun, 1995) suggesting that encounters with adversity can lead to personal growth. Yet it is important to hold in mind the social conventions which may affect what stories are told, notably the social and cultural pressures to tell stories of 'quest' (Frank, 1995), particularly when someone is being directly asked about positive change in an interview context (and by someone unfamiliar). Furthermore, it is also worth considering that stories of 'restitution' and 'quest' may also be underpinned by working in a setting underpinned by a medical model – that there is a remedy for suffering.

All but two of the reviewed studies (Galehdar et al., 2020; Kackin et al., 2020) report that nurses described positive growth or change from working during the pandemic, although this was to differing degrees. Of note is that Galehdar et al. (2020) focused on psychological distress whereas Kackin et al. (2020) focused on the 'short term coping strategies' employed by nurses. With much of the international literature reporting on elements of growth, this may reflect how compelling stories of 'quest' are across cultures.

4.4.3.2 "There was this whole talk of the second wave…": An ending out of reach.

With the interviews taking place between December - February 2021, the pandemic was very much still 'live'. Indeed, for many of the nurses, the accounts point to how a neat finale to the pandemic was still out of reach.

For Rose, with the interview taking place in early December 2020, as the infections numbers were beginning to increase again:

"people can't even be bothered to talk anymore. Um (3) yeah (2) I think people are just, are just really exhausted and just:: yeah, just a bit kind of over the whole, whole fucking covid thing. Sorry, I shouldn't have sworn haha."

Rose (84m)

"If I (2) everyone's just like, "If I hear the words covid or coronavirus one more time, then I'll just (2)" And there was this whole talk of the second wave and people are sort of, "'for God's sake', please, no." Like, like we'd barely just gotten over the first wave and then to, to have talk of it happening all over again, people were just, "Oh my God, please don't. Like I don't think I can deal with this." And even I thought, I don't want you to think I've got the:: the strength(1) t- to do this again. Um, I don't think it will happen in quite the same scale, but um, yeah, when things were a bit, you know, there was just talk of it happening again and people just thought, oh my God, no, please (2). Yeah."

Rose (85m)

For Rose, there is a clear shift in her story throughout the interview, from her initial motivation and excitement *("part of me was kind of excited")* to, in the face of a looming threat of a further wave, later constructing a story of extreme exhaustion ("*oh my God, please don't. Like I don't think I can deal with this."*). Despite this, however, it continued to be important for Rose to not be seen to 'complain', overwhelmed or in any way 'unprofessional': "*Sorry, I shouldn't have sworn haha".* Rose's tone briefly shifted slightly by embedding a glimmer of hope ("*I don't think it will happen in quite the same scale")* within these worries of a further wave. Perhaps with the hope of trying to make her story more hopeful for me as the listener, and for herself.

Jane's interview took place in February 2021 as the second wave was beginning & g to ease off:

> *"I do feel stronger coming out, I'm saying coming out the other side, I know we're still in the pandemic, um, and I'm not saying, you know, I have hope that haha it's going to start to ease because it, it hasn't. [Hospital site] at the moment its starting to ease now, um, so I guess I'm hopeful and if it goes back into a full-blown (2) you know, numbers raising again and maybe I'll feel a bit different because I'll, I'll start to lose hope again and feel like, how long is this going to go on for"*
>
> *Jane (105m)*

Like Rose, Jane particularly pointed to there being no end in sight *("how long is this going to gone on for"*). Laughter was also woven into her account, perhaps making an uncomfortable story easier to narrate (particularly as it was drawing to a close), or building on the storyline of not being seen to 'complain' 'too much' (Edwards, 2005).

By contrast, Leia (ICU-trained but had returned to specialising in another department) and Anna (redeployed nurse who had returned to her usual department) narrated different stories. They both continued to draw on narratives of the 'heroic' genre (Kelly, 1994) when they spoke about the prospect of returning to ICU to work during the pandemic: *"but then, if the pandemic takes over, I'm ready to go back to critical care and do that"* (Leia) and *"yeah, I don't mind to help out. I know it's going to be a tough one again, but I think we are more ready for it than the first one"* (Anna).

Future uncertainty, on individual, healthcare systems, national and international levels was a theme in the study by Feeley et al. (2021). As discussed in Chapter One, uncertainty about the future is not explicitly captured in the models of occupational stress. However, stories of uncertainty draw parallels to the DCS model (Karasek & Theorell, 1990) that asserts that wellbeing is low when workers are faced with high work demands and low control over work. This storyline aligns with the 'psychological response phases' (BPS COVID-19 Staff Wellbeing Group), whereby the proposed 'recovery phase' and 'anticipatory anxiety' phases may not be sequential depending on the course of the pandemic.

Chapter Five: Conclusions

5.1 Chapter Overview

This chapter summarises the analysis, considers the strengths and limitations of the study, and discusses my reflections on conducting this research. I then discuss future research suggestions and recommendations for clinical practice.

5.2 Summary of the Analysis

This research explored the narratives of six nurses to address two questions: firstly, how nurses who worked in ICUs during the COVID-19 pandemic construct this experience, and secondly, to explore what identities are constructed in their narratives.

Within the individual accounts, narratives included: initially underestimating the pandemic, changes in patient procedures, fear, 'duty', inability to provide the usual standard of care, juggling home and work life, use of social media as an outlet, negotiating positions on war and 'hero' discourses, and personal growth.

From considering the accounts collectively, three broad stories were observed: 1. "It came with like a bang", 2. Working in the red zone, and 3. Looking back, looking forward. The substories are summarised below.

5.3 Summary of The Substories

Stories of the arrival of the COVID-19 pandemic were constructed as a sudden, unexpected disruption, with emotionally and morally fraught decisions that needed to be made early in the pandemic. The performance element of the analysis in this

study takes the existing literature further; in highlighting nurses' use of discursive devices, they construct identities as plausible narrators with accounts that need to be taken seriously.

Whilst the existing literature discusses nurses' 'duty' to work in the pandemic, this topic is explored more in-depth in the present study. Similar to the literature, 'duty' had different nuances such as professional commitment (Cui et al., 2020; Goh et al., 2020), and an obligation (Lee & Lee, 2020; Zhang et al., 2020). Exploring the construction of identities has drawn out more fully the sometimes-contradictory impacts of identities, such as one's duty professionally, and to one's own health and their family (Kherbache et al., 2021). This study also illuminates the role of hierarchies within healthcare teams, which also contributed to nurses' sense of obligation and duty.

This also may speak to psychological theory such as social identity theory (Tajfel & Turner, 1986), where one's sense of who they are is based on their group membership. For example, this is may suggested in the collective identity of the ITU trained nurses - which may have been protective - and those redeployed nurses, in turn, may have been positioned as 'the other'. Another theory potentially relevant here is the narrative construction of identity. Hinchman and Hinchman (2001) state that all narratives involve positioning the self in relation to the other and, therefore, constructs one's identity, in the context of broader social discourses. For example, nurses narrating how they felt a 'duty' to work during the pandemic may speak to broader discourses of nurses as 'heroes' 'on the front line'.

As the accounts continued, stories of facing many challenging situations relating to patient care further drew out the tensions between identities and appeared to contribute to moral distress (Greenberg et al. 2020). These challenges echo the

literature (Fernández-Castillo et al., 2021; Galehdar et al., 2020; Jia et al., 2021; Tan et al., 2020). However, exploring performance in the present study adds another dimension, notably how the nurses worked to present themselves as credible but 'not complainers' in the face of broader contention. This speaks to how, although nurses appear calm and professional, we must not take this at face value.

This study explored the redeployment of nurses from the perspective of both ICU-trained nurses and those non-ICU trained, redeployed nurses. This is not discussed in the literature. Lack of adequate support (for those redeployed), and not being able to provide adequate support (for those ICU trained) contributed to distress. The

performance aspect also further builds on how it remained important for nurses to uphold 'professionality' and to 'not complain'.

This study supports the COVID-19 literature on the physical and psychological challenges of wearing PPE and fears about whether it was protective (Cui et al., 2020; Galehdar et al., 2020; Goh et al., 2020; Lee & Lee, 2020; Sheng et al., 2020; Zhang et al., 2020). However, this study went further in illuminating how depleted PPE led the nurses to be creative to make their own PPE to ensure their safety. This alluded to broader narratives that nurses felt let down by the system at times, and subsequently not valued. Another novel storyline that adds to the research was how PPE led to the disappearance of communication barriers, which added to the sense of collective identity.

The present study brings attention to the impact of public misconceptions and media portrayals – something that goes beyond the existing literature. It appeared important for nurses to uphold 'professionality', despite their frustrations at other narratives undermining their accounts. This points to how the nurses were 'treading carefully' when conveying the many challenging situations they encountered.

Several nurses narrated frustration at the media for their portrayals, notably the military and heroes metaphors, which also is a novel contribution to the literature. This storyline ties into others - specifically public misconceptions and inadequate PPE – all of which speak to broader issues of nurses being exploited and ignored, despite being depicted as 'heroes' (Catton, 2020; McIlroy, 2020; Slavitt, 2020).

This study highlights that high workload contributed to stress for nurses (Cui et al., 2020; Fernández-Castillo et al., 2021; Goh et al., 2020; Lee & Lee, 2020; Sun et al., 2020; Tan et al., 2020). Stories of the repeated cancellation of annual leave

hampered the already demanding work, further perpetuating frustrations. It also brings into focus the juggling of identities between one's professional role and looking after one's own wellbeing. The present study also highlights the impact of the relentlessness of the work stemming from the immediate restoration of non-COVID-19 patient care.

Across the accounts were stories of personal growth (Tedeschi & Calhoun, 1995) which supports all but two of the reviewed studies (Galehdar et al., 2020; Kackin et al., 2020). Many described feeling more confident professionally, pride in making a contribution, and a stronger sense of teamwork. Others described an appreciation for life and a shift in life priorities such as valuing one's family and health. Yet this appears to be the only study that comments on the cultural pressures to tell stories of 'quest' (Frank, 1995).

In parallel to stories of growth, the nurses narrated the perils of a future wave of the pandemic. For those returning to other departments within the hospital, they again narrated a clear commitment to return to ICU if needed, reflecting a need to continue to construct a professional identity. Others, however, constructed stories of exhaustion and dread. This was highlighted through the study's focus on temporality, which focused on the nurses' imagined future, and aligns with Feeley et al. (2021) that future uncertainty about the trajectory of the pandemic contributed to distress.

5.4 Quality Assessment

Consistent with the appraisal of the existing literature, I assessed the quality and rigour of this study using Tracy's (2010) quality assessment (Appendix T).

5.4.1 Strengths.

By exploring how nurses, within a UK NHS context, construct their experiences of working in ICUs during the COVID-19 pandemic, this research adds a new layer to the existing literature. The performative aspect of the analysis takes the literature further, notably that amid the broader contention, nurses appeared to present themselves as 'credible', 'professional' narrators, who are 'not complaining'. The study of performance also illuminates the juggling of competing identities not explored as fully in the literature, including the 'good nurse', 'good mother', and the 'skilled ICU nurse'. The temporal dimension of narrative invited stories about how the nurses perceive their uncertain future.

This study recruited from a specialist hospital. With expertise in cardiac and respiratory conditions, surgery, and ICU, the hospital cared for some of the most unwell patients with COVID-19 disease. Yet, even despite this expertise in respiratory conditions, the nurses were faced with a novel virus. Nurses not only had to learn about COVID-19 disease and provide complex care, but were also faced with a sense of threat to themselves, and risk of infecting others.

5.4.2 Limitations.

A notable limitation relates to conducting the systematic literature review. Despite narrowing down my search with inclusion and exclusion criteria, the initial search results were large (n = 1770) and many unrelated papers were captured (n = 1715). This is likely a reflection of being a novice researcher, and in the future, I would re-think search terms to appropriately narrow down the literature.

Whilst conducting a topic that is so current has many advantages, it also comes with its challenges. With the rapidly evolving literature, it was, at times, hard to keep

pace. It was important to put in place strict time boundaries for the literature review, however, this will inevitably mean the project will be limited in scope.

The initial difficulties with recruitment were a limitation. This may be linked to the stage of the pandemic in December 2020, during the resurgence of the second wave, when nurses' basic safety needs were not being met. This may highlight how more basic safety needs need to be met first before they feel able to engage in wellbeing services. A further limitation relates to the demographics of the sample. In particular, all nurses were women, which may have influenced the content and performance aspect of the stories.

5.5 Ethical Tensions

Although there were initial recruitment difficulties, after a few months, more nurses expressed an interest in the study. However, due to only having capacity to interview six nurses, I was unable to interview some nurses. Whilst it was made explicit that not all those who express an interest will be interviewed, it felt uncomfortable to turn away nurses who offered to share their stories with me. Timing may be relevant here. As I began recruitment in October 2020, at the start of the resurgence of the second wave, it may be that at this point, nurses' basic physical and emotional safety needs were not met (Maslow, 1970), and therefore may have struggled to reflect on their experiences. A further tension has been related to the timing and socio-political context of this research, particularly between the nurses' narratives and prevailing political and public discourses. I have had to hold in mind the audience of this thesis, who will have their own lens which may be very different to the meaning behind the nurses' narratives. However, I feel strongly of my ethical responsibility to honour (and not censor) the nurses' stories. It is important to state

that this dilemma arises not through the content of the accounts, but through a highly emotive and politically sensitive climate, and the different interpretations that this gives rise to. This also speaks to how social constructionist approaches are inevitably political (Gergen, 1999). Relatedly, whilst every effort was taken to preserve anonymity of the nurses and third parties, some nurses did not want me to change certain aspects of narratives, although they were aware this may compromise their anonymity.

5.6 Reflections

The reader will notice from earlier chapters that I anticipated trauma to appear in the nurses' stories (something which surprised me). This makes relevant the work of Johnstone (2020b; Johnstone & Hickox, 2021) that the trauma and PTSD narratives have been overstated. The interview may not have set up this type of talk. For example, perhaps those who were on the hospital site when the interview took place, emotional expression or certain narratives did not feel 'authorised' in such contexts. It is also worth considering whether nurses felt they *could* have included this in their talk, if they were experiencing more severe trauma reactions. Additionally, perhaps those that were experiencing more severe trauma experiences were unlikely to want (or able) to engage in interview. Another factor may be the importance for nurses to convey themselves as polite, professional, and 'not a complainer'. That said, however, perhaps if the nurses were experiencing more severe trauma reactions, they would have conveyed this in the interview to convey the distress of the experience. Although it did not appear in the present study, many nurses may have been experiencing cumulative trauma (Khan, 1963, revisited by Martin et al., 2011) particularly given the ongoing nature of the pandemic – and the absence of an

ending - and the cumulative stressors this brings. Despite this, many of the nurses still narrated stories of 'quest' (Frank, 1995), which may reflect the culture pressures to tell narratives of self-development and positive change. Frank (1995) originally developed his work for those living with long-term health conditions. Yet there appear to be parallels between living with a long-term condition and learning to live in world with a pandemic – adjustment to both involving a degree acceptance and long-term management.

I have been aware of the authorial responsibility I hold in how I have chosen in how to present the analysis in this thesis. Striving towards credible research, it was important to ensure that I was not over-interpreting the 'data'. Relatedly, although I explored distinct features across accounts, there was an element of 'grouping' certain stories together. I wondered whether this may be perceived as though the 'meaning' behind the stories were similar, which would be at odds with the project's constructionist lens.

I notice that I found certain accounts and storylines more compelling than others, which raises the issue of there being stories I was not hearing. For the accounts that consisted of more fragmented, brief stories with little detail, I felt an urge to represent them in a way that would be easier to follow for the reader. This is linked to what Aarikka-Stenroos (2010) calls 'narrative smoothing'. However, this would raise the issue of me imposing my voice on another's more so than I did with the other accounts.

Similar to the nurses I interviewed, I have both questioned and drawn on dominant language. For example, whilst an important storyline from this analysis in this research was the grappling with the use of military terminology and the 'heroes' discourse, I have used wartime and natural disaster terminology within this thesis. This includes the use of language 'redeployed' and the tsunami metaphor of 'waves'. Yet this is not without consideration; I have used war metaphors where the nurses did not specifically critique this language in the interviews, and in order to convey meaning easily. In keeping with a reflexive approach, it has been important for me to reflect on my use of language, why I have felt attuned to some over others, and how my experiences may have shaped this.

Conducting pandemic-related research whilst *in* a pandemic has at times been difficult. Particularly at the start of the pandemic, I experienced anxiety about myself and my family contracting the virus. This influenced the co-construction of the accounts. For example, I was aware that in some interviews I asked more questions about the demographics of the patients treated, checking whether I or my family fit the profile.

5.7 What Now? Implications of This Research

Given the constructionist lens to this research whereby knowledge is viewed as context-dependent (Burr & Dick, 2017), care needs to be taken when thinking about 'generalisability'. However, this research has relevance and implications to consider.

5.7.1 Basic safety needs.

5.7.1.1 Unmasking the mask: The safety of PPE and beyond.

Basic safety needs need to be considered to support nurses in feeling able to provide adequate patient care. As stated above, the initial recruitment difficulties encountered in this study highlight that basic physical and emotional safety needs should be prioritised first, prior to wellbeing services (Maslow, 1970). This research has highlighted the importance of meeting nurses' basic physical and emotional safety needs. This includes adequate and sufficient PPE, not only so that nurses are and feel protected, but also so they can stay hydrated and use the toilet without feeling guilty they are wasting PPE.

PPE appeared to provide protection, physically and to some extent psychologically. At the time of writing, ICU nurses continue to wear full PPE and patient visitors are only permitted in extreme circumstances, such as potentially end of life care. However, with the easing of these restrictions – and although visitors might reduce the burden of emotional support for patients on nurses - there is the benefit of emotional support with increased visitors - there is potential this may infiltrate nurses' sense of physical safety. Nurses may benefit from emotional support for this.

5.7.1.2 Protected time for breaks.

Nurses require protected time for breaks and respite from the inevitably high workload. This would ensure nurses' basic needs of toileting and rest are met, help support psychological wellbeing due to exposure to traumatic situations, and reduce physical exhaustion. Adequate staffing would also permit staff to take annual leave when needed (British Medical Association, 2021).

5.7.1.3 Adequate training and clear information.

In line with the DCS model (Karasek & Theorell, 1990) which proposed that wellbeing is most impacted when workers have high demands and perceived low control, adequate support and training needs should be made available to both ICU-trained and non-ICU-trained redeployed nurses, particularly for unfamiliar and novel tasks. Redeployed nurses may benefit from the implementation of a 'mentor' system. Nurses also require clear and concise information to support them in feeling in control. This would also fit with the person-environment fit (P-E fit) model (Caplan, 1987) that an individual's abilities need to be matched with their abilities for wellbeing.

5.7.1.4 Emotional safety needs.

This study has pointed to the protectiveness of a collective identity and the importance of nurses' sense of belonging (King's Fund, 2020b). Ongoing encouragement of supportive team working would be beneficial, particularly given

that ICU nursing comes with emotional distress (Mealer et al., 2007; Poncet et al., 2007). It is important to mitigate further distress, for example, handover meetings to 'check in' with staff about whether they feel able return to the 'red zone'.

The narratives highlight the emotional toll of nurses. More spaces to support nurses' emotional wellbeing within working hours are needed. This could include reflective rounds, 'safety huddles', reflective supervision, 'check-ins' with peer mentors, or more informal spaces to 'decompress' with colleagues.

Hearing the voices of nurses needs to be balanced with recognising that due to physical and emotional exhaustion, they may not be able to tell others what they need. Therefore, it would be beneficial for psychologists and managers to adopt an active rather than passive approach of waiting for nurses to approach them.

5.7.1.5 Longer-term community support.

The nurses told stories of how they valued donations and deliveries to the hospital, such as food, drink and toiletries. Whilst this was helpful in the short term, as the second wave loomed, this appeared to stop suddenly despite the pandemic continuing, which contributed to the nurses stories of being forgotten. With the pandemic ongoing, and nurses facing the repercussions of the pandemic in the form of intensely restoring routine treatments, donations could be spaced out over time to support the ongoing sense of feeling valued for their work.

5.7.2 Wellbeing services: Spaces to share stories.

Nurses were, and still are, playing a critical role in healthcare during the pandemic, despite the dangers of doing so. This study has contributed to the conversations around how it may be possible to protect the wellbeing of nurses. The arrival of the COVID-19 pandemic sits against a backdrop of a healthcare system that has long been underfunded (Catton, 2020) with chronic difficulties with the recruitment and retention of ICU nurses (Khan et al., 2018; RCN, 2021b; NHS Employers, 2015). ICU services cannot run without ICU nurses; this is a workforce that we need to retain.

Instead of gestures of appreciation and gratitude, nurses need to be genuinely valued by the Government and the public. Nurses require appropriate pay for the highly specialist skilled work they deliver. This is something they have always delivered, but the pandemic saw ICU nurses pushed to their limits. Better working conditions are needed through regular breaks and rotating staff on different areas when needed, especially during a pandemic.

This research has highlighted the importance of opening up space for nurses to share their stories during and beyond such crises. Emotional responses need to be normalised and validated even in the midst of a crisis (Bennett et al., 2020). This needs to be appropriate for a range of presentations of distress. For example, for those where trauma work appears to be inappropriate, Compassion Focused Therapy (CFT) and Acceptance and Commitment Therapy (ACT) may be considered. At the time of writing, the COVID-19 pandemic is ongoing, further waves remain likely (Johns, 2021; Torjesen, 2021), as do future pandemics (Dodds, 2019; Gill, 2020). Alongside the organisational costs of recruitment and retention, particularly for specialist centres having invested in the nursing

workforce as highly skilled HCWs, there is a corporate responsibility to protect the wellbeing of these nurses.

However, psychological interventions are not beneficial to all in crises, and so whilst they should not be mandated (BPS COVID-19 Wellbeing Group, 2020), they should be designed to ensure they are accessible. This research has illuminated that these wellbeing spaces can be virtual, for example, nurses can use their own homes for protected, confidential space. With the world becoming increasingly more connected through technology, remote research interviews are becoming more common and widely used (Dodds & Hess, 2020; Heath et al., 2018). This, therefore, may lead to nurses being more likely to access wellbeing services. As ICU nurses are integral to ICU care, rotas need to be designed to ensure there is sufficient staff on shift to allow for other nurses to attend wellbeing spaces during working hours (and avoid further workload).

Related to the need to ensure therapeutic spaces are tailored to the individual, it is important to consider novel therapeutic approaches. Mental Health Awareness Week 2021 focused on connecting with nature (Mental Health Foundation, 2021). This may involve grounding techniques to manage distress, or that connect with nature. A recent article has highlighted horse therapy has been helpful for an NHS nurse who cared for patients with COVID-19 during the pandemic (BBC news, 2021c).

This research has highlighted the challenges the ICU-trained nurses faced were often different from that of those redeployed. As such, wellbeing services need to be flexible to meet the needs of different nurses, for example, to be tailored to individuals or teams.

Consideration is needed of the longer-term psychological fall out of the pandemic.

Not only did nurses care for patients with a novel virus, they experienced personal

threat, with longer working hours, and disruption of usual standards of care. They also returned to high work pressures involved with the restoration of 'routine' patient care (BPS Staff Wellbeing Group, 2020). Whilst this is just a snapshot in time, it is important to consider how we look back and reflect on this period, and consider preparation for the future (Highfield, n.d.).

5.7.3 'Heroes'… or highly skilled professionals?

This study has highlighted that an alternative framework or discourse is needed for those who do not see themselves as 'heroes' but are given this identity by the mass media, the public, and the Government. One of the nurses, Leia, suggested in her interview: "*ideally, I would like us, all of us, to be recognised as professionals, highly skilled professionals more than heroes".* This highlights the importance for nurses to feel valued and recognised for their skill.

5.8 Future Research Suggestions

This study explored the stories of six nurses, but many stories remain untold. Areas for further exploration might be the experiences of more redeployed, non-ICU-trained nurses, or other professions that were redeployed to ICU, for example as healthcare assistants.

This research explored narratives of nurses who are highly skilled and trained in respiratory conditions. It would be worth exploring the narratives of nurses who work in district general hospitals.

It is apparent that the redeployed, non-ICU trained nurses did not need to sustain the level of work in ICU for as long as those ICU trained. This may contribute to why the ICU-trained nurses had more to say about working during the pandemic, as indicated by longer interview length. This also brings into question whether those redeployed felt 'entitled' or 'legitimate' to make certain claims, such as those related to the role of the media, public misconceptions, and insufficient PPE. This suggests that nurses from different backgrounds will need support in different ways, and is worth further exploration.

A further area for research may include, how, with the easing of infection control restrictions how the protective collective identity narrative evolves.

Given all participants in the present study were women, further research would benefit from exploring the stories of other genders. As the sample were also aged between ages 26 to 56, it may also be helpful for future research to include nurses who are younger and older than this, as well as ethnicities other than White British, White Italian and Asian. It is also recommended that exploring the experiences of more nurses who were redeployed to an ICU during the pandemic.

5.9 An Ending… But Is It Really?

Writing in May 2021, there is not yet an ending to the COVID-19 pandemic. Whilst routine hospital activities have been restored, there continues to be an impending threat for potential further waves of the virus and future pandemics. Listening, and hearing, the experiences of nurses remain paramount, particularly at a time where the nurses spoke of feeling forgotten and undervalued. Whilst one might describe the work of these nurses as heroic, in the words of Izhac (2020), 'actions

speak louder than words - or in this case, applause'. We must hear our nurses' stories and we must not take the appearance of calmness and professional at face value. This is not, and should not, be the end of the story.

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Appendices

Appendix A: Full systematic review quality assessment (Tracy, 2010)

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
Cui et al. (2020)	Criteria met – specifically focused on those who volunteered to travel to the Hubei Province, the global epicentre of the pandemic.	Criteria not met - appropriate method and data collection, but all participants were female and had children. Collecting other demographic details (class, ethnicity) would situate sample more. Interviews were short at 30-50 minutes.	Criteria not met – no reference to epistemological stance/ theoretical orientation/reflexivity.	Criteria not met – member checking employed but details are vague. No triangulation or details on *how* consensus reached. No details on how interview checklist was developed. Description of how the data was analysed is vague; more detail needed.	Partially met – clear presentation of findings supported by additional text. As a Chinese paper, the authors discuss the role of Chinese values which may not be generalisable to European populations. Also sample likely to consist of nurses who have worked in previous epidemics which may have influenced experiences – questionable generalisability.	Criteria met – the authors detail implications for policy makers and nursing managers and make specific recommendations. Specifically explores those who volunteered to travel to Hubei and was conducted in April - May 2020 when the infection levels in Hubei had reduced – therefore likely to allow for more reflection Use of content analysis – does not explore patterns and temporality	Criteria met – briefly discuss consent and confidentiality but no details on emotional distress.	Criteria met – the paper achieves it aims but content analysis often lacks exploring deeper meaning and patterns in data. Means and standard deviations of sample provided which is odd given it is qualitative.	High
Tan et al (2020)	Criteria met – novel conducted at Wuhan Union Hospital, in the global epicentre of pandemic one of the very first COVID-19 designated hospitals globally, and in early stages (January -	Criteria not met - data collected in different ways (face to face, telephone, video, voice recording) -level of richness in data likely to vary. Interviews short in length (30-50 minutes) However, good sample size (n=30).	Criteria not met – details the role of each individual on the research team, but no mention to epistemological stance or reflexivity.	Criteria met – triangulation employed. Member checking only employed with two participants. The researchers who analysed the data were not those who conducted the interviews.	Criteria met – aesthetic presentation- findings separated into 'negative' and 'positive' is clear to the reader and transparent. Generalisable to European populations and for public health crises in future generally.	Criteria met – very clear implications for nursing management and public health emergencies generally. One of the first qualitative studies in this topic. Limitations of contribution due to type of analysis (see above)	Criteria met – comments on consent, confidentiality and right to withdraw. No mention on emotional distress.	Criteria met – the paper achieves it broad aim. Appropriate methodology. However as employed content analysis, limited in terms of exploring deeper	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
	February 2020).	The sample included roles with varying levels of experience of responsibility - difficult to draw themes. Recruitment strategy is vague. No field notes.		Although this could be a strength in terms of a person analysing is separate to the interview and may not analyse with a previous bias from how the interview was, they are inevitably likely to be less emersed in the data due to the lack of context. Thick description of why method was chosen and data collection.	Vague details of initial recruitment mean unclear as to how generalisable findings are.			meaning or patterns in data.	
Kackin et al. (2020)	Criteria met – this appears to be one of the few qualitative studies conducted in Turkey. Although the pandemic arrived in Turkey later than other countries, there was opportunity for preparations but still some unforeseen risks.	Criteria met - appropriate method. Interview length was between 45 and 90 minutes, which appears to be offering a good amount of time for participants to share their experiences. Collection of many demographic details which	Criteria not met – paragraph on reflexivity and situate the research team, including their age, gender, position and relevant training. However, this is not commented on later on in the paper - how this may have influenced interpretations. This would have been helpful particularly as term like 'psychiatric disease' is used.	Criteria met - study was credible using Lincoln & Guba's (1985) criteria. Triangulation and member checking used. Describes how interview guide was developed with references, as well as thick description of data collection.	Criteria met – clearly presented e tables for participant details. Participants quotations throughout which helps the reader resonate. Provide context of COVID-19 in Turkey which is also helpful for those unfamiliar. However, discusses the 'KORDEP' –	Criteria partially met – study has contributed to the literature, particularly as it is a study conducted in Turkey, but does not add any new findings to the literature. Few practical recommendations.	Criteria met – in terms of consent and confidentiality but no details on distress.	Criteria met – paper achieves its aims. Embeds findings within other literature and discusses MERS and SARS.	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		helps situate the sample. Pilot interviews conducted with two participants other than the main participants. However, no details of how the questions were modified in line with this.			('mental health programme for coronavirus') however this appears to only be Turkey specific? Not accessible to UK contexts.				
Lee and Lee (2020)	Criteria met – conducted in South Korea, which was a country affected by the MERS epidemic previously and therefore links can be made in terms of nurses' experiences.	Criteria met – telephone interviews may lack rich data, but field notes made for nonverbal data (pauses, pace, emotional expression) Interviews approx. 60 minutes. Snowball sampling strategy employed – lack of detail about this and recruitment generally. Analytical procedure is transparent. Large sample (n=18), and	Criteria not met – no reference to epistemological stance or theoretical orientation however there are hints at this when it is stated that the interviewer tried to avoid leading questions that may influence direction of response.	Criteria not met – used Lincoln & Guba's quality criteria. Member checking and checking with nurses who were not participants. Additional interview conducted with two participants due to unclear meanings Thick description of method (including figure) and data collection.	Criteria partially met – although the themes and subthemes presented clearly and supported by participant quotations, not generalisable to nurses who volunteered. Snowball sampling strategy also limits the generalisability. Strong use of war time language may not resonate with all readers.	Criteria met – one of the few papers that refers to those who also were a nurse during MERS - important given that there is more awareness of the likelihood or future epidemics and pandemics. Detailed discussion with recommendations interwoven with examples. One of the few studies to discuss the role of stigma towards nurses. Relates this back to literature on HIV nurses. Adds an interesting angle.	Criteria met– in terms of informed consent, confidentiality. Each participant received token of appreciation. No discussion of emotional distress. Telephone interviews may be less exposing for nurses.	Criteria not met – questionable whether the paper achieves its aim notably because sample consisted of those who did not volunteer to provide COVID-19 patient care and had 'extremely limited nursing experience' caring for critically ill COVID-19 patients. Also heavy use of war language in theme titles which is disproportiona te the	Low

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		transcription completed by the researcher who conducted the interview within three days of interview.						participant quotes – seems like a jump.	
Galehdar et al. (2020)	Criteria met – conducted in Iran between March – April 2020.	Criteria not met – lack of rich data due to telephone interviews lasting 25-40 minutes which is a relatively short time. Very limited details on recruitment strategy. No reason for why minimum of 2 weeks COVID-19 experience	Criteria not met – the authors state that they tried to maintain reflexivity by 'avoiding own opinion affecting data' - however provide no further details on this, and no reference to epistemological stance.	Criteria met - Lincoln and Guba's quality criteria was used. Member checking. Peer checking. Specific details on method.	Criteria partially met - The name of the country the study was conducted in was not included in the abstract and not clear at what point in the pandemic the study was conducted. Paper is only focused on distress rather than experiences generally. Problem saturated. Widening the aim to consider experiences more broadly could be useful in terms of how more positive aspects influence/are enmeshed with distress. The findings table is brief - clearer if	Criteria met - explicitly to death anxiety in this context, which links to practice ie how this may impact communicating with dying patients and families. However, lacks specific practical recommendations around this. The authors comment on research on the impact of other infectious diseases on nurses (SARS, MERS, Ebola H1N1). More elaboration on this would have been helpful. Use of content analysis – does not explore in depth, meaning, patterns or temporality.	Criteria not met - Information about nurses' shift patterns were given, and nurses were contacted directly prior to nurses giving consent. Likely invasive. This was also outside of working hours when it may be that nurses value this 'down time'. Interview questions prompts include "Please talk about your unpleasant experiences" and follow ups such as "what do you mean" sounds abrupt, particularly as these were short telephone interviews, and may influence the data somewhat. Very problem saturated. No mention of how research team considered potential participant distress particularly given the interview questions and aims.	Criteria not met - some aspects of the discussion lack coherence with the findings ie more discussion on 'nurses' attitudes towards death may affect empathy'. The study achieved its aims but interview lengths short and over telephone so questionable.	Low

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
					participant quotes were included in the table. The results section is visually difficult to follow. Use of non-pathologising, categorical language used such as 'psychological distress' is likely to help with resonance. Multiple quotations to support each category was useful and helps with transparency.				
Lapum et al. (2021)	Criteria met – first paper in this area using narrative methodology.	Criteria not met – no field notes or reflexivity. Recruitment via selection from hospital unit listservs as well social media – more detail needed i.e. how were they approached and how consent obtained. Interviews conducted over zoom which provides both	Criteria not met– no comment on epistemology, biases or assumptions. No comment on reflexivity. Vague description of methodology and only two examples of interview questions provided.	Criteria not met – no credibility checks. As the author's do not provide details on epistemological assumptions, it is not clear whether this is an omission or whether certain credibility checks (member checking, triangulation) do not fit with this i.e., if from	Criteria not met – paper is lacking important information, i.e., date study conducted (and therefore what stage in the pandemic) and the length of each interview. No participant demographic details. No comment on the role of gender (or any other aspects of participant demographics)	Criteria met - methodology allows for exploration of broader narratives which has been under researched. Opens with a discussion on media narratives i.e., 'selfless sacrifice' of nurses and how this can play in diverting attention from the emotional wellbeing of nurses. Also discusses views on the contact	Criteria met – but more detail needed. Stated ethical consent provided but no further mention of this. Use of plural pronouns (they/them) when referring to the nurses in order to protect identity. Interviews conducted on zoom with option to have only audio if participant preferred.	Criteria not met – the fact that key details are omitted (date study conducted, length of interviews, details of participants (even if some anonymised) mean the paper lacks some coherence). The lack of the date is a particularly important	Low

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		audio and video, thereby providing richer data. Good sample size for this type of analysis (n=20). But no further details on sample provided.		constructionist stance. Thin, vague description of narrative methodology. Only gave examples of two interview questions	and how this may link to broader societal and cultural narratives. Very text heavy - tables for participant details and findings would have been visually helpful.	tracing apps which appears to have been un-explored in this area. Discusses how the emotions that participant experienced were complex and enmeshed. Quotations interwoven throughout narratives to help preserve nuances in the data, and they use the metaphors that the participants used.		omission given it is unclear and what stage of the pandemic the study was conducted in, both nationally and globally.	
Zhang et al (2020)	Criteria yet met – novel as conducted in Wuhan from February – March 2020 - one of the earliest studies and at global epicentre. Explores the 'psychological change process' rather than just experiences generally.	Criteria met – video interviews aiding richer data. Field noted were taken including tone of speech, facial expression, gestures, rhetorical questions, repetition, summary etc. Large sample size (n=23). Interviews were between 30-50 minutes in length, which is short,	Criteria not met - no comment on epistemology, values or assumptions. States field notes were taken, but these are about features of the participant rather than researcher's reflections.	Criteria met – triangulation employed. Details of recruitment, data collection and analysis process.	Criteria not met - study involved those who volunteered to work so is limited in its generalisability to other nurses who did not volunteer to work Findings are separated into three distinct and categorical stages - rigid and may not capture the nuances in the data. However, the findings are presented in	Criteria met – balance of recommendations that are individualistic self-care strategies with recommendations that are more directed at leaders. Implications are presented aesthetically. One of few studies that found nurses experienced inequality and unfairness. Adds a new angle to literature.	Criteria met - ethical approval obtained. Authors also discuss confidentiality. Emails were used to recruit nurses - respectful recruitment strategy as not invasive. No details on participant distress.	Criteria met – given the aim is on a change process – narrative would have also been appropriate due to exploring change over time.	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		particularly for a video interview and the fact the authors state that they encouraged participants to 'elaborate'. Transparency in analysis process. Interview guided tested with two nurses.			terms of chronological stages which is easy for the reader to follow and answers the aim of the 'change process' More quotations to support each stage would have been helpful in grounding the data. No comment or critical evaluation of some language used such as diagnostic categories such as PTSD in reference to SARS, and other language such as 'sacred mission' and how this may have been influenced by the media, and the impact that this could have on nurses. May not resonate with other countries i.e. UK.	First study that has discussed age. However, this interpretation seems a jump. More information needed as to how these interpretations were made.			
Goh et al. (2020)	Criteria met – novel and needed as conducted in	Criteria met - interview conducted over Zoom - rich	Criteria met - authors do not comment on adopted	Criteria met - triangulation used.	Criteria met - participant quotations are woven into the	Criteria partially met - only paper so far that collected details of	Criteria met – ethical approval obtained but vague and no discussion on	Criteria met - final paragraph 'relevance for	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
	Singapore, which has a high population density therefore high nursing pressure. Singapore reported one of the highest cases of COVID-19 in Asia.	data collection and rapport building. Interviews were long between 45-75 minutes. N = 17 (11 female, 6 male). More details on recruitment strategy needed. No reason given for participants needing at least one year work experience in both inpatient and outpatient experience.	epistemology forthe project but researcher recorded values, beliefs, thoughts throughout.	The Consolidated Criteria for Reporting Qualitative Research (COREQ) used. Audit trail established for dependability through the transparency of data to allow future researchers to replicate and to document research decisions. Interview guide developed by research team with reference to literature. Good amount of detail provided in methods and analysis.	findings section which reads fluidly, however more participant quotations could have been added. Nurses in this sample had adequate PPE supplies, which may have influence resilience. Therefore, may lack generalisability to samples without adequate PPE. Clearly presented.	participant ethnicities and religion, however there was no reference to this in the findings or discussion. One of the early studies conducted in Singapore. Thematic analysis – whilst can clearly identifies themes, it lacks in depth exploration.	participant distress. Interview length varied and open questions, giving participants agency.	clinical practice' which is helpful, allowing the reader to come away from the paper with implications in mind. Although Figure 1 with summary of themes is visually helpful, the findings would be better in a table, with the addition of columns for subthemes and participant quotations. Thematic analysis employed means study lacks in depth exploration.	
Sheng et al (2020)	Criteria met – this is another study based in Wuhan, China with a focus on nurses' professional identity	Criteria met - interview guide was developed based on literature. Video interviews – field notes on	Criteria met - no comment on epistemology but interviewer noted reflections.	Criteria met – detailed how ensured credibility, dependability, confirmability and transferability.	Criteria met - presented clearly with tables. Sample was only those who volunteered to work with	Criteria met - one of the few studies which has found and discussed the unfairness and inequality (in workloads, rewards) that some nurses felt	Criteria partially met – interview questions open giving participant agency. An outline of the key ethical considerations is provided. Acknowledge participant distress in interview– however	Criteria met – achieves its aims with appropriate method and discussion and recommendati	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		body language made Interviews short at 25-45 minutes		Interviewers were previously trained in qualitative interviews. Rich description of methods and analysis process.	COVID-19 patients so may not be generalisable to those who were not given an option/felt they couldn't say they did not want to work with COVID-19 patients. No discussion on language used such as 'rescue mission'. Furthermore, although the authors comment on the portrayal of nurses as 'heroes' and 'soldiers', no comment about the negative implication this could have had aided the paper. This language may not resonate with other countries.	compared to other medical staff. Authors call for strategies to shift the public perception of nurses. The authors explicitly link to theory - social identity theory in the context of nurses' identities. The implications section is thorough, with a focus on nursing managers, rather than the individual nurses themselves.	state that pauses or 'changes in topic' were applied when it was felt that participants were uncomfortable or upset. However, more detail about how the question was changed – this may be experienced as closing down signs of distress leaving participants feeling invalidated?	ons that clearly links.	
Jia et al. (2021)	Criteria met – explicitly focuses on ethical challenges encountered by nurses, which adds an angle to the literature	Criteria met - pre interview took place with 4 experienced nurses, amendments based on this Interview length relatively long at 60-120	Criteria not met - no comment on epistemology/theoretical orientation - would have been useful given language used ie 'unhealthy emotions'	Criteria met - some interviews were conducted via voice chat - less rich data. However average interview length was	Criteria met – paper presented clearly with tables for demographic details and findings. Also provides research questions in a clear, list format.	Criteria met – focuses on ethical issues, encompassing broad range from patient care to management. One of few studies to explore unfairness and inequality which	Criteria not met – ethical approval obtained and authors detail how PIS provided, however, as with the other papers, there is no discussion around how the researchers managed participant distress particularly given the	Criteria not met – paper achieves its aims however is not clear how all the data fits the themes. Presented well with	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		minutes allowing for exploring experiences in data. Some interviews were conducted via choice chat which is likely to be less rich in data – and difficult to compare themes with those interviews conducted via videocall. Data was analysed by two researchers. Transcription occurred within 24 hours after interview.		long. Data analysed by two researchers and would consult third person if consensus not reached. Pilot interviews conducted. More detail on analysis would aid the paper. Rich description provided of data collection and analysis.	Authors define ethical challenges at the very start and how this will be addressed in the paper. However, not clear whether sample consisted of those who volunteered to work during the pandemic or not.	adds new lens to literature. But very brief and vague recommendations ie to 'give more respect, care and understanding to COVID-19 nursing personnel' and to 'provide early, full-course personalised and comprehensive psychological assistance'.	focus for the study may be upsetting.	strengths and limitations paragraph and conclusion paragraph.	
Sun et al. (2020)	Criteria met – conducted in Henan – province next to Hubei. Conducted early on in January – February 2020.	Criteria met - states it was necessary to collect data at multiple time points however no details for this rationale and how the interviews differed and what the gap in time was. Interviews relatively long at 40-60 minutes.	Criteria not met - although details of the experience and qualifications of the interviewer is provided, no comment on their perspective/ epistemology. The authors do state that the researcher 'remained neutral' however. Furthermore, the background experience of those who analysed the data is not provided.	Criteria met - interview outlined by consulting literature, expert's opinion (although do not state who these experts are?) Completed 2 pilot interviews. Two researchers independently analysed the	Criteria met – table of findings presented clearly with many excerpts which aids transparency. States 'negative pressure wards' – unclear what this is, may not resonate to all readers.	Criteria met - collected data at multiple time points which led to finding that distress more intense at start of pandemic. Clear practical recommendations suggested.	Criteria met - Some interview questions about coping strategies – meaning that the interview is likely to not be problem saturated and potentially empowering. Also discussed participant distress and therapeutic techniques (acceptance, active listening) - one of few studies to mention this.	Criteria met – achieves its aims appropriately. Not problem saturated due to questions on coping skills and growth. This was woven into the discussion. Also reference to how nurses managed working	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		Some interviews video call or some via telephone – not clear when either was used/based on what decision.	However, outlines the interviewer's experience and qualifications.	data, when there were conflicting opinions, these were discussed in team of wider researchers. More detail on the data analysis process needed. However, no rationale for why data collected at multiple time points and did not discuss the difference in interviews.				through SARS. However, paper provides means, medias and SDs when presenting participant demographic - odd given it is a qualitative paper. Brought in theory into discussion such as stress and coping model.	
Fernández-Castillo et al. (2021)	Criteria met - Spanish study focusing explicitly on ICU nurses.	Criteria partially met - contextualises research in the introduction by providing background to the pandemic in Spain. Collected basis demographic details of sample such as age, gender, ICU experience. Whether they had any health conditions, or live with someone with a health condition is missing.	Criteria not met - no details about epistemology, background, biases or any hint to reflexivity. Would have been helpful to understand lens given certain language use i.e. "grief will undoubtedly turn into pathological' and also when working out how the researchers develop themes.	Criteria met - triangulation and member checking used. States interview guide determined by previous literature but provided no references. Rich detail of method, and concrete steps provided of the analysis and interview guide. Use of thematic analysis and	Criteria met – tables for interview guide and sample provided, in addition to a figure presenting summary of findings. Authors present long participant excerpts which helps reader resonate. However, authors note that the nurse-to-patient ratio was 1:1.5, which is better than some other	Criteria met – adds additional angle in terms to focusing explicitly on ICU nurses and raised themes of the miss and over information provided by media and the impact this had, as well as the limitations of working with redeployed staff. Also has a theme of 'resource management.' Recommendations woven into the discussion section as well as an implications section at the end.	Criteria met – but vague. Interview questions appear to be open, giving participants agency. The very short interview length may have resulted in patients feeling uncontained. However, the final question on interview guide was "do you have something that you would like to express or add?"	Criteria met – achieves its aims in an appropriate way Refers to other literature in the discussion.	High

Paper	Worthy topic	Rich rigour	Sincerity	Credibility	Resonance	Significant contribution	Ethical	Meaningful coherence	OVERALL RATING
		Interviews were via video but length very short ranging from 22 to 45 minutes. Sample appears to only include ICU nurses who usually work in ICU, rather than re-deployed nurses. No discussion on this.		therefore lacks exploration of patterns and coherence, although the figure provided helps with this somewhat.	countries in Europe where it was much higher – therefore may not be generalisable. The diagram helps the reader see the interconnectedness of themes alongside the text.				

Appendix B: Excerpts from IRAS form

A6-1. Summary of the study.

This study will explore the experiences of nurses working in intensive care units (ICU) during the COVID-19 pandemic. In the face of a high number of deaths, pressures on resources, staff shortages, ethical dilemmas, unwell colleagues, and greater exposure to COVID-19, for nurses working in ICUs emotional distress is anticipated. There is already a known shortage of nursing staff in the NHS, particularly ICU nursing staff, even before COVID-19. It is therefore paramount that their experiences are explored to support the retention and future recruitment of nurses. There has been a considerable amount of quantitative research, mainly through surveys and questionnaires, regarding nurses' emotional wellbeing during COVID-19. However, studies that only use self-reported questionnaires do not explore the experiences in depth. Largely absent from the literature is research that explores narratives. Approximately eight participants will be recruited from the hospital site, for in-depth analysis (see below). This study will take the form of an individual semi-structured interview (approx. 90 minutes) with Hannah. Participants will be invited to talk about their experience of working in the ICU during the pandemic. The interview will either take place face to face, at the hospital or over remote video technology, such as Accurx or Webex, as per security and data protection measures provided by the University and the NHS Trust. This study is supported by the University of Hertfordshire in collaboration with the hospital. Provisional approval has been granted from the Trust's Research and Developmental Team. As this study is part of a Doctoral qualification, there are time limits to the project and therefore is anticipated to be completed by June 2021, and submitted for publication to peer-reviewed journals soon after.

A6-2. Summary of main issues. Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.

Recruitment and consent: *A member of the research team who works at the hospital site will advertise the study through three main platforms: Band 7 WhatsApp group, email group for all ICU nurses, and in the weekly newsletter for ICU staff at the hospital site. Those who wish to express an interest in taking part will be asked to complete the Expression of Interest form and to email this to the Hannah. Only Hannah will have access to the names of participants who express an interest. It will be assumed that the email address potential participants email the Expression of Interest form is the email address they wish to be contacted on.*

Consent will be sought by Hannah, who has experience of assessing capacity in clinical practice. Within the interview, Hannah will discuss each item of the consent form with the participant. This will include stating that consent for the study includes an agreement for the conversation to be audio-recorded (or video recorded dependent on whether the interview is allowed to be conducted by face to face), an agreement that anonymise d extracts from their interview may be published in the final project paper and papers for an academic journal(s). If the interview is taking place at the hospital site, this consent form will either be in hard copy format and completed by hand. Alternatively, if the interview is taking place over remote technology then this will be completed electronically.

It is important to acknowledge that informed consent is not a one-off event but rather an ongoing process; therefore, participants will be reminded that they can withdraw participation during or up to 14 days after the interview. If a participant becomes emotionally distressed during the interview, Hannah will remind them of this.

It may be that more than the required number of nurses express an interest in the study. It will be made clear on the Participant Information Sheet that the research team cannot guarantee that all participants who register their interest will be interviewed. If more than the required number apply, it may be that a stratified sampling strategy will be used to select participants that are diverse in terms of race, gender, age and a mix of those who usually work in ICU, and those who do not but are doing so due to COVID-19.

Participant wellbeing: *It is not anticipated that this research will cause significant distress. However, the research team are aware that participants may have been distressed by their experiences of living and working through the pandemic, and that talking about this may be difficult. The interviewer and members of the research team all have experience of managing distress through their training as clinical psychologists and work with both clients and staff in the NHS. Additionally, the team is guided by specialist advice from a highly experienced clinical psychologist at the University of Hertfordshire in the field of trauma, on shaping the interview structure and management to reduce the chance of additional distress. Participants will be reminded that they only need to talk about what they feel able and willing to talk about, at a level of detail and a way that they feel comfortable with. Participants will also be reminded that they can take breaks if they need, or they can withdraw their participation at any point, without having to provide a reason. Hannah will use her clinical experience and judgment to monitor participant distress during the interview and to manage this. If Hannah has concerns at the end of the interview regarding the participants' emotional wellbeing, they will be reminded that they can speak to (psychologist at hospital site) in addition to a list of contact details for further support.*

Confidentiality: *All data collected will be anonymized and kept confidential in compliance with the Data Protection Act 1998 and GDPR. Personal identifiable information about the participant and all third parties will be removed from the transcribed interview. As part of consent taking, participants will be invited to choose their pseudonym. All personal identifiable information will be password protected, anonymised, and stored in a locked cabinet that is only accessible by Hannah.*

Face-to-face contact in light of COVID-19 restrictions: In the context of the COVID-19, any face-to-face contact would be subject to and in line with restrictions set out by the Government, by the NHS Trust, and by the University at that point in time. This would include whether face to face contact was permitted at all (there are currently University restrictions on this for University members undertaking research, although this may change shortly). As such, it is not clear yet whether the interview will take place at the hospital site or over remote video technology. If the study is face to face, audio recordings will be encrypted, anonymised and password-protected and before being stored on a laptop till the end of the project.

If the study is over remote technology, it will be video recorded. These recordings will be accessible by Hannah and the internal supervisor to the project. This is to enable them to return to recordings, should they need to, whilst reports are being written. Again, any electronic data will be anonymised, password-protected, and stored on an encrypted memory stick. At the end of the study, the recordings will be deleted securely. Transcripts will be anonymised and stored on an encrypted hard drive (128 bt encryption) for five years, in line with the University of Hertfordshire guidelines. After this time, it will be destroyed securely. Before the interview, confidentiality will be discussed with each participant. This will involve informing the participant that conversations will be confidential to the research team. This will also be outlined in the Participation Information Sheet. When completing the questionnaires or interviews, if a member of the research team feels concerned about

participant risk to themselves or others (these issues may be physical, sexual, verbal, or emotional abuse), they have a duty of care to raise these concerns. Hannah will always aim to discuss this breach of confidentiality with participants before sharing the information.

A24. What is the potential for benefit to research participants?

There are no direct benefits for taking part in this study, however, participants may experience some indirect benefits. This study endeavours to provide a space where they can share freely their individual experience of working in an ICU during the COVID-19 pandemic to someone impartial. The semi-structured nature of the interview may help the participants share their stories, which may be helpful in the meaning-making of their experience, as well as feeling heard and valued. Furthermore, contributing to a growing area of research, which may improve the provision of health care services and the support available for other health care staff is also likely to offer some psychological benefits.

A26. What are the potential risks for the researchers themselves? (if any)

In the context of the COVID-19, any face-to-face contact would be subject to and in line with restrictions set out by the Government, by the NHS Trust, and by the University at that point in time. This would include whether face to face contact was permitted at all (there are currently University restrictions on this for University members undertaking research, although this may change shortly), physical distancing guidelines, and advice on the use of PPE. Furthermore, Hannah does not have any underlying health conditions that would put her at risk of more severe illness if she were to contract the virus. It is also important to state though the hospital had COVID-19 positive patients at the end of March 2020, as the hospital was a designated pan London cardiac surgery hub. The hospital is continuously cleaned in line with infection control procedures. There are designated COVID-19 Protected Areas and COVID-19 Risk Managed Areas. All patient rooms are deep cleaned according to the guidance of infection control-not just for COVID-19, but also including MRSA, VRE, and CRE. However, these interviews would not take place in a patient area. Furthermore, the hospital staff are undertaking stringent monthly surveillance COVID-19 testing. It is not expected that the researchers will be exposed to many risks. It is anticipated that it is unlikely that the study will lead to emotional distress in the research team, however, if this were to occur, support from other members of the research team, as well as support from the University of Hertfordshire. The researchers will use self-care strategies for the duration of the project. Hannah will also make use of a reflective journal throughout.

A38. How will you ensure the confidentiality of personal data?

Every effort will be made to protect the identity of participants with personal details changed or removed where necessary to preserve their identity. Hannah will not have access to personal data of potential participants until she receives the expression of interest form by the potential participant themselves. Personal identifiable information, including the consent form and expression of interest form, will only be accessed by Hannah. All data collected will be anonymised and kept confidential in compliance with the Data Protection Act 1998 and GDPR. Personal identifiable information will be removed or changed from the transcribed interview. Participants will be invited to choose a pseudonym. Transcripts will be given participant codes by Hannah. Furthermore, a non-disclosure agreement will be signed by the transcriber.

Appendix C: Email from Health Research Authority – amendments / further information request

12/08/2020, 1:53 PM

IRAS 284812. Request for information

Dear Ms Solomons,

Thank you for your application.

I have now undertaken an assessment of your application. Please would you answer the following queries?

- We would normally expect audio/video recordings to be deleted once they have ben transcribed, please clarify your decision to only do this at the end of the study.
- In order for your PIS to be GDPR compliant, please updated with HRA GDPR wording available as a template here: https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/transparency-wording-for-all-sponsors/
- Please clarify the recruitment method of using a Band 7 Whatsapp group when Nurses of Band 7 level are excluded from the study.
- Please supply a copy of the sheet given to participants with contacts for further support.
- Please submit a copy of the topic guide/questions you will use for the interviews.

Please submit the requested documents electronically through IRAS by 12 September 2020. To enable the application to progress without delay we encourage you to provide these documents as soon as possible. Please contact me if you think you will not be able to submit any information by this date.

Kind regards

Health Research Authority
E. approvals@hra.nhs.uk
W. www.hra.nhs.uk

Appendix D: Email of amendments to the Health Research Authority (in response to Appendix C)

University of Hertfordshire UH

Summary of Amendments

13/08/2020

Study title: 'Narrative of NHS nurses working in ICUs during the COVID-19 pandemic'
IRAS project ID: 284812

To whom it may concern,

Many thanks for your feedback to the proposed research project. In response to your feedback, the following amendments have been made

**additional comments/amendments in red italicised font*

'We would normally expect audio/video recordings to be deleted once they have ben transcribed, please clarify your decision to only do this at the end of the study.'
A37
Audio recordings will be encrypted and the video recording platform will be one that is secure. Audio recordings and documents containing personal identifiable information will be password-protected and stored on an encrypted memory stick until the end of the project. After this, the audio recordings will be permanently deleted in a secure way. *The recordings will be kept until the end of the project for several reasons. Firstly, this study will use a private transcription company for initial transcription. Ideally, the transcription will reflect the recording, although this is not always the case; relying solely on this transcription make compromise study validity. Qualitative research, specifically narrative inquiry, involves multiple layers of analysis, and so without original data, audit trail is obstructed which may impact the scientific rigour of the study. Furthermore, access to the recordings beyond the transcription stage helps the researchers return to recordings, should they need to, when analysing the data or when reports are being written. Although the data will not be deleted until the end of the study, it will be kept safe, which is explicitly stated on the participation information sheet and consent form. Additionally, audio/video records will only be accessible by Dr. Wendy Solomons and Hannah Cutler. As such, I am of the view that this is in line with the Data Protection Act (1998) that data is stored no longer than for initial purposes.*

'In order for your PIS to be GDPR compliant, please updated with HRA GDPR wording available as a template here:'

PARTICIPANT INFORMATION SHEET (please see PIS 1 and PIS 2)
What will you do with the information I give you?
All information collected is strictly confidential. Information will be stored in a locked filing cabinet that is only accessible by Hannah. Encrypted documents and on password protected folders on encrypted devices. Personal identifiable information will only be accessed by Hannah. Information that could identify you, such as your name and other details, will be removed or changed. We will ask you to choose your own pseudonym so that your real name will not be used.

If the interview happens face to face, it will need to be audio recorded. If it happens over technology, then the interview will be need to be video recorded. This is because it is then transcribed for analysis later on in the research. These recordings will be accessed by Hannah, Dr Wendy Solomons (University of Hertfordshire) and the independent transcribing company transcriber. The recordings will then be sent to the independent company to be transcribed into written form, but this will be using your pse udonym. *People who do not need to know who you are will not be able to see your name or contact details.* The transcriber will sign a non-disclosure agreement. The written transcript of your interview will be kept in a secure location for five years. After this time, it will be destroyed securely. *We will keep all information about you safe and secure.*

What are your choices about how your information is used?

- *You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.*
- *We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.*

Where can you find out more about how your information is used?

- *at www.hra.nhs.uk/information-about-patients/*
- *or contacting the University of Hertfordshire's Data Protection Team on dataprotection@herts.ac.uk.*
- *by sending an email to the Hannah on XXX*

'Please clarify the recruitment method of using a Band 7 Whatsapp group when Nurses of Band 7 level are excluded from the study'
A27-1
**Despite recruiting for Band 5 and 6 nurses, a Band 7 WhatsApp will be used as one way of advertising the study. Band 7 nurses will be informed so that they can then pass on the information of this study i.e. in the team meeting. As Band 7 nurses are often in lead roles, they can cascade this information on to potential participants. This is to supplement the other methods of advertising. Furthermore, working in busy ICUs means that nurses do not have frequent access to emails, therefore, this additional platform to encourage talk about the potential study will be helpful in recruiting sufficient participants. It is important to note that there will not be any communication between the research team and the Band 7 nurses regarding who expresses interest/participates in the study unless the participant wishes to express this.*

Also uploaded on to IRAS as requested:

- Contacts for emotional support
- Interview guide and questions (please note that as this study is using a semi-structured interview that this is a guide only).
- PIS (1, 2) (Versions 0.2) as per your suggested amendments

Many thanks again, and please do get in touch if you require any more information or amendments. I look forward to hearing about the progress of the application.

Kind regards,

Hannah Cutler
Trainee Clinical Psychologist
Doctorate in Clinical Psychology | University of Hertfordshire

Appendix E: Health Research Authority (HRA) approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Ms Wendy Solomons
Doctorate in Clinical Psychology
Health Research Building, College Lane Campus
University of Hertfordshire
AL10 9AB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

14 August 2020

Dear Ms Solomons

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Narratives of NHS nurses working in intensive care units during the COVID-19 pandemic**
IRAS project ID:	**284812**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

Appendix F: Letter from Hospital Trust

[redacted]

To Whom it May Concern:

Re: Narratives of NHS nurses working in ICUs during the COVID-19 pandemic

[redacted] NHS Foundation Trust is willing to be a participating site in the above research project provided that all relevant and applicable approvals are obtained.

Confirmation of Capacity and Capability should be issued prior to the project starting.

Yours Faithfully,

[redacted]
Non-Commercial Research Business Manager

Appendix G: Confirmation of capacity and capability

[redacted]

28 September 2020

[redacted]

Dear Dr [redacted]

Project Title: Narratives of NHS nurses working in intensive care units during the COVID-19 pandemic
REC Ref: N/A
IRAS Project ID: 284812
EudraCT number: N/A
Study Sponsor: University of Hertfordshire

Recruitment End Date: 31/08/2021
Study End Date: 31/08/2021
Recruitment target: 8 (maximum)

Confirmation of Capacity and Capability

Thank you for registering the above research project with the Research Office.

I am pleased to provide confirmation that the Trust has 'capacity' to participate and 'capability' to deliver the above project in line with the requirements of the research protocol, as approved by the Health Research Authority (HRA).

This Confirmation of Capacity and Capability is granted on the basis that the study will be conducted as described in the study protocol and supporting documentation as approved by the HRA, and on the understanding that the study is conducted in accordance with the principles set out in the UK Policy Framework for Health and Social Care Research (V3.3, 07th November 2017 and its subsequent amendments), and [redacted]

It is the responsibility of the Local Collaborator to ensure that all members of the research team, and external visitors, have appropriate training and experience to conduct the research project in accordance with the research protocol. The Local Collaborator must ensure that appropriate employment contracts are in place prior to any external staff visiting the site. All visits must be performed in line with Trust guidance, in particular relating to Covid-19.

Patient recruitment

The Trust is contractually obliged to measure and publish data on the days elapsing between the time we receive a valid research application and the time when the first participant is recruited to the trial. This applies to all clinical research where confirmation of capacity and capability has been issued.

The Trust is obliged to regularly report on various research metrics to the National Institute of Health and Research (NIHR) and Department of Health (DoH).

It is the responsibility of the local collaborator to ensure that the following responsibilities are appropriately delegated within the project research team to ensure timely communication with the Research Office:

- That all participant recruitment is recorded, on a monthly basis, and is uploaded to the EDGE research management system. Please confirm the Local Data Contact for the above project to the Research Office to enable us to arrange appropriate training for your research team and provide the relevant access to EDGE.

Study Amendments

HRA approval applies for the duration of the project, unless otherwise notified in writing by the HRA. It is the responsibility of the Sponsor to ensure that all study amendments are submitted to the HRA and notified to the Research Office and study research team in a timely manner.

Please ensure that all amendment submissions to [redacted] in line with the national process, are sent to [redacted] to ensure timely review and acknowledgement.

Please note that Category C amendments are logged but not acknowledged.

Changes to the status of the project, including study suspension or premature termination, should also be communicated to the Trust Research Office *via* [redacted]

Safety Reporting

All patient related incidents must be reported internally by the study team in line with the Trust Adverse Incident Management and Reporting Policy *via* the Quality and Safety Department database **Datix** and marked "research-related".

In addition, **all** Serious Adverse Events/Reactions (SAE/Rs) must be reported to the study Sponsor by a member of the study team immediately and as specified in the study protocol and sponsors' Pharmacovigilance SOP.

Copies of **all** SUSAR reports should be sent to the Research Office immediately and in parallel to informing the study Sponsor.

It is the responsibility of the study Sponsor to ensure that Development Safety Update Reports (DSURs) and quarterly safety reports are sent to the Research Office in a timely manner.

Audit

Please note the Trust is required to monitor research to ensure compliance with the UK Policy Framework for Health and Social Care Research and other legal and regulatory requirements. This responsibility is delegated to the Research Office and will be achieved by random audit of active research projects across the Trust in accordance with the [redacted] Audit SOP.

Yours sincerely

[redacted]

CC: Hannah Cutler

Appendix H: University of Hertfordshire ethics approval notification

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Hannah Cutler
CC	Dr Wendy Soloman
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE	08/09/2020

Protocol number:	**LMS/PGT/UH/04269**
Title of study:	Narratives of NHS nurses working in ICUs during the COVID-19 pandemic.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Wendy Solomons - staff number 722118

[redacted]

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 08/09/2020

To: 01/04/2021

Appendix I: University of Hertfordshire sponsorship in full

University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

Dr W Solomons & Miss H Cutler
Department of Psychology and Sport Sciences
School of Life and Medical Sciences

30 September 2020

Dear Dr Solomons and Miss Cutler

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: Narratives of NHS nurses working in ICUs during the COVID-19 pandemic
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Wendy Solomons
NAME OF INVESTIGATOR (Student): Miss Hannah Cutler
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGT/UH/04269

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission and notification to the Health Research Authority or University of Hertfordshire Ethics Committee with Delegated Authority (ECDA) as relevant, and I must also be notified of the outcome. It is essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as they are received. Copies of annual reports and the end of study report as submitted to the HRA also need to be provided. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)

Appendix J: Participant information sheet

Participant Information Sheet

An invitation to take part in research…
Narratives of NHS nurses working in the ICU during the COVID-19 pandemic

Are you a Band 5 or 6 nurse who worked on the intensive care unit (ICU) at XXX Hospital during the COVID-19 pandemic?

What are the aims of this research?
We would like to understand better the experience of nurses who on the ICU at XXX Hospital during the COVID-19 pandemic. This includes those who usually worked on ICU and in other departments. We are hoping that this understanding will help services to provide better emotional support for nurses in the future.

What would this involve?
The lead researcher for the project, Hannah, would arrange a time to meet with you for the interview. This would either be at XXX Hospital or over remote video technology (depending on COVID-19 guidance). Hannah will interview you for about 90 minutes; this is to allow you time and space to talk about your experience. You will only be invited to talk about what you feel willing and able to.

What will you do with the information I give you?
All information collected is strictly confidential. Information will be stored in a locked filing cabinet that is only accessible by Hannah. Encrypted documents and on password protected folders on encrypted devices. Personal identifiable information will only be accessed by Hannah. Information that could identify you, such as your name and other details, will be removed or changed. We will ask you to choose your own pseudonym so that your real name will not be used.

If the interview happens face to face, it will need to be audio recorded. If it happens over technology, then the interview will be need to be video recorded. This is because it is then transcribed for analysis later on in the research. These recordings will be accessed by Hannah and Dr Wendy Solomons (supervisor on the research team, University of Hertfordshire). The interview recording will be sent to an independent transition company, using your pseudonym. They must follow our rules about keeping your information safe. No one other than Hannah will know your real name. Those who do not need to know who you are will not be able to see your name or contact details. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

How will you use this information?
The results of the research will be written up in a report for Hannah's Doctorate in Clinical Psychology. This may contain anonymised quotes from the interview. The research will be written up for submission to peer-reviewed academic journals and conferences, so that other health professionals can learn from the research.

Are there any situations when information I tell you will be shared?
Disclosure of any personal information from the interview would only occur in exceptional circumstances, such as if you revealed information that may indicate a risk to yourselves or others.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

- at www.hra.nhs.uk/information-about-patients/
- or contacting the University of Hertfordshire's Data Protection Team on dataprotection@herts.ac.uk.
- by sending an email to the Hannah on XXX

Are there any potential benefits in taking part?
There are not any direct benefits for taking part, but we hope to provide a space where you can share your story of working in ICU during the COVID-19 pandemic. Talking about your experience with someone who is impartial may be helpful in making meaning from the experience. Also, contributing to a growing area of research, which may have implications for nurses in the future, may offer some psychological benefits.

Are there any potential risks in taking part?
There are no known risks, however, there is a chance that the interview may be emotionally distressing for some (e.g., during or after the interview). Hannah has experience in providing emotional support to people who are experiencing distress, and will be sensitive to this in her interview technique and delivery. For example, if Hannah feels you are becoming distressed, she may ask you to pause for a moment and check you are not feeling too anxious. As stated above, Hannah may ask clarifying questions but not questions which will involve asking details about specifics of an event. You will be reminded that you should only talk about the experiences that feel you feel willing to talk about, and in a way that feels manageable for you.

What happens after the interview?
Following the interview, you will have no further involvement in the study. You will be offered a leaflet with some relevant support networks should participant like further support.

Following the end of the project, a summary of the findings will be documented and made available at XXX Hospital to those who took part, if you would like.

What happens if I agree to take part but then later change my mind?
You can withdraw from the interview at any time point, including during the interview and up to 14 days after the interview. You can withdraw for any reason, and you do not have to tell Hannah the reason you would like to withdraw. Withdrawal from the study would have no impact on your job role.

Who is in the research team?

Name	Role	Email
Hannah Cutler	Lead researcher for the project Trainee Clinical Psychologist, University of Hertfordshire	XXX
Dr. Wendy Solomons	Clinical Psychologist & Academic Manager & Lead, University of Hertfordshire	XXX
Dr. Melissa Sanchez	Principal Clinical Psychologist and Professional Lead for Clinical Psychology, XXX Hospital	XXX

What do I do if I am interested in taking part?

1. Participation is entirely voluntary, so we first encourage you to have some time and space to think about whether you would like to take part. If you have any

questions, or would like more information, you can email Hannah, or if you would prefer, you can email to arrange a time to talk with her over the phone.

2. If you decide you would like to take part, please email Hannah XXX who will send you the Expression of Interest form.

Please note that there is no guarantee that all those who apply to take part will be interviewed.

This research is being conducted as part of Hannah's Doctorate in Clinical Psychology, sponsored by the University of Hertfordshire. It is supported by XXX (hospital Trust). The research team work in accordance to professional code of conduct including ethical practice.

University of Hertfordshire UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Narratives of NHS nurses working intensive care units during the COVID-19 pandemic
Protocol Number: LMS/PGT/UH/04269
Approving Committee: Health, Science, Engineering & Technology ECDA

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Hannah Cutler, Trainee Clinical Psychologist, XXX or Dr Wendy Solomons, Academic Manager & Lead XXX

Appendix K: Expression of interest form

EXPRESSION OF INTEREST FORM

'Narratives of NHS nurses working in ICUs during the COVID-19 pandemic'

Please make sure you have first read the Participant Information Sheet.

This study is part of Hannah's doctoral training, and therefore there are time limits to complete the project. As more than the required number of participants may register their interest to take part, it may be that not everyone who expresses an interest can take part in the research. We want to make sure we include nurses from a range of backgrounds and different living situations. We hope that this will contribute to the literature and may inform better emotional support for nurses in the future.

PLEASE COMPLETE SECTIONS IN BLUE

First and last name:	
Age:	
Gender:	
Length of experience of being a nurse (in years and/or months):	
Length of experience working in an ICU (in years and/or months):	
NHS banding (e.g. 5 / 6/ 7):	
How would you describe your ethnic background?:	
Do you live alone or with others? If you live with others, please give brief description (eg, two children under 18; adult partner; three adult flat-mates; parents)	
Do you have any health conditions that you consider to place you at higher risk with COVID-19?	
Does someone you live with have a health condition that you consider to put them at higher risk?	
Any other information you think is important:	

If you would like to take part, and you have read the Participant Information Sheet, please email this completed form to XXX

Hannah will assume that the email address you send the form from is the preferred email address for contact.

What happens to this information?
Regardless of whether you are chosen to be interviewed, the above information you have provided will be kept **strictly confidential** in accordance with the Data Protection Act 1998. Hardcopies of documents information will be stored in a locked filing cabinet and only accessible by Hannah and Dr. Wendy Solomons. Electronic documents will be password protected and stored on an encrypted memory stick that will only be able to be accessed by Hannah. If you are selected to take part in the research, then you will be invited to choose a pseudonym so that you cannot be identified.

Thank you for your time.

University of Hertfordshire UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Narratives of NHS nurses working intensive care units during the COVID-19 pandemic
Protocol Number: LMS/PGT/UH/04269
Approving Committee: Health, Science, Engineering & Technology ECDA

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Hannah Cutler, Trainee Clinical Psychologist XXX or Dr Wendy Solomons, Academic Manager & Lead XXX

Appendix L: Consent form

CONSENT FORM

'Narratives of NHS nurses working intensive care units during the COVID-19 pandemic'

PLEASE COMPLETE SECTIONS IN BLUE

	PLEASE TICK
1) I confirm that I have been given a Participant Information Sheet for the above study. I am aware that it states the aim, methods and design, the names and contact details of key people, the potential risks and potential benefits and how the information collected will be stored and for how long. I have had the opportunity to consider and information, ask questions and have these questions answered.	
2) I understand that my participation is voluntary and that I can withdraw at any time, without having to provide reason, and that my job role and legal rights will not be affected. I also understand that I can withdraw up to 14 days after the interview.	
3) I understand that my interview will be video recorded if over remote technology, or audio recorded if happening in person.	
4) I understand that when a report is written and published about the study, quotes/sentences from my interview may be used, but all identifying information will be removed or changed. I give permission for publication of these anonymised quotes.	
5) I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.	
6) I understand that my participation in this study may reveal findings that could indicate that I might require further advice and support. In that event, I will be invited to consult Clinical Psychologist at XXX Hospital, who can redirect me to appropriate support contacts, or my GP. I am also aware that I will be emailed a list of contact details for support following the interview.	
7) I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.	
8) I give my agreement to take part in the above study.	

PARTICIPANT:	**NAME:**	
	CHOSEN PSEUDONYM:	
	DATE:	
	SIGNATURE:	
LEAD RESEARCHER:	**NAME:**	
	DATE:	
	SIGNATURE:	

University of Hertfordshire UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

Title of study: Narratives of NHS nurses working intensive care units during the COVID-19 pandemic
Protocol Number: LMS/PGT/UH/04269
Approving Committee: Health, Science, Engineering & Technology ECDA

The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Hannah Cutler, Trainee Clinical Psychologist XXX Dr Wendy Solomons, Academic Manager & Lead XXX

Appendix M: Transcription agreement

Non-Disclosure Agreement with Transcription Company

This non-disclosure agreement is in reference to the following parties:

Hannah Cutler (discloser)

and

Marianne Blomerus (transcriber)

- The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.
- If the recipient is able to identify and knows the participant in the recording, the recipient agrees to cease transcription, inform the disclosure and destroy any copies of the recording.
- The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.
- The recipient agrees to return and/or destroy any copies of the recordings they were able to access provided by the discloser.

TRANSCRIBER TO COMPLETE:

SIGNED:

NAME: Marianne Blomerus (Wise Owl Solutions)

DATE: 15/01/2021

University of Hertfordshire UH Ethics Committee

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If you have any queries concerning this document, please contact me Hannah Cutler, Trainee Clinical Psychologist, 079563 74552, hc18aav@herts.ac.uk or my supervisor Dr Wendy Solomons, Academic Manager & Lead, w.solomons@herts.ac.uk

Appendix N: Contacts for further support

Contacts for further support

'Narratives of NHS nurses working in ICUs during the COVID-19 pandemic'

Retelling accounts of working in ICUs during the COVID-19 pandemic may have been distressing for you. We hope that some of the resources will be helpful should you find yourself needing some extra support.

The professional code of conduct and ethical approval for this study means that Hannah Cutler cannot personally support individuals with support beyond the remit of the study. This is why we have created this debrief sheet with a list of contact details for further support.

- **GP or local Psychological Therapy Services:** for advice if you are feeling low in mood, anxious or other emotional difficulties since working through COVID-19.
- **National NHS Helpline:** you can call this service on 0300 131 7000
- **Support via text messages:** text FRONTLINE to 85258
- **(Psychologist at hospital site)** who can ***signpost you to other contacts of support***.

Please note: *This debrief sheet should not be considered equivalent to consultation with a professional – please do seek support should you feel you need it.*

University of Hertfordshire UH Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

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If you have any queries concerning this document, please contact me Hannah Cutler, Trainee Clinical Psychologist XXX or Dr Wendy Solomons, Academic Manager & Lead XXXX

Appendix O: Interview guide

13/08/2020 | Version 0.1 | IRAS Number: 284812

University of Hertfordshire UH

Interview Guide

Interview questions and prompts			
Interview section	**Main question**	**Prompts**	**Questions to consider throughout**
Introduction	Reminders • Consent form • 90 mins (can be less or more than this) • Take breaks at any time, can also stop at any time and withdraw including up to 14 days post interview. • Encourage you to talk in the way you feel comfortable and in a level of detail that you feel comfortable with, so you can talk vaguely about situations - and express yourself in way that feels comfortable and feels like you. • Send contacts for further support via email following the interview • Any questions? I am interested in hearing about your experience of working in ITU during covid-19. I will ask you to tell me **your** story; there are no rights or wrongs, I would just like to hear your story in **your own words.** So I will give you time and space to tell me about this as fully as you want to, or feel able to. I will try to sit back and listen to what yo u say as much as I can without interrupting, I have some areas I would like to cover.		
Context before covid ***Patients***	Starting from the beginning, and before we talk about working during COVID-19, it would be good to know about you – growing up how did you see yourself working as an adult? Did you always want to be a nurse? How did you came to work as a nurse in ITU at the hospital? Can you tell me something you remember just before covid?	How did you manage that? What was that like? Did you notice anything about their ethnicity, age, gender, weight, occupation etc? How you found out about who they were?	**Clarification** Just so I am clear and want to understand, so (repeat what they had said)? What do you mean by XXX? **Encouraging chronology/storytelling** What led to that? What happened next? Then what happened? How have things changed over time? Did you think this at the time? What was the change for you then?

	What changed when COVID-19 arrived?		How did that come about?
ITU	Can you tell me a bit about the patients who were coming into itu then? Can you tell me about what it was like working in ITU?	How did you make sense of that? What has changed for you since then? How was that different to how others managed?	
PPE	What was it like wearing PPE?		
Redeployed nurses (if ICU nurse)	What was it like working with redeployed?		
Media	What was it like with the regular clapping? What was written about nurses in the media?		
Work/home balance	(If talking a lot about home life…) If you feel able to, what was happening at work around that time? Do the same if talking about work (gently)		
Meaning-making, identity	Would you say working in ITU during the pandemic has changed you in any ways? What was going on for the people around you (the other nurses?)		
Post-traumatic growth	This may sound like a strange question but I am wondering whether there any memories where things seem better, or whether		

	anything positive has happened? How is that different to before?		
Ending	How do you see being a nurse as you look into the future? Are there any other things that you think it is important to add? How has it been talking with me today?		

Closing:

- Thank you
- Email 'Contacts for further support' sheet
- I will work hard to ensure as anonymised as possible, you may wonder if any of your colleagues could identity you. Is there anything you don't want colleagues to know? Is there anything else you would like to preserve anonymity?

Appendix P: Transcription symbols

(adapted and simplified from Jefferson, 2004)

Symbol	Example	What the symbol represents
[square brackets]	A: Then [I said] B: [Yeah] I know	Overlapping speech
= equals sign	A: Then I said= B: =Yeah I know	'Latching' where there is no clear gap between end of one person's speech and start of another's
:::::colon	Oh, I s:::::ee	Elongation of previous letter
Hyphen -	I don't under-	Broken off word
(#)	I just feel (2) confused	Number in bracket denotes length of pause in seconds
CAPITALS	I just didn't know what TO DO	Word(s) in capitals indicates it was louder than the other words
underlined	It felt so alone	Emphasis on word
xxx	At the time I felt so xxx	Inaudible speech
haha	Haha I have never worked here before	Laughter. The more haha the longer the laughter
'quote sign'	I was 'new to this area'	Lowering/quietening
(?)	How are you(?)	Question
(!)	Not really(!)	Tone in terms of strong feeling, slight raise in volume
"speech marks"	"you will be okay"	Quoting another person
[square brackets]	[name] told me to	Omitted text for confidentiality purposes
↑↓		Shift to high or low pitch

Appendix Q: Interview transcript and analysis process

healthcare and then the more I got closer to nursing I was even more convinced that I wanted to remain a nurse, because at some point, there was some question, would I want to go back and be a doctor, try medicine again, but no, definitely not hahaa. So, very happy to be where I am. And, um:: at the beginning with COVID-19::, um sp my, my background, I'm a critical care nurse and:: I've been always working in critical care. But when COVID-19 hits us, I was actually working in a different department. So for me, it was, um::, a bit of a, of a change because I was doing another job and then I had to be redeployed to go and help (1) in critical care. So for me there was, um, part of me that really struggled with the fact that I wasn't with my mates in ITU when everything started, um, because it took a few weeks for, for my:: for me to be released from my other post and go back to ICU. So, the main struggle for me was to see our, my friends in ITU were struggling and me not able to do anything because I was in another job. Uh, but then, I knew from the beginning that I had to go back to help, um:: and so I managed to go back to help. Uh, that was in: (1) So, so we started very badly sort of end of March and end of April I was able to go:: to go back, uh, and it just felt right. Uh, it was the right thing to do, uh:: with just all the challenges are associated, of course, because I've been out at that time for about four months from ICU, so for me to (1) it, it was like going back home, but if I like learning another new skills, uh, because the patients were totally different, so there was quite a lot of anxiety about, am I doing the ↑right thing. Um, I wasn't sure that the PPE are protecting us because, yes, we're being fit-tested for some face masks but then, they were not the same than we were:: given to be wearing. Um, and then, of course, there was quite a lot of pressure and, and then having this terrible PPE on causing pressure sores and trying really to work very hard mentally t- to get over the first half an hour, 40 minutes. That for me, is still the worst time when I wear PPE, just because you have to change the way that you're breathing, uh, you can't breathe with your nose, you have to breathe with your mouth. So, for me, I'm a bit claustrophobic as well, so the first half an hour, 40 minutes has always been the worst. Um, and then as soon as you get settle in the PPE, the pain starts, so again, you have to work mentally to get over the pain, um, especially around the nose and face. Um, of course, you are sweaty, so you just have to try it and ignore yourself and just look after the patients in front of you (1) patients that are super sick and they are alone and, uh, you always feel like you're not doing, um, ↑enough because you would like to be able to help them more but then, uh, yo- especially at the beginning, we didn't know anything about this, the disease or we didn't know ho- how to look after them, so trying to guess that was the right thing to do. Uh, so that was difficult. And also, because we:: the, the demand was so high, but the staff levels were low. Uh:: in fact, at some point that you were working with bodies rather, than, rather than patients. So that, that was not nice, because you would do rounds where you would prone them to help them stay on the, on the front, to help recover the lungs, but then you will start from bed one and you will, you will go to bed 20, and then one after the other, you would do the same to every single of these patients. So having this	Structure: narrative moves on quickly to start of covid without me prompting Content: 'hit us' – suggests suddenness, collective language ?collective identity Performance: clearly positions self as critical care nurse at start Structure: goes quickly into discussing challenge, but only talks about this in relation to wanting to help ICU colleagues Content: points to feelings of helplessness- wanting to help "mates" but has not been "released" yet- sense of willingness/duty as not only colleague but also as a friend Performance: 'part of me' suggests some dissonance with identity re going to work in itu Structure: only talks of anxiety about learning new skills and work being different after she tells me "it was like going back home" – conveys sense of comfortableness, competence in ICU work and further positions self as ICU nurse Structure: moves briskly onto PPE, swift change in storyline Structure: talks of physical issues with wearing PPE before talking about the psychological impact Content: "just have to get on with it" – sense of a 'doing' mode, cannot complain Performance: heroic genre narrative Structure: moves briskly on to emotions of patients – sense of helplessness. Counters wanting to do more with justification about not knowing about covid

Appendix R: Research diary extracts

03/10/2020 - Following meeting with research consultant to the project

During the meeting with the research consultant to the project, she told me that ICU at the hospital site had a difficult year leading up to the pandemic, with many deaths. As such, when COVID-19 arrived, the ICU team may have already been facing threat and emotional stress to some degree. Therefore, it is important consider asking participants about their context before the outbreak, as this is likely to shape the narratives.

Following supervision with Wendy, we discussed how it may be that nurses may say a lot very quickly, this may be linked to their role as a nurse, being used to communicating in highly pressured environments etc. To hold this in mind.

08/10/2020 – Following a narrative workshop

Following the narrative workshop with some of my colleagues also using the same methodology, we discussed narrative inquiry as a method. We discussed how narrative inquiry is ethical as it allows people to have agency over what they share e.g., where they start, where they finish and what aspects of the account they want to present. This has reminded me of the importance of stating this at the start of the interview e.g., how participants only need to share what they feel willing and able to. I will also remind participants that if I ask them a question that they do not feel comfortable with, then they can let me know.

We also had discussed identity within a social constructionist framework and ways to ask about this within the interview. We also spoke about the best way to explore identities is not to ask directly about this. This led me to change the wording of some questions in the interview such as asking how working through the pandemic has changed them in any ways.

I have also been thinking more about the potential for 'chaos narratives', particularly with the recent increase in COVID-19 cases and starting interviews soon. Therefore, I am anticipating that stories may have aspects of a 'chaotic' feel to them - with order and sequencing being difficult for the individual, and perhaps a sense that there is little control or a sense of being 'swept along'. Or perhaps this may show if the participant has difficulties speaking in the first person. I also need to be aware, however, of the role of culture and the impact this may have on the narratives, for example some cultures tell stories in different ways which may, in Western culture, be interpreted as a chaos narrative.

15/11/2020 – Following initial difficulties with recruitment

I started advertising about two weeks ago and I have only received one response from a potential participant so far. This has surprised me; I had always anticipated

that nurses would been keen to take part. As advertising began just before the second national lockdown and with the second 'wave' of infections emerging, I began to wonder whether nurses were to exhausted and perhaps not in the right headspace to talk about their experience. I shared my concerns in supervision, and we discussed how humans, for millions of years, had told stories, even in hard and challenging times. Wendy also reminded me that initially we were concerned that if the interviews take place following the peak of the pandemic (we were not sure if there was to be a second peak at the time), and the reversion to normal then this may be a barrier to participation. Now we have a situation again where events are very much 'live' currently. We discussed the importance of emphasising that this study offers a 'supportive listening space', which may be what some nurses require at this time. It is however, important to ensure that practical barriers are not present such as lack of time/exhaustion. Having thinking about these aspects, it is important for me to bear these in mind when liaising with potential participants.

20/12/2020 – Following several interviews

It am aware that I have felt more attuned to certain storylines than others in the interviews. For example, when nurses discuss the media, I am interested in their experience of this (and certain discourses such as 'heroes' and 'war'). I have long been aware I am drawn to this type of language, likely because of my personal experiences of war language in medical settings. In being attuned to this in particular, I wonder if there were other stories that I may have 'missed' or 'not heard' – this is uncomfortable but an inherent given everyone has different 'lenses'.

Appendix S: Extract of interview field notes

12/12/2020 – Amelia

At work, dressed in her scrubs, face mask and hair net, as well as being in an office at the hospital; twice was disturbed during the interview; I wonder how much her being 'in' the context played a role in how much she told me, and whether she felt she could be emotionally expressive; this may inform why Amelia appeared to jump in quickly with the narrative, telling me about the several days she spent in ICU; language barrier between us; had to concentrate in order to follow narrative; felt nervous that I was going to miss something; I think my communication style changed – spoke clearer – I wonder how this impacted Amelia's narrative – (possibly reinforcing her answering in short, brief answers).

Appendix T: Quality Assessment of this Research (Tracy, 2010)

Worthy topic	This research is worthy, novel, timely, and has met a gap within the literature. This research is important in considering how to prepare and support nurses better for future pandemics, which are thought to be likely (Gill, 2020).
Rich rigour	Throughout this research process, the various ways that narrative research can be conducted was explored. It became helpful to discuss with my colleagues and supervisor during this process. I also kept a reflective journal (Appendix X), and field notes throughout the analysis stage (Appendix X). The interview length was sufficient (between 1 hour - 1 hour, 51 minutes) and led by the nurses, to allow for the collection of rich stories and the multiple layers of analysis required. Collection of rich participant demographic details (collected via the Expression of Interest form – Appendix K, and presented in Table Two, Chapter Three) helped situate the sample. A limitation is the heterogeneity of the sample (discussed in more depth below).

Sincerity	I shared with the reader my epistemological stance to the project, which I have aimed to hold in mind throughout (see Appendix X for my research diary). How this research was developed and conducted has allowed me to challenge my position and some of my decisions when necessary. For example, following meetings with the research consultant, I adapted the practicalities of the interview process and the recruitment process (see Appendix R for my research diary extracts).
Credibility	Meetings with my supervisory team ensured the credibility of the analysis and prompted me to consider other interpretations, and challenge some of my interpretations of certain stories within the accounts. Rich information related to the stages of data analysis is provided (Chapter Three). Throughout this research, I had bi-monthly meetings with a colleague also using narrative inquiry, where we discussed all stages of the research. With narrative research exploring accounts across time (Connelly & Clandinin, 1990), it would have been useful to conduct the interviews at multiple time points. Due to conducting the research

	within the time boundaries of clinical psychology training, this was not possible. Future research may benefit from employing this.
Resonance	Given this research is so current and novel, it is likely to resonate with readers. Narrative inquiry, with its exploration of participant accounts in storied form, weaving in participant's own words, and writing in the first person, is also like to support its ability to resonate. I have aimed to present this research in a clear, aesthetic manner with the use of subheadings, tables, and figures. The sample was recruited from a specialist cardiothoracic unit, so how far the analysis has 'implications' for nurses in more general hospitals is questionable (a critical discussion on 'implications' is discussed later in this chapter). All participants were women, however, there was a diversity in participant's ethnicities and ages. From discussion with the research consultant to the project, this sample is assumed to be representative of the nurses at the hospital.
Significant contribution	Taking into account the reviewed studies, this research both supports other literature and offers alternative angles which have been discussed above.

	This research has clinical implications which will be discussed below.
Ethical	Ethical considerations were paramount to consider throughout all stages of this research. See Appendices X and X. Given this is a potentially sensitive area, extensive consideration was taken to mitigate any intended emotional distress for participants. This included ethical recruitment strategies, meetings with the research consultant, with a specific focus on the appropriateness of the interview questions. Care was also taken related to informed consent and ensuring confidentiality was maintained, particularly when conducting research during the COVID-19 pandemic.
Meaningful coherence	This research achieved its aims. Similarities and differences across accounts were explored. The analysis is presented in a coherent, narrative format, aimed to preserve nuances in the data.