

Battling extraordinary situations and conflicting emotions—A qualitative study of being a newly graduated Registered Nurse in the emergency department during the COVID-19 pandemic

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Abstract

Aim: To describe newly graduated registered nurses' (NGRNs') experiences of encountering stress in emergency departments (EDs) during the COVID-19 pandemic.

Design: A qualitative descriptive study.

Methods: Data from 14 in-depth interviews with NGRNs working in an ED for 3–36 months after graduation was analysed by the means of qualitative content analysis as described by Graneheim and Lundman. Interviews were conducted from March to November 2020 covering the first two waves of the pandemic.

Results: Data revealed three categories and nine subcategories comprised in the theme Battling extraordinary situations and conflicting emotions. Empowered by acknowledging themselves as important caregivers during the pandemic NGRNs struggle against limitations and exert themselves beyond their known limit. External stressors due to work overload in combination with understaffing force NGRNs into the role of the experienced nurse prematurely and internal stressors derives from part taking in less qualitative care.

KEYWORDS

advanced nursing, care, COVID -19, emergency department, emergency care, nurses, qualitative approaches, stress

1 | INTRODUCTION

With little time for preparation the Coronavirus disease 2019 (COVID-19) pandemic has globally changed the conditions for caring in ways hard to overview. Early research points out a new frightening and exhaustive caring reality in the absence of relatives, with extensive protective equipment difficult to work in and immense withdrawal from one's own bodily resources (Leng et al., 2021; Llop-Gironés Vračar et al., 2021; Luquiens Morales

et al., 2021; Shahrour & Dardas, 2020; Specht et al., 2021; Stewart et al., 2020). According to Benner and Wrubel (1989), caring is always relational and takes place in a specific context. Somethings matter to the individual that cares, and this involvement is a compass for being in the world but also put people at risk and make them vulnerable. It is known that not being able to bestow care in line with internal and external expectations put nurses at risk of developing moral stress and troubled conscience (Ericson-Lidman et al., 2013; Glasberg et al., 2007; Juthberg Eriksson et al., 2010;

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Lidman & Strandberg, 2020; Mazaheri Ericson-Lidman et al., 2018; Roczniowska & Bakker, 2021).

In Sweden, stress-related ill health is especially common among young female healthcare staff such as newly graduated Registered Nurses (NGRNs), who often start their nursing career in emergency care, such as in an emergency department (ED) and consequently have been placed in the frontline of the COVID-19 pandemic (Swedish Statistics, 2017). However, practicing health care especially in the context of emergency care, during a pandemic or not, is inevitably stressful as nurse's care for patients in tragedy and death every day. In the context of emergency care nurses challenge specific demands to care when the patient is seriously ill, and time is short (Adriaenssens et al., 2015; Happell et al., 2013). During the COVID-19 pandemic, parallels to nursing in battlefields as described by Florence Nightingale have been made, indicating that caring for patients during the pandemic entails extraordinary demands at the expense of physical and psychological well-being (Deliktas Demirci et al., 2021; Huang et al., 2020; Lam et al., 2020; Petzold et al., 2020; Shamia et al., 2015; Theorell, 2020). From a caring science perspective, to cope in challenges associated with this burden should not be reduced to increase distance and control. Rather, we need to consider caring as "*the essential requisite for all coping*" (Benner & Wrubel, 1989, p. 2). Thus, because caring entail both joy and fulfilment, loss and suffering coping in caring is more about the importance of maintaining the caring relationship than the diminishing of stressors (Benner & Wrubel, 1989; Eriksson, 2018; Watson, 2003). Given the importance of NGRNs' role as providers of care during the COVID-19 pandemic, and scarce knowledge about their experiences entering the profession under these conditions, this study focuses on NGRNs experiences of encountering work-related stress during the COVID-19 pandemic.

1.1 | Background

The phenomenon of work-related stress in nursing context is not new. For decades different aspects of work-related stress have been described as a threat not only to the quality of nursing care (Benner & Wrubel, 1989; Eriksson, 2018; Watson, 2003), but also to nurses' health and well-being. Especially the latter has been highlighted as an escalating problem during the COVID-19 pandemic entailing nurses in difficult and stressful situations (Chen Sun et al., 2020; Deliktas Demirci et al., 2021; García-Martín et al., 2021; Specht et al., 2021; Chew et al., 2020; Nashwan et al., 2021; Rosted et al., 2021; Shahrouf & Dardas, 2020; Sugg et al., 2021). Stress-related illness as depression, stress and Post Traumatic Stress Disorder (PTSD) among healthcare personnel are now being investigated in the light of the pandemic (Huang et al., 2020; Leng et al., 2021; Shahrouf & Dardas, 2020; Shevlin et al., 2020; Theorell, 2020).

In Sweden, initially hard hit by the pandemic outbreak, 50% of NGRNs report occupational stress-related ill health to the extent that 20% of them consider leaving the profession prior to the pandemic. This adds to already high turnover rates in health care

(Frögéli et al., 2019; Rudman et al., 2014). However, several studies show stress experienced by nurses being multi-faceted addressing the term "stress of conscience", foremost due to working conditions, feelings of uncertainty about responsibilities and authority. A review shows that troubled conscience occurs when nurses are not being able to provide good care in line with their obligations as professionals (Dahlqvist et al., 2007; Ericson-Lidman et al., 2013; Frögéli et al., 2019; Glasberg et al., 2007; Glasberg et al., 2008; Juthberg Eriksson et al., 2010; Lidman & Strandberg, 2020; Mazaheri Ericson-Lidman et al., 2018; Sørli et al., 2005). Current research addressing nurses' experiences during the pandemic show they are proud of their frontline work but describe a pendulum experience between meaningfulness and burdensome difficult situations (Rosted et al., 2021; Sugg et al., 2021).

According to Benner (1984), who's model "From novice to expert" is still considered relevant, the first three months in the nursing profession are often stressful as NGRNs lack clinical experience to bridge the gap between theoretical and clinical skills. Previous research shows that NGRNs feel unprepared for the key role they are assigned and the medical responsibility they are expected to take on early in the profession, leading to a vulnerable situation and experience of inadequacy (Widarsson et al., 2020; Willman et al., 2020). It has also been recognized as challenging for NGRNs to consolidate the prevailing medical paradigm in the ED context reducing the recognition of caring competencies in everyday work. This is added by a hierarchical structure entailing unclear occupational functions (Andersson et al., 2014; Andersson & Nilsson, 2009; Happell et al., 2013). Nurses as caring practitioners report scarce opportunity of involvement in the decision-making forming their nursing practice resulting in an endeavour where practice force them to take short cuts or leave things undone due to a stressful work environment. At the same time, in caring there is a moral agent for nurses to altruistically give care according to the recognition of human dignity. The conclusion is that nurses are held responsible and accountable for the quality of care they are not able to provide, a core issue in developing moral stress (Lützén et al., 2003).

Possessing the inner strength to cope with caregiving is described as a human resource that promotes well-being connected to health involving firmness with a drive to act and trust in one's competence, connectedness in the meaning to be in a community receiving and giving care. Furthermore, it involves creativity and stretchability to balance between options and extend oneself (Lundman et al., 2019). Adding a disaster nursing perspective means NGRNs during the COVID-19 pandemic have had to cross personal, professional and environmental boundaries. This put demands on competence and empathy, involves employing emotional commitment and having the ability to be present and to regulate one's own emotions (Hermelin et al., 2020; Hugelius & Adolfsson, 2019). As we know there is little research describing frontline NGRNs' experiences of encountering stress during the COVID-19 pandemic. The research question guiding the study was: How do NGRNs describe encountering work-related stress in EDs during the COVID-19 pandemic?

2 | THE STUDY

2.1 | Design

This study applied a qualitative, descriptive approach and subjected data to qualitative content analysis as described by Graneheim and Lundman (2004), Graneheim et al., (2017) and Lindgren et al. (2020) to gain a deeper understanding of NGRNs experiences. We used the Consolidated Criteria for Reporting Qualitative Research (COREQ) as the research reporting checklist (Tong et al., 2007).

2.2 | Method

2.2.1 | Setting

The study was conducted in EDs in rural and urban areas in Sweden. Each ED had the capacity to treat patients with illness due to surgical, medical, orthopaedic, paediatric and traumatic reasons. In 2020, Swedish EDs registered 1.6 million visits, placing demands on nurses addressing work in efficient and safe ways.

In EDs in Sweden 50% of the patients receive a physician's assessment in 50 minutes and with a median visit time just over three hours. Older people and women spend more time in the ED than younger people and men (The National Board on Health & Welfare, 2020).

2.2.2 | Participants

Influenced by Benner's (1984) theory on the development from novice to expert, this study encompassed nurses who had between 3 and 36 months of employment in an ED. After receiving permission from managers, NGRNs, meeting the inclusion criteria received information about the study and ethical procedures by e-mail followed by a telephone call one week later. Altogether, nine women and five men, between 23–44 years of age, working in the ED from three to 24 months took part in the study.

Registration as a nurse in Sweden require three years of university studies, which gives a degree of Bachelor (Andersson & Nilsson, 2009). Some of the NGRNs had a gradual introduction, including mentorship, and were excluded from night shifts during the first months. Others reported a lack of introduction in significant parts and were assigned advanced tasks usually performed by more experienced staff.

2.2.3 | Data collection

In all, 18 individual audio-recorded interviews with 14 participants were conducted by the first author. Six interviews were performed between March and June (during the first wave of the pandemic), two during the summer and six between September and November

2020 (during the second wave). The four first interviews (conducted in early March 2020), were supplemented in May and June, adding data on the impact of the COVID-19 pandemic on NGRNs' experiences. Two interviews took place in a secluded room close to the ED and the other digitally by telephone due to current restrictions. A semi structured interview guide with open-ended questions was used covering significant areas. Additionally, two pilot interviews were conducted: one with a NGRN caring for the patients in an acute setting during the pandemic and one with an experienced nurse in emergency care. The interview guide was then refined to support the research questions. To ensure consistency and accuracy all interviews were audio-taped with the participants' permission. Interviews varied from 35 to 75 minutes and started with an open question where the NGRN was asked to describe their experiences of working as a nurse in the ED during the COVID-19 pandemic followed by open-ended additional questions to anchor their stories in their lived experiences:

- How would you describe being a newly graduated Registered Nurse during the COVID-19 pandemic?
- What does stress mean to you?
- Do you experience stress in your work and if so, how would you describe it?
- How do you handle perceived stress?
- Are you trying to prevent stress and if so, how?

All interviews were later transcribed verbatim (by the first author) and supplemented interviews were analysed as one interview in the collaborative research team. During the interview process, it was noted that fewer new perspectives emerged, which supported the sample size for the research question under study (Brinkmann & Kvale, 2015).

2.2.4 | Trustworthiness

The four aspects of trustworthiness in qualitative research; credibility, dependability, conformability and transferability (Graneheim & Lundman, 2004; Graneheim et al., 2017) guided this study. To obtain trustworthiness, a broad sampling was used to obtain as rich descriptions as possible by having variations in demographics, such as age, sex, professional background and working experience. Maximum variation supports the idea of transferability of the findings to others and a broad purposive sampling was used addressing NGRNs from four different hospitals (Brinkmann & Kvale, 2015). Each unique interview situation has been addressed with reflexivity, moving the discourse from closeness to reflection. No answers have been taken for granted, instead attempts have been made to create a relaxed atmosphere enabling participants to turn their attention towards the phenomenon. To show genuine interest in participants stories and to strengthen intersubjectivity follow-up questions such as "how did you feel?" and "can you describe this further?" were posed (Graneheim & Lundman, 2004; Graneheim et al., 2017). Even

though the results may be intersubjective to other NGRNs the reader must assess transferring suitability into other setting or groups. The analysis process was encompassed by a reflexive dialogue in the research group. Finally, all research steps and procedure documents including the recorded interviews were safely stored with opportunity to give auditing and follow-up for others.

2.3 | Data analysis

The transcriptions were read through several times and imported into a qualitative data analysis software program (N'vivo) and subjected to qualitative content analysis following the steps proposed by Graneheim and Lundman (2004) and Graneheim et al. (2017). First the transcripts were investigated for meaning units connected to the aim of the study. In the following steps these meaning units ($n = 527$) were condensed and coded. Codes were then reviewed to find similarities, differences and patterns, subsequently merged into subcategories. These were merged into categories labelled close to the manifest content. This process was made by the first author and discussed with all the authors. Finally, by moving back and forth between the different levels of analysis an underlying, latent thread of meaning that re-occurred in the different categories was formulated as a theme. The interpretation process of coding and categorizing the data was non-linear and continuously discussed between all authors until recontextualization and a sufficient level of abstraction and interpretation was reached (Lindgren et al., 2020). An example of this was the continually asked question at the research group meetings; "Is this abstraction supported by the text?" (See Table 1).

2.4 | Ethics

The study was approved from the Swedish Ethical Review Authority (dnr 2019-06211 and 2020-01748) and conducted in compliance of the Swedish Ethical Review Act (2003:460) following the principles in the Declaration of Helsinki (World Medical Association, 2018). Participation was voluntary, verbal and written consent was obtained before the interviews, and information explaining that withdrawal from the study at any time without stating a reason was possible. There were no dropouts at any time. Possible participation risks were considered as small, as the risk of infection during the interviews was diminished by switching to telephone interviews. On project completion, interview data were stored in line with The Swedish Archives Act (SFS, 1990:782).

3 | RESULTS

To facilitate reading, the abbreviation "NGRNs" is changed to "nurses" and "the COVID-19 pandemic" to "the pandemic." The categories are presented under subheadings with subcategories in **bold italics** in the text. Finally, the results are further abstracted and

synthesized in the theme "*Battling extraordinary situations and conflicting emotions.*" The theme springs from three categories that summarize nine subcategories (see Table 2).

3.1 | Struggling towards control

Nurses dedicate themselves as important caregivers during the pandemic but experience loss of control by work overload in combination with understaffing. This is described in contrast to the stress of performing under pressure and at high speed (if overview and control are preserved), which was highlighted as desirable and constructive. The unpredictability in EDs in the sense of tension and drama, is described as instructive and a main reason for choosing to work in EDs directly after a nursing degree. Having to take on advanced work tasks earlier than planned during the introduction reveals feelings of unpreparedness as participants find themselves in pressing and exhaustive work situations, formulated as feelings of inadequacy. In the struggle towards regaining control, personal qualities such as staying calm in stressful situations are expressed. Support from colleagues, managers, friends and family and from people in general following restrictions to avoid being infected, is highlighted as important to endure the struggle.

It was common among participants to start their professional career directly in EDs during the pandemic. This is described as **Not feeling prepared**. To experience shortcomings in the introduction and to be forced into the role of the experienced nurse early are described as stressful, as the unpreparedness makes it hard to grasp and control the situation.

There can for example be a patient who suddenly starts to have a seizure. It was a big fear ... I pondered a lot, no one can have a seizure or a cardiac arrest now ... I do not know what to do then. (J)

Being introduced in an ED during the pandemic without time for reflection or adjustment, is described as being left behind. Participant E says:

During the pandemic you may not have had the same chance to be new or not that much reflection ... mostly you need to keep working.

Maintaining the same introduction program as before the pandemic outbreak, by gradually introducing advanced fields and not demanding mandatory night shifts, is described as strengthening and stress-preventive. However, turnover rates are high and when experienced nurses quit, expectations by managers to take on their role, often with a shorter introduction than before, occur. When experienced colleagues resign, a lack of support in situations is perceived as difficult, which gives insights into how nurses with little experience perceive EDs.

Mastering a stressful situation is described as satisfactory in terms of establishing an overview and having the ability to handle what is

TABLE 1 An example of qualitative analysis

Meaning unit	Condensed meaning unit	Code	Sub-category	Category	Theme
I walked around for months and had so much anxiety that I would take this home. Me and my relative we were always five meters away.	I was scared to carry the infection to the people I live with	Anxiety	Worrying about infecting others	Living with inner conflicts	Battling extraordinary situations and conflicting emotions
They will not get the same care they would have received if they did not have symptoms, I think it is terrible, unfair and wrong. It is nothing I support, nothing I want to accept, but I have no choice.	The patients will not get the care they would have if they did not have COVID-19 symptoms, I think it is wrong, but I have no choice but to carry on.	Lack of freedom	Being forced to participate in less qualitative care		
To see perfectly healthy people get so ill that they cannot breathe on their own.	I saw young and previously healthy persons get very ill with trouble breathing.	Insight	Knowing the seriousness of the illness		

required. *Experiencing too much work* is described as one of the main obstacles to maintaining overview and control. Fear of making mistakes and failing in one's professional practice occurs, and feelings of inadequacy appear. However, until the lack of control point is passed, working at high speed and having much to do is not automatically perceived as stressful. In stressful situations, faith in your own personal qualities such as being able to remain calm even when control and overview are lost, is highlighted.

There is a difference between when it is high tempo and when it is stressful. I like it ... it is fun. I get focused but if it gets way too much it just gets overwhelming.(L)

Lack of nurses due to turnover is a major problem leading to work overload and participants describe having to work harder because colleagues for various reasons do not partake in the care for patients ill from COVID-19. Some express a reluctance to show how they feel to prove stress resistance; others share moments of breaking down on a desk when feeling that their efforts are not enough.

When the workload exceeds one's own ability, participants describe that they are *Needing support* to regain control and strength to carry out doing the utmost at work. Being in a supportive context is described as not being alone in relation to colleagues at work and to relatives and society outside the ED. Close collegial interaction is supported by informal talks about difficult situations and having a supportive person to pose questions to without feeling stupid. Working closely with a physician and an experienced assistant nurse is described as enhancing the ability to regain control in stressful situations.

Having an appointed mentor is highlighted as beneficial as well as having offers to participate in reflection and debriefing sessions even if the opportunity of partaking in scheduled conversations is scarce due to heavy workloads. If not used, knowing that the opportunity exists is described as protective.

Support in the private sphere is expressed as not having to partake in everyday chores. On the other hand, participants also

express difficulties in talking about their own feelings outside work. Confidentiality and not wanting to burden family members with problems are highlighted as the main causes. Participant A talks about the suppression of emotions in relation to family and friends:

At home I could go to the toilet and cry and then pretend like nothing ... I think I am very stress resistant ... but I have not experienced stress like this.

Some participants describe how support from the healthcare system is missing, when stress continues between shifts.

I tried to seek ... psychiatric health care and my health center did not really respond to me ... they sent me to a cognitive behavioral therapy team, and they said, right now you cannot expose yourself to your fears more than you do. (J)

3.2 | Balancing on the verge of exhaustion

Staying compliant to various demands in nurses' everyday work, entailed by the pandemic, affects nurses' own health and challenges the strength to provide good quality care to patients. Adjustments on different levels about how nursing activities are carried out to minimize the risk of infection being spread further, together with diminished influence over working hours, are described as exhaustive. To stay compliant and manage carrying out one's utmost over time, recovery time between work shifts is needed but hard to find. When found, recovery time is filled with various activities to nurture their own bodily resources.

Nurses express *Endeavouring endless demands on compliance* and adapt beyond their known limit. This is expressed as difficult to cope with, especially about not knowing the timeline of the adjustments. Not being able to get an overview and predict how long the

TABLE 2 Result overview

Subcategories	Category	Theme
Not feeling prepared Experiencing too much work Needing support	Struggling towards control	Battling extraordinary situations and conflicting emotions
Endavouring endless demands on compliance Experiencing lack of recovery Being hindered and protected by protective equipment	Balancing on the verge of exhaustion	
Being forced to participate in less qualitative care Worrying about infecting others Being constantly aware of the seriousness of the pandemic	Living with inner conflicts	

pandemic will last when working exclusively with COVID-19 patients is expressed as burdensome. Nurses express feelings of confusion due to conflicting directives from the employer about the availability and level of protective equipment in certain situations, especially at the beginning of the pandemic. These are described as feelings of uncertainty. They hold managers responsible for questions about lack of clear directives on how to carry out the work:

We got new directives ALL the time ... every work shift we got new directives. How we would protect ourselves, what we would dress in, what to think about. (D)

Complying with the ban on hospital visits is expressed as ambiguous. On one hand, the relationship with the patient is described as favourable when relatives are not present, as relations to relatives can be difficult. On the other hand, relatives help to monitor patients, which decreases the workload. The benefits of not having relatives present does not apply when the patient is seriously ill. Patients not being accompanied by a relative when being seriously ill was described as difficult.

Experiencing lack of recovery is described in relation to less work satisfaction and motivation, and in relation to enduring working on one's absolute limit. Mandatory schedules and exceeding working full-time are expressed as burdensome. They deplete bodily resources and are described as a lack of freedom. This is primarily linked to work life conditions, even if the importance of recovery from working only with COVID-19 patients is emphasized.

It was rather with the schedule ... one did not get enough recovery ... more such things ... than working with Covid-19 patients. Everyone works double shifts all the time ... so I do not know how many double shifts I have had ... you are completely beat ... it is not healthy to work fourteen to fifteen hours every other shift. So I resigned (B).

Recovery is described as achieving inner peace through exercise, getting out into nature and hanging out with friends.

Being hindered and protected by protective equipment is described as an ambiguous experience: partly protective against transmission, partly hindering as facial expressions are excluded and it is difficult to

hear what anyone says when wearing a mask and visor. Among older people, hearing disorders and dementia are common and to children the masks can be frightening. Protective equipment needs to be adjusted accordingly. This is described as stressful and a hindrance to nurses providing the care they want. Meeting own basic needs during the work shift is described as adjusted by the need to save on protective equipment and the time consumed dressing and undressing. Performing acute activities such as cardiopulmonary resuscitation (CPR) while wearing protective equipment is described as additionally stressful. This is summarized as tiring both physically and mentally.

Insight of the impossibility to protect oneself or others from being exposed to the Coronavirus in EDs, even if supplies of protective equipment are sufficient, is mediated as an experience of fatigue despite one's utmost efforts. Conflicting information from patients about medical history and symptoms is common leading to insights that protective equipment is needed even though the patient denied symptoms of COVID-19.

3.3 | Living with inner conflicts

On an individual level, working as a nurse during the pandemic entails struggling to be the nurse one wants to be. The dedication to care in the frontline is challenged by decisions on how work is to be carried out conflicting with convictions of what constitutes good care.

Even though nurses rarely worry about becoming seriously ill or dying from COVID-19 themselves, they are afraid to pass the disease on to others, expressed as unavoidable and feelings of powerlessness. Being able to make a difference to patients in need of emergency care nurtures the motivation to carry on.

Limitations in bed-side time are perceived as emotionally difficult leading to feelings of inadequacy and ethical struggles concerning **Being forced to participate in less qualitative care**. Meeting older, ill patients who are not being admitted to proper wards in acute situations and encountering patients who after a long life are denied a dignified death is difficult, described by participant E:

It is something you have in mind all the time ... they will not get the same care they would have received if they did not have symptoms. I think it is terrible ...

unfair and wrong ... it is nothing I support ... nothing I want to accept ... but I have no choice.

The need of separating patients with suspected COVID-19 from others means less overview for nurses responsible for their nursing care. Restrictions on the number of visits in patients' rooms, systemized nursing activities and patients being left alone creates a forced distance to patients and their next of kin expressed as emotionally exhausting. Participants describe being unable to comfort patients when caring needs were identified, such as when having difficulties to breathe, leading to struggling with ethical issues described as feelings of sadness.

I feel sad they (the patients) just need someone, and you do not want them to be alone. During Covid it is not possible to sit with the person... and it is horrible I think ... (crying). (M)

Despite efforts made to keep up the pace in the ED, patients often had to wait longer during the pandemic and heavy focus on COVID-19 patients tends to overshadow other patients' needs.

Receiving negative reactions from patients is a daily phenomenon, hindering work and arousing feelings of inadequacy. Dissatisfied patients are approached in caring ways to acknowledge the patient's situation while harbouring feelings of inadequacy. Threats of violence occur regularly.

You toil and you try ... it's like you just put out fires ... and do it as good as possible with the few resources you have. Then there is someone who stands up and shouts ... that you ought to be reported ... when you already felt so inadequate. (N)

The burden on the healthcare system causes concerns and is expressed as anxiety that health care, despite all efforts, will eventually not be able to give good care to patients in need of emergency care.

I can be afraid that the workplace ... that we can fail ... now we are not enough for the patients. (F)

The risk of being infected with COVID-19 at work is perceived as high. Patients can carry the virus with low initial suspicion and guidelines saying protective equipment is not to be used makes nurses reflect upon the risk of becoming infected themselves. Nurses with close relatives in a COVID-19 risk group find stressful situations hard to manage. Fear of being infected from being exposed to infection at work creates stress primarily by **Worrying about infecting others**, patients and own next of kin:

And I could not go in... when there was someone lying anxious because they could not breathe properly ... I stood at the door two meters away and said ... it's okay. It was very hard. (J)

Even with little fear of becoming ill, lack of routines for infection control, expose nurses to more virus in the ED than necessary. Work could be carried out in safer ways. Eventually getting infected is to some extent expected and participants consider themselves as young and healthy with a low probability of serious illness. Hearing about colleagues who had tested positive for COVID-19 with very mild symptoms makes one think about whether oneself may have contributed to the spread of infection.

Participants describe making stricter restrictions on everyday life in order not to pass on the infection. In that sense, the previous stress management strategy of meeting friends and family is diminished. On the contrary, meeting as few as possible is described as reducing stress.

Being constantly aware of the seriousness of the pandemic even among young and previously healthy individuals, is expressed as an insight into the pandemic, which is different from the media portrayal, as expressed by participant I:

We had this tent outside. Suddenly they shouted ... we need a nurse now ... and I ran and met a young girl who could not breathe, and we tried with everything ... but nothing helped and ... I saw the panic in her eyes and ... she just seemed so helpless. They were so young patients ... and so ill.

People in society being compliant to recommendations to avoid infection is described as keeping the motivation to try beyond one's known limit. Observing people not being compliant to restrictions is expressed as difficult and provocative. Participant D says:

Here we fight as warriors. We do our utmost to make this as good as possible. It's like a slap in the face ... when you see people outside sitting close together in outdoor cafes.

Some nurses describe inner conflicting emotions, questioning if proper precautions had been taken by the patient to avoid infection. This is expressed as feelings one is not proud of and because of being in a struggle, depending on support from the outside to stay motivated.

The theme in this study, *Battling extraordinary situations and conflicting emotions*, comprises a common experience that nurses dedicate themselves as important caregivers during the pandemic while they simultaneously battle limitations forcing them to exert themselves beyond their known limit. Nurses put forth their motivation to start their career in an ED and highlight self-awareness of own strengths and qualities to handle stressful situations as empowering. When the limit of control and overview is exceeded, feelings of inadequacy are expressed in relation to oneself, the team, the organization and to society. War metaphors are frequently used, and nurses describe themselves as frontline warriors protecting patients against an invisible enemy at the expense of meeting their own physical, psychological and social needs. Negative emotional stress responses due to the profound impact on their nursing work caused by the pandemic are highlighted.

Life is limited with remaining constraints described as exhaustive for body and mind.

4 | DISCUSSION

This study sheds light on nurses' common experience in EDs during the pandemic, revealed in the theme *Battling extraordinary situations and conflicting emotions*. This comprises both experiences of work-related stress as related to external stressors in extraordinary situations, and internal stressors associated with conflicting emotions. The theme also sheds light on stress management as a matter of being in the midst of the battle despite these stressors. A core issue in this act of battling is that the nurses view themselves as dedicated and important caregivers during the pandemic. This dedication empowers them in their struggle with limitations forcing them to exert themselves beyond their known limit, risking both short- and long term work-related ill health. Our result may relate to theoretical perspectives described by Benner and Wrubel (1989), presenting caring as a profound act of being in the world, not to be equated with actions carried out by duty and/or self-sacrifice. Important findings are feelings of constructive stress in the meaning of performing under pressure in a team and at a high-speed contrasting feeling of inadequacy and loss of control. Caring and coping with stress is as described by Benner and Wrubel (1989), placed on nurses as a duty coherent with little mandate to determine how this is to be carried out, a conflict that entails stress. Accordingly, extensive nurse' shortages are work life issues threatening nurses' quality of work. However, as enhanced by Benner and Wrubel (1989), stress in caring is not only about removing stressors but creating an environment where nurses are given the opportunity to care with their full potential. This gives meaning to caring and relate to our findings as a core issue in this study were nurses expressed persisting emotions of sadness, when revealing thoughts about part taking in less qualitative care. As previously suggested by Benner and Wrubel (1989), our findings support the value of internal and external support by intertwining psychological and work life interventions together with increased work life conditions to strengthen nurses' resilience and endurance during the pandemic. Dahlberg and Segesten (2010) explain this further from a lifeworld perspective and highlight the importance of the individual being part of a context and having one's place in the world affirmed in relation to experience health.

Nurses' descriptions connect to Lundman et al. (2019) about the characteristics of inner strength. The dedication to part take in frontline nursing care during the pandemic can be understood as firmness involving existential courage and belief in one's own ability to cope with stressful situations. The flexibility to continue when times are hard being obvious in the category **Balancing on the verge of exhaustion** by nurses' drive to stay compliant to, for example mandatory schedules and working in limiting protective equipment

with little opportunity to recover in between shifts. The commitment to continue working during the pandemic, to stay connected and having the creativity to accept nursing during the pandemic as challenging and possible to overcome, strengthens nurses' ability to protect their own health. This result relates to a caring science perspective described by Dahlberg and Segesten (2010) as compassion energy.

In line with recent published research in the field of resilience and psychological interventions we agree on the need for psychological interventions to support the well-being of nurses to promote coping with caregiving during times of crisis (Deliktas Demirci et al., 2021; Chew et al., 2020; Liu & Aunguroch, 2019; Sheraton et al., 2020) and we further emphasize that focusing primarily on adjusting nurses to existing conditions is insufficient. It is crucial to consider that nurses need working conditions, encouraging them to stay and enable them to give care with their full potential (Nashwan et al., 2021; Deliktas Demirci et al., 2021). According to our findings, emotions of reluctance to make the effort appear when nurses do not feel properly valued and highlight the importance of being in cohesive teams, at work and in society, to endure the struggle. This is described using metaphors of being in a war. The battle is carried out by a work force filled with compassion in an armour of protective equipment, partly protective against transmission, partly experienced as burdensome, causing stress, hindering high quality care and being an obstacle to meet own bodily needs. Visible actions in this battle are a willingness to take on extra work shifts, the implementation of heavier social restrictions knowing one is frequently exposed to infection and acceptance of having less time for recovery between shifts. From a caring science perspective, this connects to caring as based on an act of love, to carry out caring actions with empathy and intention of relieving suffering and supporting health processes in a patient (Arman, 2006; Dahlberg & Segesten, 2010; Eriksson, 2018). In challenging times, compassion for self and others must be acknowledged as pivotal in relation to well-being and care. Wiklund Gustin (2017) found compassion as a uniting component that holds caring relationships together.

Nurses highlight exhaustion as a negative stress response due to loss of control by work overload in combination with understaffing and feelings of unpreparedness and having to take on advanced work tasks earlier than expected. This is described in contrast to stress in the meaning of performing under pressure and at a high speed, which nurses address as constructive, providing overview and control are preserved connecting to recent research by Specht et al. (2021). It is known that work-related stress in the sense of loss of control can be devastating to the individual with the task of relieving suffering for others. Stress creates frustration, which is a breeding ground for further stress and risks burnout (Durkin et al., 2019; Sharma et al., 2014; Waddill-Goad, 2016).

Persisting emotions of sadness were expressed, when participants relived memories about carrying out nursing care, which was less qualitative than their inner compass, – ethos. Being restricted from being close to patients and their next of kin by only performing

a minimum of and multi-coordinated, bed-side visits to patients ill with COVID-19 is highlighted as stressful and affects nurses' own health negatively. Especially, burdensome was not being able to provide high quality care to severely ill, older and dying persons. Experiencing first hand the impact of the disease on young and previously healthy people was also particularly burdensome. Caring actions from one's ethos, heart of goodness and love has been found important for different levels of health (Wiklund Gustin, 2017). It is also known that carrying out less qualitative care than one wants and experiencing deficient social support can lead to troubled conscience and burnout (Ericson-Lidman et al., 2013; Glasberg et al., 2007; Glasberg et al., 2008).

The change between movement and rest, described as the rhythm of life needs to be acknowledged (Dahlberg & Segesten, 2010) and by intertwining psychological and work life interventions, nurses may find themselves supported in their struggle providing high quality nursing care in EDs during the pandemic and after.

4.1 | Limitations & strengths

This study had the unique opportunity to gather data from the very beginning of the outbreak of the pandemic and the months to come. As memory is blurred over time this gave us a unique lens to mediate the results early. During that period, the impact caused by the pandemic on health care varied, which is also in line with the findings. In addition, this study adds a gap in caring science on how to encourage NGRNs in their struggle in EDs during the pandemic.

This study entails potential limitations about gender, as more female (9) than male (5) participants took part in the study. The numbers correspond to reality as more nurses in health care and especially in EDs are female. Participants were also introduced in the profession both before, during and after the start of the pandemic, which may have an impact of how these nurses experienced their work situation in relation to the pandemic. The interviews also reflected differences in how the introduction was carried out between regions leading to various perspectives on their work tasks.

This study covers data collected from March to November 2020. The timeline for inclusion was prolonged due to inhibition on research activities in regions especially hard hit by the pandemic. Ban on in-hospital visits made data collection switch to telephone interviews, limiting the opportunity of addressing non-verbal communication. On the other hand, we could include participants from different regions without taking distance or risk of virus transmission into account. Thereto, the data collection bridged both the first and second wave of the pandemic, and we noticed how the narratives changed. Those who in the autumn of 2020 had the opportunity to reflect on their experiences in the beginning of the pandemic were partly reminded of their feelings and memories. Those interviewed in the pandemic's outbreak described the uncertainty, which was then to some extent replaced by experience and knowledge. We conclude that a discourse analysis might be a favourable method to add valuable insights in this direction.

In this study there is senior competence in caring science research (LWG, KS), and in physiotherapy (PHW) and competence in intensive care (KS) and in emergency care (HC).

4.2 | Conclusions

Understanding NGRNs experiences in the pandemic, the struggle towards control, lack of recovery and balancing on the verge of exhaustion endeavouring endless demands on compliance whilst living with inner conflicts is a unique lens of illuminating caring during a worldwide crisis. This study adds input how nurses dedicate themselves as important and battling caregivers, exerting themselves to the verge of exhaustion and at the expense of meeting own bodily needs during the pandemic. Nurses highlight need of support to give best possible care for patients, regain control in stressful situations, explicit directives from managers, recovery time in and in between shifts.

Further research on perceived stress in new nurses and the impact on the care they give in EDs during the pandemic is required. Further research is also needed on new nurses' troubled conscience in caring situations and how this can be eased. With knowledge of perceived work-related stress and coping various interventions can be tailored to prevent the risk of stress-related ill health in this group in the future.

AUTHORS' CONTRIBUTIONS

The contribution of the authors is as following; Study concept and design: Hillewi Carnesten (HC), Petra von Heideken Wägert (PHW), Lena Wiklund Gustin (LWG) and Karin Skoglund (KS), Data collection: HC. Data analysis: HC in collaboration with PHW, LWG and KS. Drafting the manuscript: HC. Critical revision of the manuscript: HC, PHW, LWG and KS.

The manuscript, or part of it, has not been published or is currently under consideration for publication by any other journal. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST

The authors declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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