Psychosocial resilience: Challenges and facilitators for nurses from four New York City hospitals responding to the first wave of COVID-19, spring 2020: Qualitative findings from a mixed-methods study

Nancy Van Devanter, DrPH, RN, MEd, FAAN
Victoria H. Raveis, MA, MPhil, PhD
Christine Kovner, PhD, RN, FAAN
Kimberly Glassman, PhD, RN, FAAN
Gary Yu, PhD
Laura Jean Ridge, PhD, RN, ANP-BC

ABSTRACT

Frontline workers are at great risk of significant mental health challenges as a result of responding to large-scale disasters. We conducted a mixed-methods study to identify the challenges experienced and the resources nurses drew upon during this first phase of the COVID-19 pandemic in the spring of 2020 in New York City (NYC). The qualitative data presented here are on 591 nurse participants in the qualitative arm of the study. Responses to qualitative questions were reviewed by one of the investigators to identify emerging themes. Two qualitative researchers used both deductive (guided by the Resilience Theory) and inductive approaches to analysis. Challenges identified by nurses included concerns about well-being and health risk; mental health symptoms such as depression, anxiety, and difficulty sleeping; fears about the ability to care for patients with severe life-threatening symptoms; and home–work challenges such as risk to family and friends; and lack of availability of institutional resources, particularly, personal protective equipment (PPE). Facilitators of resilience were institutional resources and support available; social support from coworkers, friends, and family; and positive professional identity. Recommendations for promoting resilience in future disaster/pandemic responses included clarification of disaster-related professional responsibilities, integration of disaster preparedness into professional education, and engagement of nurses/frontline workers in preparation planning for disasters.

Key words: mental health, COVID-19, nurses

BACKGROUND

There has been a global rise in the incidence of COVID-19, declared a pandemic by the World Health Organization in March of 2020.¹ It is the fifth pandemic, but by far the largest, since the 1918 Spanish flu that infected 500 million people. Due to globalization and the increased mobility of human populations, the COVID-19 virus has rapidly spread worldwide. The first COVID-19 case in New York City (NYC) was confirmed on March 2, 2020.² The number of cases rapidly increased and by the spring of 2020, NYC was the hardest hit of any city in the United States, with the highest number of cases in the county. By June of that year approximately 203,000 cases had been diagnosed there. Among those hospitalized in NYC during this initial wave, about one-third died. African Americans, Hispanic Americans, and those living in neighborhoods with high poverty levels experienced the highest mortality rates.³ This ongoing pandemic is the deadliest
disaster by death toll in NYC’s history, though the impact is similar to that of the 1918 flu.4

NYC’s hospitals were quickly overwhelmed by the pandemic despite an initial bed capacity of 20,000. With little time for preparation, to ensure adequate availability of personal protective equipment (PPE) and essential medical equipment, such as ventilators, and the limited and evolving knowledge about how to manage the pandemic, medical personnel experienced unique challenges when confronted with the accelerated volume and acuity of the incoming COVID-19 patients.5

A robust, extant literature documents the mental health and social impact of responding to large-scale disasters, such as pandemics, on frontline responders, including healthcare workers. Numerous studies have shown increased rates of anxiety, depression, somatization symptoms, and post-traumatic stress disorder (PTSD) in this vulnerable population. Significant stressors identified in the pandemic disaster literature include frontline responders’ concerns about personal health and that of family and friends; the stigma of infectious disease; expanded workload; and ethical, moral, and professional dilemmas.6

The purpose of this study was to identify the challenges nurse frontline workers experienced, in their own words, during the initial outbreak of the COVID-19 pandemic in NYC during the spring of 2020 and the personal assets and institutional resources that supported them.

METHODS

Study setting

This study was conducted in four greater NYC hospitals that comprise the NYU Langone Health System (NYULH) including a comprehensive medical center, an urban community teaching hospital, a suburban community teaching hospital, and an urban specialty hospital.

Design

To obtain a more in-depth understanding of this complex environment, we conducted a mixed-methods study.7 Data collection consisted of a cross-sectional, internet-based survey and an open-ended question at the end of the survey: “Are there any concluding comments you would like to share on how your work life changed since the COVID-19 pandemic?” The findings presented here are a thematic analysis of the additional comments that 591 (24 percent) study participants shared as part of the survey.8

Theoretical framework

Resilience has been studied for many decades to explain individuals’ response to multiple kinds of stressful events, including natural disasters, crime, war, accident, and abuse. Resilience theory is the conceptual framework for understanding how some individuals can return to their former ability to function after experiencing an adverse event.5,10 Resilience is considered the process of overcoming the negative effects of exposure to trauma. The theory hypothesizes that the presence of “promotive” factors, including personal characteristics, such as self-efficacy, self-esteem, and adaptability (referred to as assets), together with social support and institutional support (resources), enhances the ability of the individual to return, or recover, from a stressful event to a prior level of psychological functioning.

Data collection

With collaboration from the four participating hospitals, all registered nurses (RNs) at these facilities were sent an email in the spring of 2020 inviting them to participate in an online anonymous survey. Researchers were blinded to the individual email addresses. Following the Total Design Method, we used multiple email reminders.11 We sent an alert email, an email with a link to the survey, and two reminder emails, each with a link to the survey. As the respondents were anonymous, the email reminders were sent to all nurses, whether or not they had responded to an earlier request. We collected the survey data between May 27, 2020, and July 11, 2020. Respondents entered their survey and qualitative question responses electronically, online, into a RED CAP survey located on a secure NYU drive. The survey data were then downloaded to another NYU secure drive and cleaned.
approved by the New York University Medical School Institutional Review Board.

Participants

All RNs who worked at NYULH (comprised of the four participating hospitals) on May 5, 2020, were included. Surveys were sent by email to 7,219 nurses, and 2,495 responded, for a response rate of 35 percent. Ten surveys were eliminated because the respondents were Licensed Practical Nurses (LPNs), and two other surveys were eliminated because respondents did not indicate that they had a professional nursing degree, leaving a total sample of 2,483 respondents. Among those who completed the survey, 591 (24 percent) responded to the qualitative question.

Qualitative data analysis

The research team read the responses to the open-ended question and conducted a thematic analysis of the responses. Data reduction was a three-level process: open coding, focused coding, identification of themes, and the identification of theoretical constructs related to resilience theory. A codebook was then developed, and the data were coded by members of the research team (NV and VR). A 20 percent sample of the data were coded by another member of the team (LR) to establish inter-rater reliability. Consistency was 82 percent, appropriate for inter-rater reliability. Description of the quantitative survey data has been published elsewhere. Respondents were demographically similar to the most recent national RN survey. The more the nurses cared for COVID-19 patients as well as experienced home–work and work–home conflicts, the higher were the nurses' depression and anxiety scores. When asked what has helped the nurses to carry out their care of patients, the most common responses were support from and to coworkers, training in proper PPE, and support from family/friends. There were no significant differences between individuals who responded to the quantitative survey only and those that also completed the additional qualitative question with regard to age, marital status, number of children, education, psychosocial variables, and the NYULH hospital where they were employed.

RESULTS

Findings are presented in the participants’ own words as challenges to and facilitators (assets and resources) of resilience that supported their psychosocial well-being while they were carrying out their specific frontline roles during the initial surge in the COVID-19 pandemic. The themes and subthemes related to the challenges and facilitators of resilience that emerged from this analysis are listed in Table 1.

Challenges

Concerns about personal well-being and health risk: Nurses shared their fears and worries about the risk to their health, working in an environment that exposed them to COVID-19. The extreme anxiety and stress they experienced was intensified by their first-hand knowledge of the suffering that their COVID-19 patients were undergoing.

a. Fear of being infected.

During the peak of the pandemic, I went into work extremely nervous, anxious, and terrified; wondering what assignment I would get, and how much stress I’d be in. I was on edge about when and how I would contract the virus and was disappointed that we did not get the PPE we needed and deserved. I cried several times due to work-related stress, and seeing the conditions my patients were in. I cried seeing someone my age die from COVID. I cried from being separated from my new-born niece. It was depressing having to deal with all that at work and then coming home feeling trapped due to the ‘lock down’. It felt like there was no air to breathe and no room to think.

Mental health challenges of working in a setting with COVID-19 infection: Caring for COVID-19 patients was very demanding, stressful, isolating, and emotionally distressing. For some nurses, over time, the cumulative impact of these experiences generated PTSD symptoms. Nurses felt traumatized,
distressed, and isolated; had trouble sleeping; and experienced nightmares.

- a. Inability to sleep and nightmares.

I have PTSD. This experience has given me extreme anxiety and I continue to be extremely emotional. I have trouble sleeping and have nightmares. I reached out to the mental health that was provided and I feel it did not do any good. It has been very difficult to adjust to my home life. I have difficulty sleeping. I am, however, surrounded by family, which makes it a bit easier to cope.

### Table 1. COVID-19 challenges and facilitators of resilience among frontline nurses

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<tr>
<th>Challenges</th>
<th>Facilitators of resilience</th>
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Vol. 26:399-419 (Volume publication date 21 April 2005) First.
b. Feeling traumatized, depressed, distressed, and lonely.

I was transferred for two months to the COVID-19 ICU and the first month (end of March to April) was very traumatic, depressing, and lonely. It was the hardest experience of my nursing career so far. I struggled to properly take care of two very sick, ventilated patients at the same time. As someone who is single and living far away from my family, I was on my own to cope with my new work situation. I was transferred to a unit where I did not know any nurses from beforehand, and even though everyone was very nice and helpful, it was a very lonely experience. I did not have any close nurse friends to help me cope, and I did not have anyone at home to help me cope. My mental health took a heavy toll and I struggled.

Everyone did an excellent job working together with the illness being scary and unknown. I truly believe I have PTSD from it. And can cry at the drop of a hat when thinking about COVID-19.

Professional challenges of working in a setting with COVID-19 infection: COVID-19 profoundly challenged nurses’ skill set and raised personal concerns that in their limited experience of caring for COVID-19 patients they could inadvertently cause harm to the patient. In addition, the restricted care options that were available early in the pandemic generated feelings of futility and helplessness at their inability to help COVID-19 patients.

a. Concerns about personal competency to provide care to COVID-19 patients.

Due to COVID-19, I was asked to take care of patient population that I never took care of before. I know there are other nurses who are experienced and can be provided as a resource. I felt anxious and worried when taking care of those patients, afraid that I do not have the competency to care for those patients and end up causing harm to a patient, not being able to pick up early signs of clinical changes among those patients.

b. Feeling helpless and distressed at being unable to help COVID-19 patients.

It feels terrible to not be able to really help most of these COVID patients. We oxygenate and monitor them and they either live or they die. It’s like being a farmer in a drought.

Home–work life challenges: Nurses’ concerns and worry over the possibility that their work environment posed an infection risk to family and other network members precipitated a lengthy implementation of social distancing practices and other cautionary infection control routines that dramatically altered nurses’ home life.

a. Risk to family and others from caring for COVID-19 patients.

Coming home, leaving bags in hallway and running to shower, disinfecting everything I touched, trying to keep distance from my family in a small apartment and always thinking, thinking, thinking what will be tomorrow? When will it be over? Everyday hear from one friend, another friend—his/her family member, neighbor, relative, friend died . . . It was challenging emotionally. My co-worker/close friend got sick with COVID, told me that she was writing a will and contacted lawyer . . . It was scary. Now we are back to ORs, there are no more patients at the hospital and this brings a sign of relief.

b. Need to remain separate from family.

The hardest part has been not being able to see my grandson or my mom since...
mid-March. I became COVID+ at end of April. It is a very scary, lonely illness. I was very sick and afraid of dying. Still not recovered.

Since COVID, I have not been able to stay or see my family since my dad has a compromised immune system. This has severely impacted my life with my family.

**Deficiencies in institutional resources and support response:** The scope of the pandemic overwhelmed the capacity and resources of the healthcare facilities. Deficiencies noted included inadequate institutional preparation, limited pandemic trainings, as well as insufficient PPE and supplies. Other issues were a lack of involvement of nursing staff in decision-making and response planning.


I think the whole hospital wasn’t prepared enough and regulations kept changing too often, everyone were confused. We were not being trained properly. We’re constantly being exposed to COVID patients still because we're still not screening properly.

I think that our hospital (as well as most of the nation) was wildly unprepared for the pandemic. I hope that history does not repeat itself in the future.

The pandemic opened my eyes to how unprepared the hospital was, but I am grateful for the level of teamwork and our ability to come together during extreme difficult times.

b. Insufficient institutional communications.

While I understand the need to make quick decisions without a lot of time to disseminate information at the beginning of this crisis, I think some later decisions regarding plans for unit COVID designation and staff deployment could have been much better planned in advance, been more transparent in the plans to other leaders, and thereby communicated much better to staff.

c. Lack of PPE and training in proper use.

I will never ever take for granted the importance of having enough personal protective equipment. It is disturbing having to reuse N95 masks. This should not happen!

I don’t think this hospital was amply prepared to take on this challenge of COVID-19. There wasn’t enough PPE for us nurses to adequately change them daily and were left to re-use the same mask, gowns, and face shields for weeks at a time.

d. Lack of inclusion of nurses in planning for staffing and reassignments.

I hadn’t worked on an inpatient med/surg unit for about 8 years, yet our nursing leadership redepolyed myself and one other co-worker to an inpatient COVID unit. The month that I worked on this surge unit caused me anxiety with physiological symptoms like insomnia, loss of appetite, and chest tightness. The main input I would like to offer is that leadership should be more transparent with frontline workers about emergency plans and redeployment in the future. Involve US in the process so that we have a sense of agency in what will be happening to us. I definitely feel like the mental health symptoms I suffered could have been significantly reduced if there was frequent, open, and honest communication with leadership.
and those in charge of reassigning staff to assist during this emergency period.

Post-pandemic, potential workforce loss anticipated: For some nurses, the challenges and risks nurses experienced caring for COVID-19 patients precipitated a re-evaluation of nursing as a career choice. Experienced nurses, who are considering leaving the workforce, acknowledge that they are weighing the benefits of the nursing profession against the harsh reality that COVID-19 has generated and the challenges of achieving a work–life balance.

a. Risks and demands of COVID-19 pandemic precipitated a reassessment of the commitment to the nursing profession.

I have to say that over the years and especially now I would caution anyone considering entering the nursing profession. The demands of the job have continued to grow and with the new reality of life with COVID, I don't know if the benefits of the job outweigh the risks anymore. No one signed up for this type of pandemic ‘warfare.’ It’s a harsh reality in the nursing and medical world right now.

I have decided to retire (I am 66 y/o) in light of the COVID pandemic and the recent decline in my spouse’s health (unrelated to COVID). It is far too stressful to work in this environment of wearing masks and social distancing, working from home and caring for a sick spouse.

I used to enjoy this noble profession that I took 10 years ago. But due to what happened recently, and also, as for how management was addressing this grave issue, and the way management provides PPE, not mentioning the zero hazard pay to all the staff, I am considering on taking a new path towards success in which I can spend more time with my family, especially my baby.

Facilitators of resilience

Institutional resources: Nurses reported a range of institutional resources that facilitated their resilience in the wake of the multiple challenges that COVID-19 posed. These ranged from various management activities such as communication and extra staffing to institutional resources such as mental health counseling.

a. Management activities.

The institution provided commitment to excellence, support and sufficient resources to ‘do the job.’

I am proud to work at this hospital I feel the institution for the most part has handled the situation well, it is just very stressful.

I feel that how this hospital handled the pandemic made me feel very confident in our ability to handle whatever pandemic or future crisis will hold. We hired numerous capable travelers and retrained staff to take on different roles which they were very willing to step up to the plate in uncertain times. Also, the ongoing communication and support we received from collaborating hospitals was very encouraging. It all made me feel very proud to work here.

b. Availability of counseling.

My hospital did offer counseling services and I had my own therapist as well, but it was still a very hard month for me.

Thankfully, I made an effort to utilize the mental health resources offered by this institution, engaged (and still participating) in tele-mental health visits, and was started on an anxiolytic medication. . .

Social support: The social support that nurses received during the pandemic also contributed to
their resilience. A broad range of social support resources were noted. Not surprisingly, fellow nurses supported each other, working as a team to carry out their nursing responsibilities. Also noted was the mutual emotional support and solace they give to each other during the stress and sadness of the pandemic, the suffering and deaths of the patients, and the isolation from family and loved ones. The importance of skilled help from travel nurses as well as the support and donations the community provided were also acknowledged. And finally, the nurses valued the gratitude the patients and their families expressed.

a. Nurses supporting each other.

I've also never appreciated my fellow nurses more. I found comfort in being with them. Because I couldn't be close to family at home, they became my family. I found solace in talking with my colleagues, sharing the good and the bad. It made this whole ordeal a little more bearable, because I knew I wasn't the only one feeling lost and alone in it all.

We were there. We were there for the first death of the COVID positive patient. It was the first confirmed case of COVID positive patient, and the first to die. We couldn't fix her. This death only confirms two things, we did what we can but this is a novel disease and RNs are there for each other when we need each other.

b. Excellent teamwork.

I think this pandemic was an eye opener for physicians and advanced practitioners to come together and work more closely with RNs and appreciate the work we do. It will make the healthcare system stronger in the end.

The only thing that came from this was teamwork, we ALL pulled together and were there for each other on the front lines every day, working tirelessly. I thank my fellow nurses and nurse managers and travel nurses for coming in and helping us. I only hope this continues to get better because I don't know if I can handle it again; but I will if I have to.

c. Highly skilled help from across the country (travel nurses).

It was great having the travel nurses to take some of the burden off of our shoulders. Once they came in the nurse-to-patient ratio definitely made working during this crazy time much less stressful and it was deeply appreciated.

The Travel Nurses were a god send!!! I only wish they could have come earlier in turning our floor to full COVID . . . there were emails constantly about studies being done, but the majority of caring from patients was learned from fellow nurses.

d. Support and gratitude from patients.

There was so much gratitude from the patients and their families for the work that we did—for showing up to work and doing what we were supposed to do. It was incredibly moving. This experience has changed us forever. We will not be the same.

e. Support from the greater community.

I just want to be thankful for my team and the generous donations from the public in this pandemic period. Without this kind support, our jobs at bedside would have be tougher. Thank you for all.

Professional identity: Attending to the intense COVID-19 patient-care needs precipitated an enhanced sense of self-worth, self-recognition of their
professional competence, the value of their nursing skills, and an enhanced pride in their profession.


I have learned the real value of being a nurse. I felt competent in MCI, we had patients lining the hallway and realized constant across the room observation. I hope the appreciation for the profession remains, these patients were sick and scared, and it was up to the RN to provide top care.

I love what I do and was happy to be able to help in an ICU setting. I do not regret any part of this experience.

b. Pride in nursing profession.

I have a renewed sense of pride and purpose in the nursing profession, as I know my skills are still strong and relevant.

I’ve never been prouder to be part of a profession that showed up, every day, and risked their own well-being and that of their loved ones, to care for the people in need. I strongly feel that every great hospital is built on the back of their nursing staff. This hospital is most fortunate to have nursing staff such as ours.

Suggestions for supporting resilience post-pandemic: The societal impact of the pandemic will be long lasting. Nurses and other frontline healthcare workers may need formal and/or informal support to recover from the intense stresses and trauma they experienced during the pandemic. For some, the recovery process may be lengthy and sufficient resources should be made available for those in need. The pandemic also raised awareness of the importance of advance planning and setting in place preparations and resources to ensure worker safety during future disasters and pandemic events.

a. Need for formal and informal support in the recovery process.

I appreciate this survey and I hope that it helps support our profession and our patients. Although I did not participate in the evacuation of patients during hurricane Sandy I worked at this hospital throughout that experience. The hospital knows how to respond to disaster. That being said—these types of disasters take a toll on us, our staff, colleagues, and patients. We need to look to the next phase of care for nurses (and all hospital staff) as the trauma of this situation is just starting to set in.

b. Time and resources needed to process and recover from trauma, stress, and loss.

I think the effects of this pandemic will last a lot longer on the mental and emotional health of nurses, far longer than we expect. We have been put through the absolute worst and continue to do so.

There were shifts when all we saw were patients being transported to the morgue and getting ready for more. There were weeks when all I would do is cry getting home from work, cry in the shower and cry randomly. It took a toll on my husband and affected his mood as well. It changed who I was. While I am still working with COVID patients and have more time and resources, I know I have not been able to process what happened. It is all a blur, most of which I choose to block out. I think in order to help nurses cope, it is imperative to ask us for our input more in these times and give us more surveys.

b. Better preparation for nursing/healthcare workforce safety.
I think it is very important for the organization to consider ongoing staff safety moving forward. Are there safe places for staff to eat while adhering to social distancing? For shared office spaces—can staff sit 6 feet apart? If not, can anything be done? As hospital workers, of course we cannot always maintain distance. We should still make every effort to ensure that we are employing measures to distance when possible.

**Lessons learned: Promoting disaster/pandemic resilience in frontline healthcare workforce:**
The lessons learned from the COVID-19 pandemic can inform efforts to enhance reliance in nurses and other frontline healthcare workers in future disaster or pandemics. Specifically, the pandemic has demonstrated the necessity of integrating into the nursing curriculum training on disaster and pandemic response. It is also important to define the scope of practice in these public health situations. Another take away lesson is the value of involving nurses, at all levels—frontline workers, staff nurses, not just nursing administrators, in disaster preparedness planning in the practice setting was also noted.

a. Nurses’ scope of practice in a disaster needs to be clarified and appropriate training provided.

With less than a year of nursing experience under my belt, COVID has been a terrifying experience. I have always stood by this hospital as a top healthcare system through my months of working here. These last three months have been unsafe. I feared for my license, with new policies changing everyday so nurses can do more, alone, inside the room—while other team members stand from the outside. Without proper PPE, hours without gowns, weeks with the same mask, and all day in a room with a deadly virus—who is to say I am not getting it next.

b. Need for integration of disaster role in formal education.

Nurse’s pre-licensure educational preparation for response to disaster needs to be expanded and integrated into the nursing curriculum.

c. Nurses who will be providing the care need to be involved in planning the disaster response regarding issues of practice.

Nurses IN PRACTICE NOT JUST NURSING LEADERSHIP need to be involved in the planning for pandemics and other disasters with regard to policies about reassignment, standards of care, critical care training and role expectations and safety policies to protect them and their families and compensation for hazard duty.

**DISCUSSION**

Over the last several decades, many scientists have predicted an increase in the emergence of old and new infectious diseases and suggested that the modern world was unprepared for them. The increase in epidemics and pandemics over the last two decades has clearly demonstrated that those predictions are correct, but nothing has been a more dramatic example of the risks the world faces than the COVID-19 pandemic of 2020. Not since the pandemic of 1918 has the entire world experienced such a dramatic and fatal event. Studies of the impact of this virus on healthcare providers and other frontline workers provide critically important information about how to better prepare a response effort that could reduce the negative consequences to the frontline workers who are severely impacted. A prepared and supported workforce may also improve patient outcomes. The study employed a theoretical framework, Resilience Theory, that has been frequently used in studies of frontline workers in disaster settings as well as other stressful life events. The findings from the study that
are presented here demonstrate the profound physical and psychosocial impact COVID-19 has had on nurses from four NYC hospitals in the initial phase of the pandemic. Analysis of the qualitative responses by these hospital nurses has reaffirmed the quantitative survey findings, while providing a deeper understanding of their lived experience on the front line as well as their recommended actions for improving the public health response in future disasters. Our findings are also consistent with two recent national reports on the lessons learned from the COVID-19 pandemic for nursing preparation and practice. The recommendations of the National Academy of Science on the Future of Nursing identified key areas for strengthening the nursing profession over the next decade to meet the challenges of emergency preparedness. Their recommendations include the expansion of the educational preparation to include the articulation of the roles and responsibilities of nurses in disaster response. Similarly, the National Academy of Medicine report on lessons learned from the COVID-19 pandemic for clinicians and professional societies highlights the importance of addressing the mental health of providers as well as the development of clinical guidelines, adaptations to the delivery systems, and education and training needs, as well as professional roles in advocacy and activism to educate the general public about future pandemic risks.

CONCLUSION

During public health emergencies and disasters, frontline workers, such as healthcare personnel, experience significant burdens and demands, enduring personal risk in the delivery of essential services during the duration of the event. Hospital nurses, key frontline workers, are also at risk of experiencing compassion fatigue, burnout, and trauma given the nature of their occupational tasks. Our analysis of both the quantitative and the qualitative arms of this study identified the challenges nurse frontline workers experienced during the initial outbreak of the COVID-19 pandemic in NYC, as well as some of the personal characteristics, and social and institutional resources that facilitated their ability to respond and adapt to the challenges they faced.

Most importantly, the nurses’ qualitative accounts of their lived experience provided firsthand recommendations toward decreasing challenges to responding in future disasters as well as structural approaches to promote resilience in hospital nurses, an essential frontline workforce. This information, once implemented, will not only improve patient care and patient outcomes it will also facilitate the retention of skilled healthcare personnel for future public health emergencies. One respondent’s comments on her experience reflect many dimensions of the experience others underwent. It also underscores the commitment to care and the resilience that has characterized the nursing workforce throughout this pandemic:

It was extremely difficult when this all began in our hospital. I have never in my life or career seen anything to this extent. This is a time I will never forget. I tried my hardest and hope the patients and families we dealt with have found peace. I hope the ones that survived live long wonderful lives. The only thing that came from this was teamwork, we ALL pulled together and were there for each other on the front lines every day, working tirelessly. I thank my fellow nurses and nurse managers and Travel Nurses for coming in and helping us. I only hope this continues to get better because I don’t know If I can handle it again; but I will if I have to.


Christine Kovner, PhD, RN, FAAN, New York University Rory Meyers College of Nursing; New York University Grossman School of Medicine, New York, New York.

Kimberly Glassman, PhD, RN, FAAN, New York University Rory Meyers College of Nursing, New York, New York.
Gary Yu, PhD, New York University Rory Meyers College of Nursing; New York University Grossman School of Medicine, New York, New York.

Laura Jean Ridge, PhD, RN, ANP-BC, University of Michigan School of Nursing, Ann Arbor, Michigan.

REFERENCES