Untold Stories of the ER: Providing Care During the COVID-19 Pandemic as Narrated by Emergency Room Nurses in Toronto, Ontario, Canada

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A thesis submitted to the University of Ottawa
in partial Fulfillment of the requirements for the
Master of Science in Nursing

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Abstract

As the COVID-19 pandemic has taken hold of Toronto, Ontario, Canada, and the world, it has highlighted many challenges healthcare workers face. Those nurses working in the emergency room (ER), settings that are under normal circumstances unpredictable and acute, have been particularly affected. This research aimed to explore the stories ER nurses tell to describe their experiences of working during the COVID-19 pandemic in Toronto, Canada. Narrative methodology was used to understand the thoughts, feelings, and problems facing ER nurses. The research study includes the stories of three Toronto-based ER nurses who share their experiences of working during the COVID-19 pandemic. Participants were interviewed twice, and data was analysed using the three-dimensional narrative inquiry space of time, sociality, and place. Plotlines of 'before they were heroes', 'hero', 'fall from grace', 'villain' and 'to be continued', organized each story. Resounding narrative threads emerged across the three narrative accounts and are presented as understandings. Threads that resonated across the stories include mistrust in leadership, fear and isolation, expectations and duty to care, nursing shortages, personal safety and PPE, workload and stress, moral and psychological distress, and lost voice. The findings of this inquiry offer a new context for understanding the thoughts, feelings, and problems facing ER nurses working in Toronto during the COVID-19 pandemic in a way that preserves, values, and respects the voices and stories of the nurses themselves, thus allowing for emotional healing while offering insight for nursing education, practice, and research.

Co-Authorship

This thesis is the work of Andrea Marsh in collaboration with:

- Supervisor: Jane Tyerman, RN, PhD, Associate Professor, The University of Ottawa, School of Nursing
- Committee Member: Michelle LaLonde, RN, PhD, Associate Professor, The University of Ottawa, School of Nursing
- Committee Member: Marian Luctkar-Flude, RN, PhD, Associate Professor, Queen's University, School of Nursing

Dedication

This thesis is dedicated to my Nanna, V. Alfreda Marsh, who never hesitated to make her voice heard or her opinions known. Thank you for teaching me to always advocate for my patients and the nursing profession. I hope this work makes you proud.

Acknowledgements

I want to express my deep appreciation and sincere gratitude to those who have guided and supported me in completing this research. First and foremost, I would like to thank my supervisor, Dr. Jane Tyerman. Your leadership, sense of humor, and profound belief in my abilities have enriched my life in ways that extend far beyond our work on this project. Thank you for your patience, guidance, friendship, and support. I am very grateful to have worked so closely with you over the past two years. I could not have imagined a better advisor and mentor for my MScN studies.

I would also like to extend my sincere thanks to the other members of my thesis committee: Dr. Michelle LaLonde, whose experience and expertise in emergency nursing, and Dr. Marian Luctkar-Flude, whose insight and knowledge into narrative inquiry, helped steer me through the research process. Your encouraging words and thoughtful, detailed feedback have been invaluable to me.

To my family and friends, thank you for the love and support you have shown me. My accomplishments and successes are because you all believed in me.

A special thank you to my son, Owen Marsh, for your patience and understanding when this work has taken my attention away from you. Without your tremendous understanding and encouragement over the past two years, it would be impossible for me to complete my study. I hope that I have inspired you to realize that it is never too late to chase your dreams and that hard work is the key to success.

A very special thank you to my partner and best friend, Shachar Gabay, for constantly listening to me talk things out, for being a thesaurus and sounding board when required, for being a shoulder to cry on, and for cracking jokes when things became too serious. I am forever

thankful for the love and support you have shown me throughout the entire thesis process and every day.

Finally, a very heartfelt thank you to the three nurses who voluntarily agreed to share their stories for this study. Your time, honesty, courage, and willingness to share your experiences made this thesis possible. I hope that I have honoured your stories in a way that makes you feel heard. You have not only inspired me and my commitment to advocating for improved nursing work environments, but you have also provided hope for the future of nursing.

List of Abbreviations

CBRN	Chemical, Biological, Radiological and Nuclear
CCL	Clinical Care Leader
CEO	Chief Executive Officer
COVID-19	Coronavirus Disease of 2019
CPR	Cardiopulmonary Resuscitation
CRL	Clinical Resource Leader
EMS	Emergency Medical Services
ER	Emergency Room
ESBL	Extended Spectrum Beta-Lactamase
ICU	Intensive Care Unit
MERS	Middle East Respiratory Syndrome
MRSA	Methicillin-Resistant Staphylococcus Aureus
NYGH	North York General Hospital
PCM	Patient Care Manager
PPE	Personal Protective Equipment
PTSD	Post Traumatic Stress Disorder
RAZ	Rapid Assessment Zone
RN	Registered Nurse
RT	Respiratory Therapist
SARS	Severe Acute Respiratory Syndrome
UWO	University of Western Ontario
VRE	Vancomycin-Resistant Enterococcus

WSIB Worker's Safety and Insurance Board

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Chapter 1: The Path to Understanding the Experience of Providing Care During the COVID-19 Pandemic in Toronto, Ontario Canada

> *"If you want to know me, then you must know my story, for my story defines who I am. And if I want to know myself, to gain insight into the meaning of my own life, then I, too, must come to know my own story." (McAdams, 1993, p. 11)*

Introduction

This initial chapter begins by providing context to the research in the form of my own narrative as a nurse and a researcher interested in the experience of ER nurses providing care during the COVID-19 pandemic. Clandinin & Connelly (2000) encourage narrative inquirers to begin each study with an autobiographical narrative to help set the personal, practical, and social justifications and shape the emerging research puzzle. The following section is comprised of plotlines resembling a connected series of events highlighting aspects of my nursing career and experiences of trauma and healing that led to my narrative inquiry. After the autobiographical portion is the background, problem statement, purpose and research questions that guided my study.

Personal Narrative

Prologue: Introducing my Story

I have been a Registered Nurse (RN) for eighteen years and have spent the majority of my career caring for patients in the Emergency Room (ER). Despite the chaotic and sometimes hazardous nature of the ER, I managed to work relatively unscathed for fourteen years. However, in December of 2018, I was physically assaulted by an aggressive patient. The incident led me into a tailspin of emotions that I could not process, which eventually led my diagnosis of Post-Traumatic Stress Disorder (PTSD). Through my healing, I discovered my desire to improve

nursing work environments and systems of clinical care delivery. I knew that completing my Master of Nursing degree would be a critical factor in achieving my goal of obtaining a position where I could drive this change. I applied to the Master of Science in Nursing Program at the University of Ottawa so I could explore the topic of improving nursing work environments formally.

Plotline One: Before They Were Heroes – I wanted to be a nurse

"I don't know what I want to do!" Sitting in the parking lot of the Ontario Universities' Application Centre in Guelph, Ontario, I sobbed to my dad. It was Friday at 4 pm and the last day to submit an acceptance for an offer of admission at an Ontario university for undergraduate studies. I remember that day like it was yesterday, for it was the day that I decided I would be a nurse.

Unlike my friends, who seemingly knew what they wanted to be when they grew up, I had no idea. When university applications were made available to high school students in the fall, I was so confused about what I wanted to do as a career choice that I applied to five different universities in vastly different programs. After sitting in the parking lot with me and trying to help me weigh the pros and cons of each decision, my dad finally said, "I think you should choose nursing. You have always said you wanted to be a nurse." For a moment, I stopped crying and thought about what he said.

As a child, I loved going to the doctor's office for check-ups, and I was always excited when my appointments included a visit with the nurse. Of course, the nurse visits were often task-oriented, so they usually occurred when I needed a vaccine. My parents love to tell the story of one particular visit in which I sat on the examining table waiting for my vaccines, calling out, "Oh needle nurse! Where are you?!" Although I remember those visits and the feeling of being

excited to see the nurse, I do not remember any particular reason as to why I was so fond of her. In looking back, I think my admiration for the nurse was related to equating her to my Nanna who was also a nurse. Moreover, I think it was my admiration for my Nanna that led me to "always saying" I wanted to be a nurse.

My Nanna was one of the most influential people in my life. I always loved visiting her and my Poppy in Owen Sound during school holidays and summer vacations. They were both loving and warm and would smother my sister and me in hugs and kisses at every visit. During our stays with them, I would often follow my Nanna around, helping her do whatever tasks she had given herself for the day. "Helping Nanna" often involved going to the post office, bank, or the grocery store. My Nanna was extremely outgoing, and it always seemed like everyone in Owen Sound knew who she was. As she would stop to chat with people she knew, she would introduce me as her granddaughter, Andrea, "Nanna's little nurse." I am not sure why she ever started calling me this. Perhaps I helped her bandage someone? Perhaps it was wishful thinking on her part? Alternatively, she saw something in me that no one else did. Whatever it was, it stuck with me. Ultimately, it was thinking about her that day in the parking lot of the Ontario Universities' Application Centre that finalized my decision to go into nursing.

My Nanna – Alfreda (Freda) Smith, was born and raised in Grand Bank, Newfoundland. As one of ten children, she was labeled the 'odd one' in the family because she was headstrong and independent. Upon completing her schooling, a young Freda declared to her family that she wanted to become a nurse. This announcement came as a shock to her parents, as young women at that time often worked as domestics or were married. Despite her parent's dismay, my Nanna obtained a job as a nurse's aide at the Burin Cottage Hospital in Newfoundland. Although she had no experience with the sick, the experience taught her the fundamentals of nursing. She

stayed there for 18 months before deciding to become a real nurse. After applying and being accepted to four 'training' schools, Freda accepted her offer at the Grace Hospital in St. John's, Newfoundland.

She began her training in 1941 and found the experience challenging. Her schooling involved both classes and practicums that equated to working twelve-hour days, six days a week. Students were given one-half day off a week, and one late leave a month. There were no overnight passes and no pay. Additionally, students were given three weeks of holiday in the summer only. The training was not only rigorous, it was exhaustive. By graduation, it was expected that trained nurses would be able to work independently in remote areas of Newfoundland, both diagnosing and treating illness, as they were often unable to call for assistance.

In 1944, Freda graduated from the Grace Hospital. She worked as a nurse for one year in St. John's before realizing that she wanted more of a challenge. In 1945 she accepted a position as a nurse in an 18-bed hospital in the isolated outport of Burgeo, Newfoundland. Given that most doctors and nurses were overseas for the war, Burgeo had not had a doctor or nurse working in the hospital for over six years. It was remote and barren. There were no cars, no electricity, and no modern conveniences. Communication was by mail, and the cargo-passenger steamship came once a week, weather permitting.

Upon arriving in Burgeo, Freda worked diligently to improve the conditions of the hospital. She wanted the hospital to be more efficient and helpful for patients. She immediately began training nurses aides, diagnosing and treating patients, dispensing medications, delivering babies and performing minor surgeries. She planned patient meals, ordered supplies and assisted with cooking and laundry when the cook or the maid had their day off. Once a month, she sent a

statement to the Department of Public Health and Welfare in St. John's, that included a report on the number of patients seen, their diagnoses, treatments, and prognoses. The doctors in St. John's would send back letters with both their commendations and suggestions for more effective treatments in future cases. In addition to nursing, in the community, she was tasked with caring for sick animals, making wills, and settling fisherman's accounts, as she was classified as the most knowledgeable person in town.

In 1946, Freda left Burgeo to go to Canada to meet and marry her childhood sweetheart Joseph (Joe) Marsh (my Poppy). She arrived in Montreal, Quebec on July 1, 1946, where she nursed alongside Dr. Wilder Penfield at the Reddy Memorial Hospital for 14 years. Initially, Freda found the transition to Canadian nursing difficult. In Newfoundland, there were no limits to her nursing responsibilities. In Canada, she often overstepped her duties. Freda continuously thought about going back to Newfoundland, however, after speaking to her charge nurse about her abilities and qualifications, and the difficulty in curtailing certain tasks that she had back home, she was eventually made responsible for advanced nursing services at the hospital. This made her much happier with the work she was doing, and she stayed there until June of 1960, when she and Joe moved their family to Owen Sound, Ontario – a small community three hours northwest of Toronto. Freda worked as a nurse at the local community hospital in Owen Sound for five years before switching to private nursing practice. She continued nurse privately until 1996, when after 50 years of practice, she decided to retire formally.

When I accepted my offer of admission to the University of Western Ontario (UWO) for Nursing, I knew that my Nanna would be proud. I even joked around with my sister that I was now going to be the favourite grandchild. Indeed, when I called to tell my Nanna that I would be entering my "nursing training" in the fall of 2000, she was over the moon with excitement.

During every visit with my Nanna throughout my four years of undergraduate studies, she would ask me how my "training" was going. I would tell her stories about my experiences as a student nurse. She would listen intently and then counter my stories with a story about her "training," explaining how nursing was no longer the same as when she was a nurse. She was very opinionated and did not agree with the "type of nursing" that I was doing. She never understood why I was not forced to wear a white nurses' uniform and cap and believed that my scrubs confused patients as to my role within the hospital. She made explicit her disgust for the fact that she could no longer tell "the nurse from the doctor from the cleaner." She and I would get into heated discussions about this. At the time, I found it odd that she could not appreciate why wearing scrubs was more practical when trying to do patient care. After reading her book, *A Small-Town Nurse*, I grew to appreciate her stance on the subject matter. In Newfoundland, nursing caps were earned after completing four months of nursing education and several comprehensive examinations. The white dresses, stockings, and shoes were only allowed to be worn once your nursing education was completed and you were registered as a nurse. These items were signs of hard work, dedication, and respect in a profession that she loved.

Along with her beliefs of how nurses 'should' look, my Nanna had several values and beliefs about how nurse 'should' care for their patients, that she eventually imparted onto me. She believed in "caring for patients the way you would care for your own [loved one]" and that when it came to patient care, "nothing less than the best is good enough." Indeed, my Nanna treated every patient like a family member. During her time as a private duty nurse, she once brought a patient into her own home for convalescence to help alleviate the burden and stress that the family was feeling and to allow them to go home and rest. Furthermore, my Nanna believed that there "should be no cutbacks when it comes to medicine or human lives." She

never hesitated to make her voice heard and her opinions known. When she disagreed with a change to healthcare policy or procedures, she would write letters to both Owen Sound city hall and her members of parliament. In this sense, she taught me to always advocate for my patients and the nursing profession.

By the time I had finished my four years at UWO, I had come not only to appreciate my Nanna's ideals of nursing practice but also embraced them as my own.

Plotline Two: Hero – 'SARS Hero'

In February 2003, I secured a summer job as a clinical nurse extern at a busy hospital in downtown Toronto. I was finishing my third year of nursing school at UWO, and I was excited to have found a job that allowed me to utilize my nursing knowledge and skills. Additionally, the pay was seventeen dollars an hour – nine more than minimum wage at the time. For a financially struggling university student, the pay was one of the most significant selling features of the job. As the winter school term in London was wrapping up, news started to emerge that a new virus – SARS – had made its way from China to Canada, and that suspected SARS cases were now appearing in Toronto. By the end of March 2003, with case counts increasing and hospital staff and visitors becoming ill, Ontario's premier activated a Code Orange for all Toronto area hospitals. The heightened emergency level resulted in stopping all non-essential services and restricting visitors to hospitals. Additionally, clinical placements for nursing students were also suspended.

By mid-April, I received a letter from the hospital I had been hired by, stating the possibility of canceling the clinical nurse extern program due to SARS. At the time, I did not understand the gravity of the situation in Toronto. Instead of recognizing the threat that SARS posed to my health and wellbeing, I saw it only as a hindrance to my employment. Worried

about the potential inability to secure alternative employment, I became irritated at the possibility of not having a job for the summer term. After all, everything in London was normal, so how could Toronto – a city only two hours away – be much worse? A few weeks later, I received an email stating that the hospital had decided to allow the clinical nurse externs to continue with their employment should they wish, but that they would need to follow the stringent infection prevention protocols. These protocols involved daily SARS screenings, frequent handwashing, and the use of personal protective equipment (PPE) while at work. Again, I did not comprehend what this entailed. Instead, I was just excited to hear that I still had the opportunity to work at such a prestigious organization.

Throughout May and June, all hospital employees were required to wear N95 masks while at work. N95 masks were distributed to employees as they entered the hospital after passing the daily SARS screening requirements. Additional use of gowns and gloves were required when entering patients' rooms. If you have never worn full PPE, including a properly fitting N95 mask, it is difficult to imagine how restricting and uncomfortable it can be. The masks are not easy to breathe through and were only meant to be worn for short periods of time, not for an entire day. I would often become lightheaded and fatigued from breathing my own air. The only reprieve from these symptoms came with the removal of the mask, which was allowed only during breaks. Indeed, on several occasions, I found myself in the staff lounge to give myself a breath of 'fresh' air.

By July 2003, with no new SARS cases being reported in Toronto for one month, hospitals had removed their vigilance. Hospital employees no longer had to complete daily screenings, nor did they have to use PPE while in patients care areas. Excited to be free from the constraints of properly fitting PPE, I along with my co-workers, were happy to oblige. I worked

throughout July and August without any PPE or fear of contracting the disease. In late August, having just returned to school in London, I received notification that I had encountered a suspected SARS case while at work, and that I would have to go into self-isolation for ten days. Again, not understanding the impact of potentially being infected by SARS, I found the isolation to be more of a nuisance than anything else. A few days into my isolation, I was informed that the patient of concern tested negative and that I no longer had to remain in isolation. What was believed to look like a SARS infection on x-ray was actually a progression of metastatic lung cancer.

In September of 2003, I was awarded two certificates – one from the Board of Directors of the hospital and one from the Mayor of the City of Toronto – recognizing my 'heroic efforts' during the SARS crisis in Toronto. These certificates became a joke among my friends and me. Although I worked in a hospital in Toronto during the pandemic, I did not have contact with any SARS patients; and while working in PPE was not something I would ever want to do again, I was never afraid for my safety. Moreover, given that the hospital did not have any SARS positive patients throughout the entire pandemic, I felt that awarding the certificates with the hero rhetoric was not only wrong but also undermined those who were directly affected.

Upon graduation from UWO, I was hired as a nurse in the ER of North York General Hospital (NYGH). NYGH is a community hospital serving north central Toronto and the southern region of York. During the 2003 pandemic, NYGH was declared a SARS designated hospital and saw a total of 101 SARS cases: 47 of whom were healthcare workers; and of six of whom died (SARS Commission, n.d.). Working at NYGH opened my eyes to the long-term effects of pandemics on ER nurses. When I started in April 2004, it was the first anniversary of the SARS crisis in Toronto, and the aftereffects of SARS were still lingering. At the beginning of

my employment, I would only overhear a few comments suggesting that some nurses still felt a personal insecurity because of SARS. This would come out as expressions of concern when patients with potentially virulent contagions entered the department. However, as time went on, my colleagues started to openly express the horrors of working through SARS. They articulated the fears and anxieties of watching friends and colleagues contract the disease, taking care of critically ill patients on ventilators, the isolation of work quarantines, and the stigma of being a SARS nurse. One of these conversations is forever etched into my mind. Three nurses and I were sitting in the resuscitation room one night chatting about work when the topic of SARS came up. They had recently been given a survey regarding their experiences of working during the pandemic. The purpose of the study was to inform future policies for pandemic planning. As we chatted, one of the nurses started to tell her story of contracting SARS. She expressed her anger with not feeling protected enough, her anguish of being separated from her husband and child, and her fear of dying. She began to tear up and stated, "I will tell you this. If SARS comes back, I quit immediately!"

Having a more in-depth knowledge of the experience of working through SARS at NYGH gave me an appreciation for my own experience of working in Toronto during SARS. I continue to feel thankful for my naivety at the time of SARS and believe that it was my naivety that ultimately protected my mental wellbeing, allowing me to continue to work in a profession that I chose.

Plotline Three: Fall from Grace - My opinions often fell on deaf ears

Eighteen years ago, I crossed the stage and accepted my nursing degree at UWO. At the time, I was excited to end that chapter of my life and start the new one as a nurse. Like every new graduate, I entered my nursing career full of optimism. I believed that nursing was a

respected profession and that I would make every patient's hospital experience as pleasant as possible. I always had my Nanna's voice in the back of my mind, reminding me to "take care of patients the way you would care for your own [loved one]" and that when it came to patient care, "nothing less than the best is good enough."

I began my professional nursing career in 2004 – the post-SARS era. Because patient overcrowding and understaffing of nurses in the ER were now a 'thing of the past,' it was easy to uphold my values and beliefs. I had the time and support to learn how to be an ER nurse and to successfully provide my patients with the high-quality care that I believed each patient deserved. I loved working in the ER. I loved the fast pace, the critical thinking, and the skills that I got to use. I loved the autonomy. More importantly, I loved knowing that I was able to help someone and that I made a difference in the lives of others. However, working in the ER forced me to realize that I could not always help everyone. Sometimes, despite my best efforts, I would witness pain and suffering.

As a student nurse, I learned about empathic care. My nursing professors taught me that providing empathic care is how one builds solid nurse-patient relationships. Unfortunately, my nursing education did not adequately prepare me for the emotionally charged situations that I encountered while working in the ER. Witnessing the suffering of others took its toll on me, and I began to develop compassion fatigue. After three years of emergency nursing, I decided to leave the ER and began to work as a postpartum nurse. I found a renewed energy in postpartum nursing, and my compassion for others was reignited. Despite this, I missed working in the ER, and longed to go back. As quickly as I left, I returned to it once again. Only this time, I upped the ante – and began working in a level 1 trauma centre – Sunnybrook Health Sciences Centre.

My commencement at Sunnybrook occurred during the same year that the SARS Commission released its final report. When the final report came out in 2007, it highlighted many workers' safety issues and gave numerous recommendations to improve the working conditions for nurses within the hospital (The SARS Commission, n.d.). Two prominent recommendations were 1) to fix worker safety problems promptly once they have been identified and 2) to put processes in place to ensure that nursing voices and experiences were heard (The SARS Commission, n.d.). Initially, there was an apparent effort among hospital administrators to ensure the safety of patients and staff. No patients were lying in beds in hallways, staffing was adequate, and PPE was in abundance. However, as time went on SARS became a distant memory for many healthcare staff. I began to observe a slow but continual change in the quality of patient care being delivered in the ER. At first, it was minor adjustments – adding an extra patient to a nursing assignment or temporarily placing patients that arrived by EMS in the hallway until a bed was ready for them in the department. Later, it became adding one' hallway spot' to each nurses' assignment. Next, some patient bed assignments were changed into 'chairs,' where hospital administrators could cram several patients into one area to be 'rapidly assessed' by the doctor. A few years later, 'temporary hallway assignments' were born, creating a space where nurses would care for several admitted patients in the hallway until their beds were 'ready' on the floors upstairs. Eventually, these 'temporary assignments' became permanent, but now, nurses could take care of any patient – emergency or otherwise – in the hallway.

Patient volume was not the only factor contributing to the decrease in the quality of patient care being delivered in the ER. Along with the increase in patient volume, I began to see an increase in the severity of illnesses of patients presenting to the ER, and a minimal increase to the hospital's operating budget from the province. This resulted in hospital administrators

continually asking nurses to ‘do more with less.’ These three factors commonly left me caring for multiple sick patients, in the hallway, with minimal help from others. Caring for patients in this manner often caused me moral distress. It was not something that I had practiced while working at NYGH, and it went against the values and beliefs that had been instilled in me by my Nanna. I disagreed with changing or toileting someone in the hallway behind a curtain. I disagreed with communicating diagnoses to patients in a space where everyone can hear. I disagreed with putting patients with end-stage illnesses in a care setting where they could not visit with family and friends privately. I disagreed with the lack of privacy and respect we showed patients by openly providing care in a hallway filled with other patients, visitors, and staff walking by.

The moral distress I felt caused me to want to take action. I began to advocate for my patients and my profession. When hospital administrators held meetings within the ER to discuss our healthcare system’s challenges, I never hesitated to make my voice heard or opinions known. Unfortunately, my opinions often fell on deaf ears, and suggestions for change never came to fruition, leaving me feeling sad, helpless, and angry.

The continual decline in resources and the lack of administrative support to effect change also affected my colleagues. When I began working at Sunnybrook, staff morale was extremely high. Every shift was fully staffed, often with an additional nurse or two being booked to help critically ill patients or cover breaks. Hospital administrators asked nurses’ opinions when changes to the department were proposed and showed their appreciation to staff by giving them annual gifts. Nurses genuinely seemed to love work, and there was camaraderie among staff. I would often see nurses having a chat or sharing a laugh to help one another cope with the events they were experiencing in the ER. However, with time, this too began to change. Budgeting

required fewer nurses to be staffed per shift, leaving my colleagues and I to take on more patients in our assignments or cover multiple assignments at times. Busy from the increase in patient load, we had less time to talk to one another or provide peer support. The hospital administrators stopped asking for the nurses' opinions for change, and often implemented new policies and protocols, much to the dismay of those of us working the frontlines. Gifts or tokens of appreciation all but stopped. Morale dropped, and I noticed an increase in 'sick calls' as my colleagues, and I became exhausted. Moreover, I noticed that my colleagues and I were starting to provide suboptimal care. I felt guilty, sad, and angry knowing that patients were not getting the care I believed they deserved, yet I felt powerless to change it.

The decreased staffing ratios and the resulting decline in patient care quality also took their toll on patients and families. When I first began nursing in the ER, nurses had time to be with their patients. They could take the time to explain tests, procedures, and treatments. They could take the time to explain why some patients were waiting and reassure their feelings of fear. As the nurse-to-patient ratio decreased, the time pressures made it so that this was no longer possible. The lack of time allotted to soothe patients' and families' primary anxieties resulted in many angry outbursts. As time went on, I observed increasing aggressive and violent attacks from patients and families toward nurses.

Moreover, I noticed a lack of support from hospital administrators toward nurses. For example, hospital administrators often sided with the assailant when patients or family members verbally or physically assaulted nurses, asking the nurse to justify or apologize for their actions. Additionally, I observed a lack of support from nurses, who were afraid of standing up for their colleagues for fear of repercussions from hospital management. The increase of abuse towards nurses and decreased collegial support left me feeling fearful, sad, and angry.

Plotline Four: Villain - I was like a tornado, destroying everything and anyone in my path

On the morning of December 18, 2018, I arrived at work ready to begin my day. After seeing the assignment board and learning that I would be 'trauma float' for the day, I was asked by the charge nurse, Meredith[1], if I could go immediately into the trauma room to take over care of the trauma patient being assessed in bay 2. Both I and Charlotte[2], the 'Purple Zone' (minor) nurse, went into the trauma room, took the report from the night nurses, and immediately began care. Once the patient had been stabilized, I moved the patient into a room in 'Green Zone' (major), reported to the receiving nurse, and began my usual 'trauma float' routine.

Upon arriving for their shift, the usual routine of a 'trauma float' is to check and stock equipment in the trauma room, ensuring that the room is adequately prepared for the day. This check is followed by inspecting and stocking the two resuscitation rooms (in the 'Blue' and 'Orange Zones') and the crash carts in each zone. Upon completion, the 'trauma float' helps where needed in the department, covering breaks, and attending to trauma patients as they arrive. The 'Purple Zone' nurse usually helps with these checks first thing in the morning, but they must stop helping at 0830 (if the checks are not completed) to go on their first break. 'Purple Zone' is staffed by only one nurse and "opens" at 0900. As such, if the 'Purple' nurse misses their 0830 break, there is often no nurse that can help them or cover a break until the evening shift arrives at 1130.

After checking the trauma room, Meredith asked me if I could go to 'Purple Zone' to cover Charlotte's break, as she did not get one because she had been in the trauma room with me and had opened 'Purple' late. I let Meredith know that I had not yet checked the resuscitation rooms or carts. She assured me that I did not need to and that she would get nurses in those areas

[1] Names have been changed to protect identities.
[2] Names have been changed to protect identities.

to check them as it was more important to her that nurses got their breaks. So, I happily went to 'Purple,' took a report, and began caring for the zone's patients. While in a patient room, administering treatment, I was called by the unit secretary, informing me that Meredith was on the phone and wanted to speak with me. I apologized to my patient and went to answer the phone. Meredith asked me what I was doing. Confused, I explained that I was covering Charlotte's break, which she had previously asked me to do. Meredith then proceeded to ask me if I could cover both 'Purple' and triage because the triage nurse (Sofia[3]) also "needs her break."

Given that triage is in a physically separate area of the ER, I asked Meredith if I could cover triage once Charlotte had returned, arguing my inability to safely provide care to patients in both areas at the same time. My request was denied. I suggested to Meredith that she herself cover the triage area while I covered Charlotte. Again, my suggestion was denied. Meredith insisted that "Purple was fine" to function without a nurse present and that "they would call me if they needed me." Eventually, I reluctantly agreed and went to triage to cover Sofia.

Upon arriving at triage, Sofia gave me a report on the patients waiting to come into the department. Looking around the waiting room, I could see that the day was already busy and that multiple patients were waiting to come in. My attention shifted to one particular woman who was lying on a stretcher. She looked weak. Noticing my glances at the patient on the stretcher, Sofia stated, "I am worried about her. She was dropped off from the cancer centre, and I just got a call from the lab that her potassium is 6.2." Followed by, "Meredith knows about her, and Dr. D'Ath[4] knows about her, but there are no beds available inside. Meredith said they are making a bed for her, but I would keep an eye on her." Agreeing, I let Sofia go on her break and continued triaging the growing line of patients arriving in the ER.

[3] Names have been changed to protect identities.
[4] Names have been changed to protect identities.

Between covering triage and Purple, time had flown by, and it seemed like only minutes had passed before Sofia had returned from her break. Looking at the clock, I noticed that it was now 1130, and I had yet to go on a break myself. Knowing that the evening nurses were now beginning their shifts, I called Meredith to see if it would be okay for me to go on break. She agreed. I gave a report to Sofia, and I began to make my way to the staff lounge. As I was about to open the door, I heard an overhead page, "Float nurse to room 1." Not knowing who else had been assigned as a 'float,' I stopped dead in my tracks and made my way back to the resuscitation room. There I found a resuscitative effort in progress.

There was an elderly patient who had just arrived via EMS. Paramedics were performing CPR while trying to give Sofia a report so that she could triage the patient at the beside. One other nurse (Alessia[5]) was there trying to assist in moving the patient to the hospital bed and getting them on the heart monitor. Another nurse assisted the patient's elderly wife to have a seat on a nearby chair. The doctor, a resident physician, two more nurses, and an RT appeared within seconds. We ran a code on that patient for 30 minutes before the team decided to call the time of death. As soon as the patient was pronounced, the team dispersed, leaving the nurses behind to attend to the patient and the family. Like most codes in the ER, we never debriefed. The doctors went back to seeing other patients, and the RT went back to attending to their patients in the ICU. Despite feeling sad watching the patient's wife mourn the loss of her husband of 60 years, I kept my feelings inside. I engaged in a lot of self-talk, rationalizing with myself that the patient was old and that he had "lived a good life." As two other nurses were there to continue to assist with the patient's family, I excused myself and went for a break.

[5] Names have been changed to protect identities.

The day continued to get worse. By the time I had returned from my break, it seemed as though all chaos had broken loose. The EMS hallway was filled with patients on EMS stretchers awaiting beds. The waiting room was "standing room only." The two resuscitation rooms were filled with code strokes. I went into 'Green Zone' to speak with Meredith to see where I could be of the most assistance. She suggested that I go to triage and help there as the list of people waiting to be triaged was growing exponentially. Just as I turned to leave, a nurse called out from room 17 that they needed help. Looking over, I saw the nurse dropping the head of the patient's bed before jumping on their chest to perform CPR. Meredith looked at me, laughed, and said, "Maybe you should go there instead." Again, the doctors came, the RT came, and a nearby nurse came. Again, we lost a patient. Again, we did not debrief. Feeling exhausted, I went to triage to help alleviate the pressures there.

I spent a good hour helping the nurses at triage. Although I triaged a few patients, I mostly fielded angry questions and concerns from patients and families waiting in the waiting room to give the nurses some reprieve. Additionally, I brought patients into the department as beds became available. At 1520 I brought an ambulatory patient into the 'Blue Zone' to be seen in the chairs assignment. As I opened the door to 'Blue', I could see a bunch of commotion happening in room 6. I escorted the patient into room 4 before heading to the nurses' station to report to the chair's nurse about the patient I had just brought in. Dropping off the chart, I stood in the nursing station to see what was happening. There were two doctors, several nurses, and much yelling.

As I stood there, a nurse (Aidan[6]) came up to me and said, "She didn't even know the patient was dead!" Confused, I asked for clarification. It turns out that the patient in room 6 was the lady that had arrived from the cancer centre with a potassium of 6.2. She had been waiting in

[6] Names have been changed to protect identities.

the waiting room for several hours before a bed had become available to her. Sofia had asked one of the Personal Support Partners (PSP) to move the stretcher into room 6 and, as such, had not laid her eyes on the patient again. The RN assigned to room 6 (Cate[7]) had received the patient but had difficulty changing the patient into a hospital gown and had asked for Aidan's assistance. As Aidan entered the room, he noticed that the patient was not breathing. He quickly checked for a pulse and began CPR when no pulse was present. He was angry that Cate did not recognize that the patient was not breathing and had "wasted time" trying to change the patient. The doctor was angry that the patient had waited so long with a lethal potassium level in the waiting room. Cate was visibly distraught. She was a new nurse, and I do not think she understood what was happening.

I just stood there. Staring. Motionless. I had so many feelings. I was sad that the patient had died. I wondered if they had died in the triage waiting room while waiting for a bed. I was angry that the healthcare system allowed this patient to wait for so long. I felt guilty that I did not do more to ensure that the patient had gotten a bed when I had covered Sofia's break earlier that morning. I felt helpless, knowing that this lady would not come back despite everyone's efforts. I was mad that the junior staff did not seem to know a sick patient from a not sick patient. I just watched as flustered doctors and nurses attempted to save the patient. The longer I stood there, the angrier I got. When patients and families began to come out of nearby rooms to see the commotion, I began to yell at them to "get back into their rooms." I stood in the nurses' station until the patient was pronounced. I watched as the crowds dispersed, knowing that no debrief would happen once again. Eventually, I walked away.

[7] Names have been changed to protect identities.

As I made my way back to triage, I ran into an elderly lady who appeared to be confused. She was trying to get into 'Blue Zone' but did not seem to know where she was going or why she was going there. I began to ask her questions in hopes of helping her figure out what she was trying to achieve. As I talked to her, I noticed she had a large bag of Christmas decorations. Asking her about them, she stated, "I have to get in to decorate the department." I was confused because the department had already been decorated for Christmas by our unit secretary. Moreover, any decorations within the ER must be approved by the manager. I began to ask whether she had received permission from management to add the decorations. Suddenly, the lady began yelling profanities at me and demanded that I take down the decorations that had already been in place. As I was trying to deescalate the situation, the lady dropped a decoration on the ground that she held in her hand. Trying to assist her, I bent over to pick it up. Just as I bent over, she began to physically assault me, punching me in the arm and face. As I stood up, I saw red. I started screaming at her to get out of the department. I demanded that another nurse call security. When neither the woman left nor security came, I grabbed the lady's purse and began to walk out of the department, knowing that she would follow. I walked past triage and dropped the woman's purse off at the security desk with an officer stationed there. I said to him, "The lady to whom this purse belongs is no longer welcome here. Please ensure that she leaves the property." I then began to walk back into the department, passing the older woman who was headed to the security booth to retrieve her purse. I went back into 'Blue Zone' to take a minute to calm down.

I stood in 'Blue Zone' chatting with the unit clerk about what had happened. As we stood there chatting, the 'Blue Zone' doors opened, and security came with the woman who had assaulted me. Immediately I questioned why they had brought her back into the department when

she was “no longer welcomed here.” The patient flow manager happened to be standing nearby when I said this. He asked me what had happened, and I explained the situation. As I explained the situation, the lady became violent again, screaming profanities at me and threatening to hit me again. Witnessing this, the patient flow manager escorted the woman out of the emergency and off the property, explaining that she “cannot abuse staff.”

After things had settled, I decided to write an incident report to alert my manager, educator, and patient safety officer about what had transpired. As I wrote the story of the situation, I became angry at what had happened. I was physically assaulted, and security “did nothing” to help. By the time I had finished writing my report, my shift was ending, and the anger I felt was palpable.

On my way home, I got a call from Sofia telling me that she had just heard from my manager that the hospital’s CEO was planning to hold a meeting in the ER the following day to discuss the day’s events. She wanted to let me know that a) the meeting was happening and b) see if I would be in attendance as she was not booked to work and did not want to come in on her day off. I told her that I would not be going, as it was also my day off.

That night, as I lay in bed, I could not sleep. I kept thinking about the busyness of the ER, how several patients had died, and how I had been physically attacked with no support from security. I lay awake all night, tossing and turning. By 0600, I had decided that I needed to attend the meeting. I got up and went to work. When I arrived at Sunnybrook, I was fuming. As I entered the ER, I was like a bomb ready to explode. As soon as the night nurses saw me, they commented that they were not planning on staying for the meeting, but seeing me, they “knew it would be good” and proclaimed that they were “going to stay to watch this.”

At 0730, the CEO, the Director of the Integrated Community Medicine program, and my manager entered the department and announced that the meeting would be held in 'Purple Zone'. As everyone settled into the meeting space, the CEO began to speak. He spoke about how great Sunnybrook was and how lucky we were as nurses to work there. As he finished speaking, he asked if anyone had "anything they would like to add?" I put up my hand. He called on me, and I began to vent. I vented that Sunnybrook is not everything it is "cracked up to be." I vented how nurses "do not come to work at Sunnybrook because they like Sunnybrook." That "They come to work at Sunnybrook because they like working with each other." I vented how three patients had died the day before and how one likely died in the hallway because there were not enough nurses to care for them. I told him how I had been assaulted in 'Blue Zone' the day before and that "no one did anything to help me." The CEO said nothing. It was like I had said nothing. I wasn't being heard. At this point, my manager piped up, putting her hand in front of my face, and said, "I think you have said enough." I was so angry that my voice and concerns were not being acknowledged that I told my manager that I "hadn't even started yet," and began to yell at everyone. I was like a tornado, destroying everything and anyone in my path. Eventually, the CEO excused himself, saying he had another meeting to attend. When the meeting had ended, I felt even more hurt and broken than I was entering the meeting. I left the ER, went to my family doctor, and told her what had happened. She immediately took me off work on "stress".

Plotline Five: To be Continued - Through my healing, I discovered who I was and who I wanted to be

My family doctor had given me three weeks off of work. Her hope was that some time away from the ER would give me the time I needed to "reset." As the three weeks came to an end, I began to panic. I was not sleeping, I was crying all the time, and just thinking about going

back to work caused me to have emotional distress. Realizing that I was still 'injured', I returned to my family doctor and requested that she allow me to stay off of work a while longer. She agreed, stating that she thought that I had developed an adjustment disorder, because I was not yet processing the events that had previously transpired. I gave notice to the hospital's occupational health department that my leave was going to be maintained for additional three weeks. Upon hearing the news of the extended leave, the occupational health nurse told me that I would now need to file a claim with the Worker's Safety and Insurance Board (WSIB), to get compensation for my continued absence. I applied and had my claim approved under the Work Stress Program. However, the WSIB required that I undergo a psychiatric evaluation with a trained psychologist to determine the breadth and depth of my injury. By the end of my assessment, it was concluded that I was suffering from PTSD and that I needed to remain off work to get treatment for my condition. Initially, I was baffled by the diagnosis. Getting hit by an older adult was the least of my problems working in the ER. Over my fourteen years as a nurse, I have cared for the critically ill, I have witnessed the death and dying of patients, I have heard the bone chilling screams of family members who had just found out we could not save their loved ones, and I have been threatened and swung at more times than I can count. I did not comprehend why this one event was the thing that caused me to have PTSD.

Through getting help from a trained psychologist, I learned that it was not being attacked by an elderly patient that caused my PTSD, but rather, it was the catalyst to discovering just how much my time working in the ER had affected me. For fourteen years, I had taken on the burdens and stresses of the patients and families that I cared for in a system that set me up to fail. I had never learned how to process my emotions in nursing school effectively. While working as an RN, my employers never prioritized debriefing critical incidents in the ER, and they certainly

never assisted me in talking about my feelings. When traumatic events did occur, I learned that there are cultural expectations and stigmas attached to emotional expression by nurses within nursing. As a result, I learned to hide my emotions, put them away in the back of my mind, and never speak of them again. I did this to survive. Unfortunately, this practice eventually caught up to me. I did not have PTSD because a patient struck me. I had PTSD because I had witnessed fourteen years of patient pain and suffering without ever processing my own feelings of fear, sadness, or helplessness. Psychotherapy forced me to confront these feelings head-on. As I began to heal from all the traumas I had witnessed, I discovered who I was, and who I wanted to be.

In February of 2020, I decided that my goal in nursing was to achieve a senior executive role within a hospital, where I could help drive the improvement of nursing work environments and the systems of clinical care delivery. I also knew that completing my Master of Nursing would be a critical factor in achieving my goal. I applied to the Master of Science in Nursing Program at the University of Ottawa and was accepted into the program. When I began my studies my specific research interest was reducing the incidence of PTSD in front-line emergency room nurses. However, with the advent of the COVID-19 pandemic, and the help of my thesis supervisor, I refined my research to understanding the effects of the COVID-19 pandemic on ER nurses.

Attending to My Story as an Impetus for this Research Study

The preceding stories were drawn from my personal experiences as a nurse and describe my experience of providing care in the ER. Each plotline represents a period of time, and each plotline contributes to the formation of who I am today. Reflecting on my experience helped me understand the meaning of being an ER nurse and providing emergency care.

My own experience of working in the ER, including my unique journey of developing PTSD and healing from trauma, inspired a curiosity in me that was the impetus for this research study. My goal of improving nursing work environments and the systems of clinical care delivery and my desire to better understand the experience of providing care in the ER during the COVID-19 pandemic through the stories of others have shaped and guided this inquiry.

Background

On January 25, 2020, an infection known later to be COVID-19 had made its way to Ontario, Canada. COVID-19 is an infectious disease caused by a novel coronavirus associated with the severe acute respiratory syndrome (SARS) (Galehdar et al., 2021). It was first detected in December 2019 in Wuhan, China, when an outbreak of pneumonia of unknown cause was reported to The World Health Organization (WHO) (Coronavirus events as they happen, n.d.). By March 11, 2020, the WHO declared the disease a global pandemic (Galehdar et al., 2021). At the time of writing, the COVID-19 pandemic has resulted in 516,922,683 cases and 6,259,945 deaths worldwide (WHO Coronavirus Dashboard, n.d.). In Ontario, those numbers are 1,281,360 and 13,034, respectively (All Ontario: Case numbers and spread, n.d.). It is estimated that in Ontario, 47,680 cases have required hospitalization (Public Health Ontario, n.d.). As the COVID-19 pandemic has taken hold of Toronto, Ontario, Canada, and the world, it has highlighted many of the challenges faced by healthcare workers. Those nurses working in the emergency room (ER), settings that are under normal circumstances unpredictable and acute, were particularly affected.

Historical Context

Early Nursing in Canada

For Canadians today, hospitals are an ordinary place. While we find it normal to be born or die in a hospital, this was not always the case. In early English Canada, hospital visits were exceedingly rare (Bates et al., 2005). The task of nursing the ill or assisting in childbirth often fell on female family members who relied on their resources and remedies and acquired medicinal knowledge from Canada's indigenous people (Bates et al., 2005). The few hospitals that did exist were seen as a place for the indignant and a last resort for the affluent (Bates et al., 2005). Public hospital wards lacked privacy, permeated foul odours, and were full of constant noises and the moans of patients awaiting treatment (Bates et al., 2005).

Additionally, the delivery of nursing care was based more on domestic skills than medical knowledge. Many lay nurses were former patients, recruited to hospital work following their recovery. Both the lay nurses and nursing sisters lacked academic training. They were tasked with cleaning patients and changing their clothes when admitted, monitoring symptoms, restraining delirious patients, changing soiled linens, distributing medications and meals, and cleaning the rooms (Bates et al., 2005). Nurses worked long hours and were poorly paid, but were often housed and fed (Bates et al., 2005). As such, hospital nursing was perceived as a high-risk profession and to be "on par with the lowliest servant work" (Bates et al., 2005, p. 20). Even a short overview of Canadian nursing during past pandemics reveals the challenges of caring for those infected (Bates et al., 2005; Rankin, 2006).

19th Century

Several pandemics plagued Canada in the 19th Century as European immigration grew. Until this time, nursing in English Canada remained very primitive (The leaf and the lamp, 1968). With the influx of thousands of sick and destitute immigrants from Europe, the Canadian government finally had the momentum it needed to increase the number of hospitals and nurses

(Rutty et al., 2010). Although Cholera, Typhus, and Smallpox were all prevalent pandemics during the 19th Century, I will limit my discussion to Cholera as it had the most impact on nursing.

Cholera. Throughout much of the 19th Century, public hospitals were seen as a last resort for the impoverished and a terrible workplace for nurses (Bates et al., 2005). When Cholera first reached Canada in 1832, hastily constructed 'quarantine stations' or temporary hospitals were erected by the Canadian government (Bates et al., 2005). Used to shelter the ill, these poorly funded, poorly equipped, and overcrowded hospitals were not just unpleasant places to work; they were hazardous. Responsible for helping patients through the most unpleasant and deadly stages of the disease, nurses who worked in the Cholera hospitals were continually exposed to illness with little or no protection from it (Bates et al., 2005; Rankin et al., 2006). Labour shortages were common as the demand for nurses exceeded supply. Most of the nurses who worked during the epidemics of the 19th Century were not regular nurses but rather drawn into the work temporarily for reasons of benevolence or economics (Bates et al., 2005; Rankin et al., 2006).

In addition to this, it was not uncommon for citizens to flee infected cities leaving behind the sick and the nurses who cared for them (Rankin, 2006). As such, one can assume that the mass evacuation of others generated both feelings of fear and isolation in nurses. The work conditions, nursing shortages, and general fear and isolation had a significant impact on nurses' mental health (Bates et al., 2005; Rankin et al., 2006). It has been documented that nurses were often arrested for public drunkenness as alcohol was used as a method to escape the horrors of 19th-century hospital nursing (Rankin, 2006).

20th Century

In the 20th Century, nursing was relatively unscathed by outbreaks, epidemics, and pandemics. In Canada, the most notable was the 1918 Spanish Influenza pandemic. Until COVID-19 emerged, the deadliest pandemic since the middle ages left a negligible effect on public memory (Rankin, 2006). More recently, however, its attention has resumed as media outlets report the similarities between the 1918 pandemic public health measures and today's efforts to fight against COVID-19.

Spanish Influenza. The Spanish flu was the deadliest modern pandemic; it is estimated that the disease infected half a billion people, killing 50 million people worldwide (Rankin, 2006). By the end of 1918, the Spanish flu had infected one in six Canadians (Bates et al., 2005; Rankin et al., 2006) and by the end of 1920, it had killed 55,000 (Jones & Fahrni, 2012). Like with Cholera, the healthcare system was ill-prepared, and nurses were overwhelmed (Rankin, 2006).

In September 1918, the world's attention was on the Great War in Europe (Groft, 2006). As such, the world was unprepared for the Spanish Flu outbreak. Although rarely discussed in newspapers of the time, a few journalists in Canada were anxiously following reports of a severe influenza epidemic making its way up the Eastern seaboard of the United States of America (Jones & Fahrni, 2012).

Like COVID-19, the Spanish flu was challenging to differentiate from the common cold, which had a reputation for being unpleasant but not necessarily fatal (Jones & Fahrni, 2012). However, for those most severely affected by the virus, what would begin as chills would rapidly take over the body, often leading to death (Jones & Fahrni, 2012). Generally, the proportion of infected people who died from influenza is lower than other epidemic diseases, like cholera;

however, Spanish influenza was so deadly because of the extreme number of people who became ill and the impact of secondary infections such as pneumonia (Jones & Fahrni, 2012).

As the war effort persisted and troops continued to travel abroad and home again, Spanish influenza quickly migrated across the world and within Canada (Jones & Fahrni, 2012). To mitigate the spread, businesses and schools closed, church services were canceled, mask-wearing became mandatory in public spaces, and quarantines were required for infected households (Jones & Fahrni, 2016; Rankin 2006). As is customary during pandemics, people stopped engaging in social activities, and once again, hospital nurses fell victim to the stress and isolation of caring for the ill (Rankin, 2006). Unlike Cholera however, nurses were encouraged to develop friendships with their coworkers to help mitigate the stress and loneliness (Rankin, 2006).

The high numbers of patients overwhelmed the hospital system; hotels and mission houses opened up emergency spaces to help care for those who fell ill (Jones & Fahrni, 2016). Alas, a significant portion of Canada's medical and nursing personnel had volunteered in the war effort, leaving both hospitals and community beds understaffed (Jones & Fahrni, 2012). Additionally, the disease posed a high risk to healthcare workers, and many nurses contracted the virus, further diminishing the already extended resources (Jones & Fahrni, 2016). In Toronto, approximately 35% of nurses contracted the disease (Rankin, 2006).

At the time, no effective medical treatment for Spanish influenza existed. Even though several medicinal treatments were provided to the sick, the most helpful interventions were bed rest, nutrition, fever management, and care provided by nurses (Groft, 2006; Jones & Fahrni, 2016). It is documented that physicians were often heard saying that “everything depends on good nursing” when medical treatments were proven to be ineffective (Groft, 2006, p. 20). As such, the Spanish flu healthcare effort was a setback to the prestige of medicine and an

advancement for the reputation of nursing (Jones & Fahrni, 2016). Nevertheless, it is not easy to find sources that convey nurses' feelings and perceptions during this time, as the nursing voice was "systematically muted" in the public record (Rankin, 2006, p. 132). Newspaper articles published between 1918-1920 depict nurses as the "silent followers of protocol" (Rankin, 2006, p. 132). Furthermore, nursing roles are only mentioned when a nurse had died (Rankin, 2006).

21st Century

Within the first two decades of the 21st Century, the world saw six significant pandemics: SARS (2003), Avian Flu (2008), H1N1 (Swine Flu) (2009), Ebola (2014), Middle East Respiratory Syndrome (MERS) (2015), and Zika (2015). Although each event was detrimental to world health, few had a significant effect on healthcare and nursing in Canada. To date, there have not been any reports of cases of either Ebola or MERS in Canada (Update on Ebola virus, n.d.; Middle East Respiratory Syndrome Coronavirus, n.d.). During the 2008 Avian flu outbreak, only two Canadians tested positive for the virus, both of whom fully recovered after being treated with Oseltamivir ™ (Kermode-Scott, 2004). Similarly, the Zika virus infected relatively few Canadians. A total of 573 cases, 569 of which were travel-related, and four sexually transmitted, have been reported in Canada since cases started being detected in October 2015 (Zika virus: For health professionals, n.d.). The largest pandemic of the first two decades of the 21st Century in Canada was the 2009 H1N1 pandemic, causing 8678 hospitalizations, 1473 ICU admissions, and 428 deaths (Hodge, 2014). However, Canada's public health response, led to the country's highest mass immunization campaign in history (Hodge, 2014), the hospital system was able to manage these patients even at the height of admissions (The impact of the H1N1 pandemic on Canadian hospitals, 2010).

Conversely, SARS was one of the least deadly pandemics in Canada, claiming the lives of just 44 people – only two of whom were nurses – all in Toronto, Ontario (Rankin, 2006). Nevertheless, SARS seems to have had the most impact on nurses in Canada – Specifically Ontario (Rankin, 2006).

SARS. Like COVID-19, SARS is a viral respiratory infection caused by a SARS-associated coronavirus, and similar to the Spanish flu, SARS began as a mystery illness with an onset that mimicked the relatively minor seasonal flu (Duffin & Sweetman, 2006; Tyshenko & Paterson 2010). However, its relatively mild onset soon resulted in a powerful pneumonia that made up to 20% of its victims require assisted-breathing ventilation machines within days (Tyshenko & Paterson 2010). SARS was first identified in February 2003, when an outbreak of atypical pneumonia emerged in Guangdong, China (Tyshenko & Paterson 2010). Because of its meager onset, unknowingly infected individuals quickly spread the disease to other countries through international travel (Tyshenko & Paterson 2010). Two individuals traveling home from China, one to Toronto, Ontario, and one to Vancouver, British Columbia, brought the contagion to Canada (Tyshenko & Paterson 2010). When SARS hit Ontario in March 2003, it tested the once again struggling healthcare system (The SARS Commission, n.d.).

In Toronto, the disease was able to seize the population, seeding several infections of atypical pneumonia that were eventually contained within local area hospitals (Tyshenko & Paterson 2010). Given that the disease was primarily contained and spread in hospital environments, it stands to reason that healthcare workers, especially ER nurses at the frontline, were at heightened risk of exposure to the deadly disease (Phua et al., 2005; Wong et al., 2005).

To protect themselves and others, ER nurses were required to wear personal protective equipment (PPE) all of the time while working and were forced into ‘work quarantines’

(Tyshenko & Paterson 2010). While quarantine measures are standard during pandemics, the SARS 'work quarantine' allowed ER nurses to continue to work as long as they remained healthy, however, they had to follow strict at-home isolation measures (Tyshenko & Paterson, 2010). According to Tyshenko & Paterson (2010), the strict at-home isolation measures forced ER nurses to maintain the following rules:

1. Remain at home, do not leave your house, and do not have anyone visit you at home. Family or household members do not have to be isolated or quarantined at home unless a member of the household is diagnosed with SARS. Stops on the way home are not allowed (to purchase gas from a pump, for example). Dental, medical, and personal appointments are not permitted, and healthcare must be sought at your hospital of employment.
2. Wear a mask when you are in the same room with another member of your household but attempt to remain alone in a room.
3. Change your mask as directed. Family or household members do not have to wear masks.
4. Do not share personal items, such as towels, drinking cups, or cutlery. Do not kiss or hug anyone, including family members.
5. Wash your hands frequently.
6. Sleep in separate rooms.
7. Measure your temperature with your own thermometer twice a day over the ten-day period (p. 51).

These rules evoked feelings of fear, isolation, sadness, and anger in ER nurses (Tyshenko & Paterson, 2010). Some nurses reported feeling like they were in 'jail' because of the quarantine

measures that deprived them from any human contact (Rankin, 2006; Tyshenko & Paterson, 2010). Others reported feelings of loss and grief as they were separated from their husbands, wives, and children for an unknown amount of time (Tyshenko & Paterson, 2010). Additionally, media reports depicted nurses as a safety threat in the community (Farquharson & Baguley, 2003). As such, nurses were treated as "modern-day lepers" (Rankin, 2006, p. 134) and were banned from entering several businesses that posted signs to remind nurses that they were not welcomed (Farquharson & Baguley, 2003; O'Sullivan et al., 2008; Rankin, 2006). The stigma of nurses as infectious and the community abandonment that accompanied it only served to make ER nurses feel more alone (Rankin, 2006).

Quarantine measures not only furthered the feelings of fear and isolation in ER nurses, they also made staffing ERs challenging (Tyshenko & Paterson, 2010). As many ER nurses were quarantined in the early days of SARS, hospitals were left short-staffed, and finding replacement staff was difficult (Tyshenko & Paterson, 2010). The then-common practice of using agency nurses to fill staffing gaps was challenged by mandatory mask-fit testing and the ever-changing protocols handed down from the Ministry of Health (Tyshenko & Paterson, 2010). To prevent disease transmission, nurses were also forbidden to work at multiple hospital sites, so even willing nurses could not step in when asked (Farquharson & Baguley, 2003; Rankin, 2006). Ultimately hospitals were required to fill the gaps by utilizing their resources. Some nurses made extraordinary sacrifices, by working longer hours, skipping breaks, picking up multiple shifts, or even sleeping at the hospital to help with the SARS efforts (Farquharson & Baguley, 2003; Rankin, 2006; Tyshenko & Paterson, 2010). Working long hours and extra shifts in the short term is common for ER nurses (Tyshenko & Paterson, 2010). However, working long hours while being perpetually separated from loved ones, facing the uncertainty of the disease and not

knowing how long the outbreak would last only added to their ER nurses' distress (Tyshenko & Paterson, 2010).

Workload and stress also increased during SARS as the responsibility for containing the disease fell on nurses' shoulders (Rankin, 2006; Tyshenko & Paterson, 2010). The goal of preventing disease spread resulted in many day-to-day changes, including wearing PPE for an entire twelve-hour shift (Farquharson & Baguley, 2003; Tyshenko & Paterson, 2010). This practice is not custom practice, and doing so is difficult and painful (Galehdar et al., 2021). For example, the impermeable gown and gloves restrict body movements and increase body temperature (Galehdar et al., 2021). Sweating is induced by the increase in body temperature, resulting in soaked undergarments and scrubs (Galehdar et al., 2021). Furthermore, the inability to change clothes for the risk of contamination leads to skin breakdown as wet clothes sit on the skin for twelve hours (Tyshenko & Paterson, 2010). Additionally, and perhaps more bothersome, is the prolonged use of the N95 mask. The N95 mask not only makes the wearer feel suffocated, but the continued pressure can also lead to facial bruising, rashes, and skin breakdown (Galehdar et al., 2021; Tyshenko & Paterson, 2010). Meal breaks were the only time ER nurses were permitted to remove their PPE, and due to infection control measures, this had to be done alone or in small groups at a distance of three feet from one another (Farquharson & Baguley, 2003; Tyshenko & Paterson, 2010). Moreover, socialization with co-workers during breaks was discouraged, thus perpetuating the feelings of fear and isolation (Farquharson & Baguley, 2003; Tyshenko & Paterson, 2010).

While at work, ER nurses faced a steady stream of confusing and contradictory messages about the means of transmission and infection control procedures (Farquharson & Baguley,

2003; O'Sullivan et al., 2008; Rankin, 2006; Tyshenko & Paterson, 2010). An example of this is outlined by Tyshenko & Paterson (2010) in describing the daily PPE requirements for ER nurses:

> Initially, it was the use of N95 masks. Then N95 masks, one per day, with gowns. Then N95 masks (one every six hours) /face shields, gowns, gloves, hair, and shoe covers. After that, it was N95/face shields, double gowns, double gloves, hair, and shoe covers, change greens (basic uniform). Then it was back down to N95, single gown, gloves, shield as needed. And, finally, using the Stryker t4 System for high-risk procedures (p. 47).

It is well documented that this uncertainty, combined with poor communication, and healthcare administrators' disregard for nursing insights, led to ER nurses' feelings of mistrust in their employers (Rankin, 2006; Tyshenko & Paterson, 2010). An example of this occurred in May 2003 when nurses at one hospital identified a cluster of patients with SARS-like symptoms and reported it to medical staff and management (Rankin, 2006; Tyshenko & Paterson, 2010). However, at the time of vocalization, the province experienced lowered case counts, and hospitals had lessened requirements for PPE (Rankin, 2006; Tyshenko & Paterson, 2010). Thus, nurses' concerns were dismissed, and nothing was done for several days leading to the second wave of the SARS outbreak in Toronto (Rankin, 2006; Tyshenko & Paterson, 2010). Ultimately, hospital administrators' silencing of nurses' voices "proved deadly as the virus continued to spread" (Rankin, 2006, p. 135).

Although there is no exact number reported of nurses who experienced negative psychological effects from dealing with SARS, manifestations of anxiety, depression, and post-traumatic stress disorder (PTSD) were noted in several ER nurses following SARS (Tyshenko & Paterson, 2010). Some nurses were so negatively affected by SARS that they took a six-month

leave to recover; others had still not fully recovered after an entire year, several of whom chose not to return to working in the ER (Rankin, 2006; Tyshenko & Paterson, 2010). The psychological distress and physical distancing took its toll on many nurses', who, were forever changed by their experiences.

COVID-19. With the advent of the severe acute respiratory syndrome from coronavirus 2 (SARS-CoV-2), ER nurses are once again faced with an increased workload, insufficient protection from contamination, continual risk of infection, moral and ethical dilemmas, and physical and emotional exhaustion, resulting in an exceedingly high risk for the development of adverse psychological outcomes, ineffective coping strategies, and a propensity to leave the nursing profession (Cui et al., 2021; Galehdar et al., 2021; González-Gil et al., 2021; Maben & Bridges, 2020; Morley et al., 2020).

Problem Statement and Research Questions

To avoid repeating past mistakes, we must understand the lived experience of ER nurses in hopes of eliciting change. Although previously published articles have shed light on the challenges faced by ER nurses during pandemics, little is known about the experience of working as an ER nurse in Toronto during the COVID-19 pandemic. As such, what stories do ER nurses tell about providing care during the COVID-19 pandemic? Secondary questions include: 1) How are ER nurses processing the emotions experienced during the COVID-19 pandemic? 2) How are nurses' stories being honoured?

Purpose of the Study

The purpose of this study is threefold: 1) to describe, interpret, and understand the thoughts, feelings, and problems facing ER Nurses in Toronto during the COVID-19 pandemic;

2) to look for instructional messages and develop solutions to problems for future pandemics; and 3) to allow for the healing of ER nurses through storytelling.

Importance of the Study

History has demonstrated that nurses who are not well supported during outbreaks, epidemics, and pandemics suffer from adverse psychological outcomes, resulting in ineffective coping strategies and the inclination to leave the nursing profession (Bates et al., 2005, Rankin et al., 2006).

At the time of writing, Toronto is amid the fourth wave of the COVID-19 pandemic, with no clear resolution in sight. My research results will help improve our understanding of the experience of working as an ER nurse in Toronto throughout the COVID-19 pandemic. Through this, I hope to find ways to support ER nurses in their continued effort. Additionally, study results may help to inform future pandemic preparation and nursing support.

Overview of Thesis

In this first chapter, I introduced the experience of ER nurses providing care during pandemics. I then shared my autobiographical narrative to provide context for the research topic and to position myself within the research. Next, I described the problem statement to inform readers of the significance of understanding the lived experience of ER nurses providing care during the COVID-19 pandemic in Toronto, Canada, and established the questions guiding the inquiry and the purpose of the study. Finally, I described the importance of the research study.

In chapter 2, I outline and critique the current literature regarding the lived experience of ER nurses providing care during pandemics of the 21st century. In chapter 3, I provide an overview of the narrative inquiry methodology and present a detailed description of the research methods used in this inquiry. Chapters 4, 5, and 6 are the inquiry results, which I present as

individual narrative accounts. In Chapter 7, I discuss the research findings that emerged from the participants' storied experiences. Chapter 8 completes this thesis with a reflection of my experience as a novice researcher and a discussion of how the interpreted findings will serve to inform and advance future nursing education, practice, and research. Finally, I address the strengths and limitations of this study and conclude with my final thoughts.

Chapter 2: Literature Review

In this chapter, I review the existing literature to situate the inquiry and research questions in the context of our current understanding of the lived experience of ER nurses providing care during the COVID-19 pandemic in Toronto, Ontario, Canada. First, I give an overview of the search strategy and provide a discussion on how data was extracted. Next, I discuss the threads that emerged from the literature. Finally, I provide the rationale for conducting this inquiry and discuss how it addresses the gaps in the current literature.

Search Strategy

A qualitative and quantitative literature review was conducted in March of 2021. The search was completed with the assistance of The University of Ottawa's Health Sciences Librarian.

The Cumulative Index for Nursing and Allied Health Literature (CINAHL), OVID, Nursing and Allied Health Database, and Google Scholar were the electronic databases searched. Keywords used included: nurs*, AND "pandemic or epidemic or outbreak," AND "emergency room or emergency department or ER or ED," AND "experience or perception or attitude or view or feeling or qualitative or perspective." A date limitation was set for articles from 2001-2021 to provide a rich insight into emergency room nurses' lived experience during pandemics throughout the 21st century. Additionally, sources were limited to peer-reviewed articles published in academic journals. Articles included met the following criteria:

1. Emergency room nurses were the subjects of the article.
2. A pandemic, epidemic, or outbreak occurrence.
3. A part of the lived experience (thoughts/feelings/perceptions/physical ailments or recommendations for future pandemics) was reported or discussed in general.

4. Articles from 2001-present.

Articles that focused on the patient experience only or based solely on ER patient flow or redesign of ER space were left out because they were not reflective of the nursing experience. It is presumed that the lived experiences of nurses may be different depending on the area of clinical practice. As such, articles that used the phrase 'frontline workers' or 'frontline nurses' without defining the clinical setting were similarly excluded. Non-English articles were also excluded.

The initial search generated 3651 publications; 3458 were discarded for being off topic by title or abstract review or a duplicate, 193 articles were read to determine a match with inclusion criteria and finally 16 articles were included. A hand search of Google Scholar provided an additional two articles. In total, 18 articles were used to understand the prior experiences of ER nurses during pandemics (See appendix A and B for full search strategy).

Data Extraction

I extracted data about the population studied, the type of outbreak, epidemic, or pandemic, the method used, emerging threads, and lessons learned. A synthesis of findings was performed (see Appendix C for a summary of included articles). Among the included articles, five referred to the SARS pandemic, one to the Avian Influenza outbreak, one to the H1N1 outbreak, one to the Ebola outbreak, two to the MERS-CoV outbreak, six to the SARS-CoV-2 pandemic, and two were non-specific about the infectious disease outbreak. Additionally, studies from multiple countries were included: Canada (three articles), China (three articles), Hong Kong (five articles), Korea (two articles), Iran (one article), Spain (two articles), and the United States of America (two articles).

Emerging Threads

A scoping review of the literature revealed two dimensions (*personal* and *professional*), and seven threads (*fear and isolation, expectations and duty to care, nursing shortages, personal safety and personal protective equipment, workload and stress, moral and psychological distress,* and *loss of voice*), that support the further investigation of the experience of ER nursing during the COVID-19 pandemic.

Personal Concerns and Considerations

Fear and Isolation. Eleven of the eighteen articles examined considered the feelings of fear and isolation in ER nurses during emerging infectious diseases (Choi & Kim, 2018; Cui et al., 2020; Farquharson & Baguley, 2003; Galehdar et al., 2021; González-Gil et al., 2021; Kim & Choi, 2016; Lam et al., 2019; Lam & Hung, 2013; Nie et al., 2020; O'Sullivan et al., 2008; Rankin, 2006).

In the initial stages of an outbreak, there is often little known about the epidemiology, resulting in fear of contracting the disease, fear of transferring the infection to family members, and fear of death (Lam & Hung, 2013; Galehdar et al., 2021). Nurses working in the ER are especially vulnerable to illness from infectious diseases and have a significantly higher risk of infection than those working in other departments (Choi & Kim, 2018; Lam & Hung, 2013; Lam et al., 2019). As such, ER Nurses' fears when dealing with a contagion may be due to many things: an unknown pathogen or mode of transmission, questions about the adequacy of personal protective equipment (PPE), lack of effective treatment, the disease's lethality, and the possibility of transmitting the infection to friends and family.

In his 2006 article on the SARS crisis in Toronto, Rankin found that fear was the most predominant emotion reported by ER nurses during the outbreak (Rankin, 2006). He notes that the feelings of fear were rooted in the anonymous nature of the disease and the lack of

knowledge regarding transmission (Rankin, 2006). Because it was known that the disease mainly spread in hospital environments, the fear of the work environment was incredibly intense for ER nurses who often received confusing and contradictory messages about the means of transmission, infection control measures, the effectiveness of the provided protective gear, and the protocols they needed to follow (Rankin, 2006). Additionally, this fear was made worse by the potential that a nurse could unwittingly contract the disease and then spread it to family and friends (Rankin, 2006). Similarly, in their 2013 qualitative study exploring the perceptions of ER nurses during the human swine flu pandemic, Lam & Hung found that four out of ten nurses interviewed expressed concerns about their susceptibility to infections (Lam & Hung, 2013).

However, they also noted a striking difference: nurses who had worked a previous pandemic had less fear for their own wellbeing. For example, one nurse they interviewed stated that she did not consider the human swine flu a threat as she had already "come through the challenge of SARS" (Lam & Hung, 2013, p. 243). This sentiment is echoed in O'Sullivan et al.'s study on emergency preparedness. In their study, O'Sullivan et al. (2008) surveyed 1543 nurses from ER and intensive care unit (ICU) and found that nurses who had provided direct patient care for a person with SARS in the previous three years reported higher levels of preparedness in dealing with future emerging infectious diseases. These results suggest that exposure to prior outbreaks helps to enhance nurses' sense of preparedness, thus decreasing the potential fear of unknown contagions.

Like the concern about the safety of oneself, the fear of transferring emerging infectious diseases to their family members is another crucial issue facing ER nurses (Lam & Hung, 2013; Nie et al., 2020; Rankin, 2006). Lam & Hung (2013) found that six out of the ten nurses studied feared transmitting the contagion to their family members. This number was mirrored in

González-Gil et al.'s study on nurse's perceptions and needs during the COVID-19 pandemic in Madrid, Spain. In it, researchers found that 37.5% of ER nurses always think about the possibility of becoming infected with COVID-19, and 62.8% reported that they are always afraid of infecting the people with whom they live (González-Gil et al., 2021). Other studies involving the fear of the safety of self and others during the COVID-19 pandemic have reported higher numbers. For example, Nie et al. (2020) found that of the 263 participants, 82.9% showed concern about their safety, while 92% showed concern about the safety of their family.

To help alleviate some of their fears, ER nurses might choose to separate from family and friends to avoid infecting them (Galehdar et al., 2021). However, in some instances, the separation from family and friends was not a choice. For example, Nie et al. (2020) found that during the COVID-19 pandemic in China, nurses were quarantined and asked not to go home to avoid the potential risk of infection among family members. Unfortunately, in remaining separated from loved ones, Galehdar et al. (2021) observed that ER nurses developed feelings of isolation as they were cut off from their support structures.

Paralleling the stresses faced by ER nurses during the SARS pandemic who were required to isolate at home, Galehdar et al. (2021) found that the primary source of nurses' anxiety during the COVID-19 pandemic in Iran was the isolation from being separated from their families coupled with the fear of infecting family members when they returned home. In their cross-sectional study of 453 ER nurses during the COVID-19 pandemic in China, Cui et al. (2020) found that the fear of infecting family members is the most influential predictor of anxiety. Additionally, researchers found that the fear of infecting family members made ER nurses more anxious and made them more stressed and more inclined to engage in negative coping behaviours (Cui et al., 2020).

Although social support from family, friends, and colleagues has been shown to help reduce job stress (Kim & Choi, 2016), a lack of social support for ER nurses during pandemics is well documented in the literature (Farquharson & Baguley, 2003; Lam & Hung, 2013; Nie et al., 2020; Rankin, 2006; Shiao et al., 2007). For example, during the COVID-19 pandemic, 40.3% of nurses in China reported being treated differently because of working in the hospital (Nie et al., 2020, p.4221). Additionally, Nie et al. (2020) found that ER nurses were shunned by their family, friends, and nursing colleagues who saw them as a potential risk of infection. As such, ER nurses had to deal with the COVID-19 pandemic and the stigmatization of the public (Nie et al., 2020).

The experience of ER nurses during the COVID-19 pandemic in China is analogous to the experience of ER nurses in Toronto during the SARS pandemic. During SARS, the media reported that healthcare workers represented a threat in the community (Farquharson & Baguley, 2003). As such, the movement of nurses during SARS was restricted. In the community, ER nurses were asked to stop social gatherings outside of work, and many nurses were forced to miss important family events such as graduations or funerals (Farquharson & Baguley, 2003; Rankin, 2006). Businesses posted signs forbidding the entry of hospital staff, and nurses' personal appointments, such as routine dental care, were canceled by providers for fear that the disease might spread (Farquharson & Baguley, 2003; Rankin, 2006). In the hospital, the situation was similar. ER nurses were instructed to keep contact with their co-workers to a minimum and to sit at least two seats apart in the cafeteria (Rankin, 2006). The social stigmatization of SARS only added to the feelings of loneliness and isolation and made a significant impact on ER nurses (Rankin, 2006). By the time SARS was done, ER nurses who faced social stigmatization were 2.7 times more likely to leave their jobs (Shiao et al., 2007).

It was not until the Premier of the Province of Ontario and the Minister of Health publicly described the efforts and conditions to which healthcare workers in Toronto were subjected that the public view changed from stigmatization to praise and support (Farquharson & Baguley, 2003).

Expectations and Duty to Care. The dichotomy of balancing the duty to care for patients with the rights and responsibilities of ER nurses to protect themselves and their loved ones is heavily debated in seven articles (Choi & Kim, 2018; Cui et al., 2021; Choi & Kim, 2018; Farquharson & Baguley, 2003; Galehdar et al., 2021; Lam and Hung, 2013; Shiao et al., 2007; Wolf et al., 2016).

The social contract of society expects that an emergency provider, by virtue of training and education, has a duty to provide care when needed (Wolf et al., 2016). For ER nurses, the overriding ethical principle of duty to treat is a professional commitment and a moral obligation (Wolf et al., 2016). However, their duty to treat is not absolute and is tempered with both a duty to self and institutional obligations (Wolf et al., 2016). For example, Wolf et al. (2016) point out in their proposition paper on Ebola that during an emerging infectious disease, "there is no obligation for an emergency nurse… to provide care to a highly infectious patient in the absence of appropriate training and protective equipment, especially when the benefit is small and the risks high" (Wolf et al., 2016, p. S36). In these situations, the ethical obligation of nurses is to advocate for themselves just as they would for patients (Wolf et al., 2016).

Similarly, in their study aimed at determining the factors predicting nurses' leaving their jobs during the SARS outbreak in Taiwan, Shiao et al. (2007) accentuate that there is no code of ethics for dealing with the situations in which healthcare workers are at extreme risk of infection. However, they also note that the cultural background in Taiwan is such that while practicing

nursing, caring for patients should not be refused even when there is a personal risk. Consequently, balancing the duty to treat with the duty to self requires nurses to critically reflect on when they feel comfortable providing care to their patients.

In addition to the previously mentioned ethical problems facing ER nurses, in their study exploring ER nurses' ethical considerations to providing care during the MERS outbreak in Korea, Choi & Kim (2018) found that social stigmatization also affects ER nurses' decisions to work during a pandemic. As previously mentioned, during the SARS pandemic, several people avoided ER nurses for fear of infection. Similarly, during the MERS outbreak in Korea, it is reported that ER nurses once again were avoided for fear of contagion (Choi & Kim, 2018). However, this time, the stigmatization was also extended to their children who were not allowed to attend schools (Choi & Kim, 2018). One can imagine that this posed a challenge for nurses' who then had to choose between caring for patients or caring for their children.

The dilemma of choosing between one's professional role and personal responsibilities is well documented in the literature (Cui et al., 2021; Farquharson & Baguley, 2003; Galehdar et al., 2021). In their 2021 qualitative study exploring nurses' perceptions of taking care of patients with COVID-19, Galehdar et al. found that the risk of infection and the possibility of taking the infection home to loved ones caused a predicament for ER nurses of choosing between their family's health and the provision of care to patients. Furthermore, they found that nurses who chose to maintain their professional commitments were forced to be separated from their children to prevent infection, leading to increased fear and anxiety. This finding was echoed in another study on the impact of COVID-19 on anxiety, stress, and coping in ER nurses. In it, Cui et al. (2021) found that 64.02% of nurses with children have higher anxiety levels and that the burden from both family and work made them more anxious.

Conversely, Lam and Hung (2013) found that some nurses were eager to fulfill their professional requirements. One nurse in their study stated, “Everyone has to take their own responsibility towards the society. If I, as a nurse, retreated from the threats of influenza, who is going to help the sick people? It is a feeling of mission calling. I am doing what I need to do as a nurse, rather than act cowardly” (Lam & Hung, 2013, p. 244). However, statements like this also demonstrate an emerging narrative of judgment, guilt, and shame that some nurses feel when they cannot contribute to direct patient care during infectious outbreaks due to their own high risk and vulnerability, or whom, for personal reasons, chose not to work (Maben & Bridges, 2020).

Nursing Shortages. Eight studies examined nursing shortages during and after outbreaks, epidemics, and pandemics (Bell et al., 2014; Farquharson & Baguley, 2003; González-Gil et al., 2021; Lam et al., 2013; Lam & Hung, 2013; O’Sullivan et al., 2008; Rankin, 2006; Shiao et al., 2007).

As mentioned earlier, primary care responsibilities in the home can be challenging for nurses who must choose between going to work and staying and home to provide care for their dependents. Indeed, one of the prominent causes of nursing shortages during pandemics is related to obligations at home (Bell et al., 2014). For example, in their quantitative study of ER nurses (n = 332), Bell et al. (2014) found that 20% of ER nurses have primary caregiver responsibilities. Finding suitable childcare during a pandemic is often tricky for ER nurses, as others remain distant from them and their families to ward off infection. Additionally, O’Sullivan et al. (2008) found that 62.2-67.1% of ER nurses report that their institutions offer no family care supports in the event of large-scale outbreaks, thus limiting their ability to work during

pandemics (p. s14). As such, nurses who have caregiving responsibilities are less likely to report to work during a pandemic, thus contributing the staffing deficiencies.

Another factor contributing to nursing shortages throughout pandemics is the inability of nurses to work at multiple locations. During pandemics, it is common for institutions to restrict the movement of staff between facilities to prevent disease transmission (Farquharson & Baguley, 2003; Rankin 2006). As such, staff that have part-time or agency positions in multiple hospitals must choose only one in which to work. This phenomenon was well documented during SARS when nursing shortages grew as workplace limitations were imposed on nurses (Farquharson & Baguley, 2003; Rankin, 2006).

Additionally, Rankin (2006) found that because of nursing shortages and the unavailability of part-time and agency nurses to help cover nursing assignments, nurses were hesitant to call in sick during the SARS pandemic. When ER nurses become ill during an outbreak, it creates a vicious cycle that further depletes human resources (Lam et al., 2019). Furthermore, knowing that they are leaving their colleagues in a worse staffing situation by calling in sick causes a sense of guilt amongst ER nurses who already feel there are not enough nurses to cope with pandemics effectively (Lam et al., 2019).

Although the situations mentioned above are some of the reasons nursing shortages occur during pandemics, they do not consider the disparities caused by nurses leaving the profession. For example, Shiao et al. (2007) found that following SARS, 25.9% of ER nurses considered leaving their job due to increased workload and stress, perceived fatality, and affected social relationships. Interestingly, tenure may play a role in the desire to change jobs or leave the nursing profession during or after a pandemic. For instance, Shiao et al. (2007) identified that ER nurses with longer tenure were less likely to leave their jobs during emerging infectious diseases.

This may be related to their level of commitment, level of financial compensation, personal responsibilities or obligations, or the level of preparedness that experienced nurses feel, primarily if they have worked through previous outbreaks (Shiao et al., 2007).

Professional Concerns and Considerations

Personal Safety and Personal Protective Equipment (PPE). Personal safety and PPE were examined in seven articles (Choi & Kim, 2018; Farquharson & Baguley, 2003; Galehdar et al., 2021; Lam et al., 2020; Lam & Hung, 2013; Nie et al., 2020; O'Sullivan et al., 2008). It is evident from the literature that one of the main concerns of ER nurses during pandemics is their level of personal safety and that personal safety is equated to the availability and use of PPE. In their cross-sectional study exploring the ethical problems facing ER nurses during the MERS outbreak in Korea, Choi & Kim (2018) found that the main challenge for ER nurses during an outbreak is the level of agreement with infection control measures taken by the hospital. Furthermore, several studies found that the fear of contagion among ER nurses is decreased if given the proper PPE (Choi & Kim, 2018; Shiao et al., 2007).

However, the PPE supply for nurses' use was identified as inadequate during several significant pandemics (Galehdar et al., 2020; Lam et al., 2020; O'Sullivan et al., 2008). In the initial phase of SARS, there was an acute shortage of PPE and N95 masks (Farquharson & Baguley, 2003; Shiao et al., 2007). Although the recommendation after SARS was that institutions maintain adequate PPE supplies in case of another emerging infectious disease, this guideline was not followed (Possamai, 2020). With the advent of COVID-19, hospitals once again faced a severe shortage of PPE (Nie et al., 2020). Although it is reported that the lack of PPE exacerbated the safety and mental health concerns among ER nurses, it is also reported that

less than half of ER nurses believe that the PPE provided by hospitals can offer them any adequate protection (Nie et al., 2020).

Regardless of the effectiveness of PPE, just wearing it creates problems for ER nurses. In Lam & Hung's (2013) study, 60% of participants found that PPE is not 'user-friendly.' One nurse stated that "It is very uncomfortable wearing the PPE… The face-shield is quite troublesome, because there will be vapour on the screen when talking to the patient… The face-shield blocks my voice, I have to speak very loud to get myself heard" (Lam & Hung, 2013, p. 244). This sentiment was magnified by Galehdar et al. (2021), who identified that PPE not only restricts body movements and increases the body temperature of the person wearing it but also creates a feeling of suffocation.

Moreover, ER nurses reported the frustrations of not getting a reprieve from the discomfort of PPE. Due to the potential risk of contamination, nurses were required to keep their PPE on for the duration of their shift, thus negating breaks to eat, drink or go to the bathroom for a full twelve hours (Galehdar et al., 2021).

Workload and Stress. Six articles report that ER nursing workload drastically increases with emerging infectious diseases (Cui et al., 2021; Galehdar et al., 2021; González-Gil et al., 2021; Lam et al., 2013; Lam et al., 2016; Nie et al., 2020).

The increased workload during pandemics results from the increased patient volume, increased intensity of work, and the need to accommodate constantly changing protocols (Lam et al., 2016). Lam & Hung (2013) found that nine of the ten nurses they interviewed described the huge workloads during H1N1 because of the increase in attendance of patients to the ER. Similarly, Galehdar et al. (2021) found that nurses caring for patients with COVID-19 was difficult and exhausting. One of the most challenging tasks for ER nurses during an emerging

infectious disease is the continuous maintenance of the same rigorous standards and high-quality patient care (Lam & Hung, 2013). As such, nurses must cut corners to survive the workload. For example, Lam & Hung (2013) found that increased workload was a primary reason why nurses did not follow infection control measures placed by management.

Along with heavy workloads, nurses are expected to cover many more shifts and take on non-nursing-related duties to cover gaps in the system. In Nie et al.'s (2020) study on the prevalence and associated factors of psychological distress among frontline nurses during the COVID-19 outbreak, it was found that 75.7% of nurses had a change in their regular job duties, and about half of them reported working overtime (p. 4221). Similarly, Galehdar et al. (2021) found that ER nurses have been working 1.5-2 times more than usual.

Moreover, it is reported that during pandemics, nurses are required to work longer hours and take fewer breaks to accommodate the patient surges (Cui et al., 2021; Galehdar et al., 2021; González-Gil et al., 2021). Unfortunately, nurses who take fewer breaks and work more night shifts each week have higher levels of anxiety and stress (Cui et al., 2021). In addition to the decreased ability to take breaks at work, González-Gil et al. (2021) also found that nurses were afforded less time between work periods and therefore did not have enough time to rest or disconnect between shifts.

The increased workload resulting from pandemics has also been shown to lead to physical and psychological distress among ER nurses, and that workload and job stress during pandemics are the most significant influencing factors of ER nurses' burnout (Kim & Choi, 2016; Lam et al., 2013). To reduce the likelihood of burnout or other adverse psychological outcomes, some hospitals have adjusted nursing schedules during the COVID-19 pandemic. By reducing the length of shifts to four or six hours, Nie et al. (2020) found that the work intensity

and psychological pressures were reduced to some extent. Additionally, Cui et al. (2021) found that nurses who served voluntarily were less stressed than those appointed to work.

Moral and Psychological Distress. Moral and psychological distress were examined in nine studies (Choi & Kim, 2018; Cui et al., 2021; Galehdar et al., 2021; González-Gil et al., 2021; Kim & Choi, 2016; Lam et al., 2013; Nie et al., 2020; Ruiz-Fernández et al., 2020; Tham et al., 2004).

As previously discussed, working in the ER during an emerging infectious disease is highly stressful for ER nurses. Exposure to confirmed cases, lack of PPE, fear of infection, feelings of isolation, long work hours, and increased workload can lead to an increase in anxiety, depression, burnout, and Post-Traumatic Stress Disorder (PTSD) (Cui et al., 2021; Kim & Choi, 2016; Galehdar et al., 2021; González-Gil et al., 2021; Tham et al., 2004). In their study on the psychological impact of COVID-19, Cui et al. (2021) found that ER nurses have a higher prevalence of psychological distress than nurses working in other departments due to the continual inflow of patients, the highly infectious nature of the disease, and witnessing increased patients' deaths.

Likewise, data analysis from Galehdar et al.'s (2021) qualitative study revealed that the increase in witnessing patients' deaths – "especially the young ones," was unbearable to ER nurses (p. 173). Before the COVID-19 pandemic, families would be present before, during, and after end-of-life measures. However, to limit the transmission of infection, families were denied visitor access to their loved ones, making it impossible for nurses to meet the psycho-socio-emotional needs of patients and families, thus adding to their own emotional distress (González-Gil et al., 2021).

Recent studies show that 49.95% of ER nurses have responded negatively to the stress related to working during COVID-19 (Cui et al., 2021). Additionally, it has been reported that some nurses have turned to negative coping behaviours, such as using alcohol and drugs to help cope with the psychological burden of working during the COVID-19 pandemic (Nie et al., 2020).

Conversely, some ER nurses have been able to connect strongly with their own intrinsic motivation for caregiving and have gained satisfaction from compassion through actively committing themselves to their patients (Ruiz-Fernández et al., 2020). In their study of 506 physicians and nurses working in COVID-19 units and ERs, Ruiz-Fernández et al. (2020) found that nurses working during the COVID-19 pandemic showed high rates of compassion satisfaction. While this may seem counterintuitive, Ruiz-Fernández et al. pointed out that this may be related to seeing how others benefit from their efforts made nurses feel good. Another reason for these results might be related to the social movement of support and recognition for the work and effort of nurses at the time of data collection (Ruiz-Fernández et al., 2020). This study demonstrate that social support is critical in improving ER nurses' psychological wellbeing during pandemics.

Lost voice. Losing the nursing voice was described in four articles (González-Gil et al., 2021; Lam et al., 2016; Rankin, 2006; Wolf et al., 2016).

It is well documented that during previous outbreaks, nurses have been repeatedly ignored by their employers when raising their concerns. Criticisms of both the SARS pandemic in Toronto and the Ebola pandemic in Dallas found that had hospital administrators listened to ER nurses' concerns; further outbreaks could have been mitigated (Rankin, 2006, Wolf et al., 2016). For example, in Toronto, nurses identified patients with SARS-like symptoms. They

reported it to management and medical staff, who dismissed their concerns, thus leading to the second wave of the pandemic (Rankin, 2006).

Although nurses are the largest group of healthcare workers, nurses are not always invited to participate in debates, discussions, and planning when policies affecting their practice or patient care are being made (González-Gil et al., 2021; Wolf et al., 2016). During the COVID-19 pandemic in Spain, González-Gil et al. (2021) found that nurses perceived that management did not take their opinions into account, were not open to their proposals, and failed to meet their needs. Similarly, during the Ebola outbreak in Dallas, nurses were only invited to participate in discussions surrounding the ethical implications of caring for patients with Ebola after two nurses had fallen ill. The difficulty with not including nurses in pandemic planning is that guidelines made by health administrators are often idealized and impractical (Lam et al., 2016). As one nurse stated: "The planned guidelines could be extremely comprehensive, but once they were to be applied in clinical settings, unexpected flaws and limitations emerged that could only be discovered by frontline staff" (Lam et al., 2106). As such, less experienced nurses' often value the advice of senior nurses over that of health administrators when it comes to how to approach emerging infectious diseases (Lam et al., 2016). Furthermore, nursing's professional code of ethics encourages nurses to collaborate with other healthcare professionals and the public to address the nation's wellbeing (Wolf et al., 2016). As stated by one nurse participant, it is vital to listen to the nursing voice during pandemics to "make damn sure it doesn't happen again" (Rankin, 2006, p. 135).

Summary

While the existing literature offers some understanding of the ER nurses' experience of providing care during pandemics of the 21st century, little is known about the lived experience of

ER nurses providing care during the COVID-19 pandemic in Toronto, Canada. The following research study aims to fill the gap by understanding the lived experience of ER nurses providing care during the COVID-19 pandemic in Toronto, Ontario, Canada. Moreover, this study aims to provide insight into the challenges encountered by ER nurses and serves to inform future nursing education, practice, and research. The narrative inquiry approach permitted a deeper understanding of the stories ER nurses tell and how they make sense of their experiences. As such, this inquiry adds to the limited knowledge of the lived experience of ER nurses providing care during the COVID-19 pandemic in Toronto. In the next chapter, I discuss the methodology and research methods used to carry out this study.

Chapter 3: Methodology and Research Design

This chapter provides an overview of the study's methodology and research design. First, I illustrate the healing power of storytelling and describe how the middle range nursing theory – Story Theory – provided a framework for my research. Next, I position myself as a narrative inquirer and explain how I used a narrative approach to guide my research study. I then discuss the pragmatic paradigm, explaining how this particular worldview framed the project and provided a direction for the inquiry and research process. After, I provide a detailed description of the research methods I used to answer the research questions and discuss the techniques used to ensure the study's trustworthiness. Finally, I conclude this chapter by addressing the ethical considerations.

Storytelling as a Healing Modality

Human beings have long used storytelling to make sense of and provide meaning for their lived experiences (Lee et al., 2016). For thousands of years, the First Nations, Metis, and Inuit communities of Canada have relied on personal narratives and storytelling to transmit knowledge and culture, cultivate personal identity, and provide healing from trauma (Friskie, 2020).

Most commonly, storytelling is used in Indigenous cultures as a sacred method to teach history, values, natural laws, and life skills (Michell, 2015). The intergenerational transmission of knowledge connects youth to the past of their ancestors (Friskie, 2020). As such, oral stories guide how one thinks, relates to another, and takes care of themselves, others, and the natural world (Michell, 2015). It is through this that personal identity is formed. Personal identity develops as individuals integrate their life experiences into an internalized evolving story of the self that provides a sense of unity and purpose in life (Friskie, 2020).

Additionally, the ability to express stories orally or in written form is readily accepted as a means of healing (Tyler, 2007). Many Indigenous writers reference the healing aspects of story. Terry Tafoya, an Indigenous psychologist, explains that from an Indigenous perspective, "stories are a type of medicine and, like medicine, can be healing" (as cited in Episkenew, 2009, p.13). Similarly, Anishinaubae poet, Armand Ruffo, writes that "the need for healing, the need for expression go hand-in-hand" (as cited in Episkenew, 2009, p.14). Furthermore, Indigenous writers explain that to heal from the emotional trauma of past negative experiences, people must write or create a new story or script of their lives. For example, Cree playwright, Oskiniko Larry Loyie, writes that storytelling is "one way for us to deal with the anger that is present amongst us" (as cited in Episkenew, 2009, p.14). Moreover, Muskogee poet, Joy Harjo, writes that "to speak, at whatever the cost, is to become empowered rather than victimized by destruction" (as cited in Episkenew, 2009, p.14).

Although Indigenous cultures have continuously relied on storytelling to make sense of their health and healing, Western cultures cannot say the same. Until recently, western culture did not extend the notion of a story as an acceptable vehicle of healing for adults (Tyler, 2007). However, with a recent rise in spirituality and humanism, Western culture has turned its attention back to more traditional forms of healing and learning, including the art of healing through storytelling (Tyler, 2007). Indigenous storytelling is similar to narrative inquiry; they both incorporate one's reconstructed past, perceived present, and imagined future as a means of acquiring knowledge and achieving personal growth.

Recently, the WHO acknowledged the importance of traditional healing modalities in healthcare (Redvers & Blondin, 2020). In Canada, the recognition and incorporation of traditional healing methods with conventional therapies have become more prominent (Redvers

& Blondin, 2020). However, barriers to blending Indigenous and Western knowledge in healthcare still exist. One barrier is the fear of commoditizing traditional knowledge (Rogers, n.d.). Documenting Indigenous knowledge presents a risk of cultural appropriation and disrespect, as some traditions are considered sacred and not available to outsiders (Rogers, n.d.). Although the Indigenous healing modality of storytelling inspired my desire to use narrative inquiry to discover the lived experience of ER nurses during the COVID-19 pandemic, it is for this reason that I did not attempt to use their traditional ceremonial protocols for my study. Instead, I used the middle-range nursing theory – Story Theory – as a framework to guide my research.

Story Theory

Stories are a fundamental dimension of human interaction (Fitzpatrick & McCarthy, 2014). Stories bind people to people, events to other events, and times to other times (Smith & Liehr, 2014). They allow people to make sense of their experiences and interpret their past in terms of these stories (Clandinin, 2019; Lee et al., 2016). Additionally, stories have the potential to heal (Fitzpatrick & McCarthy, 2014). While caring for patients, nurses listen to the stories of patients and then use those stories to elicit positive health outcomes (Fitzpatrick & McCarthy, 2014; Lee et al., 2006). The purpose of Story Theory is to describe and explain story as a foundation for the nurse-person health-promoting process in practice and data gathering and analysis in research (Smith & Liehr, 2014).

Origins of Story Theory

Developed in 1999 by Mary Jane Smith and Patricia R. Liehr, Story Theory is a middle-range nursing theory with a wide application for nurses, both in clinical practice and research. Based on their individual work (and a serendipitous meeting at a nursing conference that led to

the discussion of the importance of story in promoting health and human development), Smith and Liehr recognized the need to articulate a theory using 'story' as the context for guiding practice and research (Smith & Liehr, 2014). They describe story as a narrative happening of connecting with self-in-relation through internal dialogue to create ease (Smith & Liehr, 2014).

Core Assumptions

The core assumptions of the theory are that persons:

> 1) change as they interrelate with their world in a vast array of flowing connected dimensions, 2) live an expanded present where past and future events are transformed in the here and now, and 3) experience meaning as a resonating awareness in the creative unfolding of human potential (Smith & Liehr, 2014, p. 229).

Core Concepts

The basis of Story Theory focuses on the nurse meeting with a patient who is faced with a developing health issue. The nurse's goal in meeting with the patient is to help the patient resolve the health issue by sharing their stories (Fitzpatrick & McCarthy, 2014). To do this, the nurse and patient must work together through three interrelated concepts: 1) intentional dialogue, 2) connecting with self-in-relation, and 3) creating ease (Smith & Liehr, 2013).

Intentional Dialogue. Intentional dialogue is the "purposeful engagement of a nurse with another to summon the story of a complicating health challenge" (Smith & Liehr, 2014, p. 230). The conversation is directed towards the nurse engaging the other person to talk about their life experiences to begin the process of transforming oneself (Fitzpatrick & McCarthy, 2014). This process demands that the nurse abandon any pre-existing assumptions, respect the storyteller as the expert, and only ask questions when clarification is required (Smith & Liehr, 2005). By focusing on the person and paying close attention to the unfolding story, both the nurse and

person realize who they are (Fitzpatrick & McCarthy, 2014). The nurse begins to understand the story from the other's perspective, identifies patterns, and helps the storyteller see potential meaning in the stories told (Fitzpatrick & McCarthy, 2014).

Connecting with Self in Relation. Connecting with self in relation is "the active process of recognizing self as related with others in a story plot" (Smith & Liehr, 2014, p. 231). This concept has two components: personal history and reflective awareness (Fitzpatrick & McCarthy, 2014). Personal history is the story told when the storyteller reflects on who they are, where they have been, and where they are going (Fitzpatrick & McCarthy, 2014; Smith & Liehr, 2014). The nurse's role is to help the person tell their story and make sense of it (Fitzpatrick & McCarthy, 2014). By venturing into and following the story's path as recollected by the storyteller, the nurse invites the person to discover the unique meanings that often lie in what appears as dilemmas. The person's sense of self is affirmed in recognizing and accepting faults and strengths and understanding how one has lived and how one envisions one's future (Smith & Liehr, 2014).

Additionally, reflective awareness involves being in touch with one's thoughts, feelings, and bodily experiences (Fitzpatrick & McCarthy, 2014; Smith & Liehr, 2014). It relates to being in touch with one's place in the world, and more concretely, being in touch with the moment. During this self-reflection, the storyteller becomes aware of how their body feels in that moment, recognizing their feelings for what they are, but not letting that feeling define who they are (Smith & Liehr, 2014). As the nurse guides the storyteller through this process, the storyteller becomes present with what is known and unknown, allowing unrecognized meaning to surface (Smith & Liehr, 2014). For example, an ER nurse states that she is angry at civilians who do not seem to take the COVID-19 public health safety measures seriously. However, by sharing her

stories of working with COVID-positive patients, the nurse may realize that she is sad that she witnessed patients die from the disease. She may also realize that she is fearful of contracting the disease herself or inadvertently infecting her loved ones through working with COVID-positive patients.

Meaning often changes when the unknown comes to light in an expanded present moment with coherence and integration (Smith & Liehr, 2014). As this occurs, ease and trust are established (Fitzpatrick & McCarthy, 2014).

Creating Ease. Creating ease is the "ease experienced as the story comes together in a movement toward resolving" (Smith & Liehr, 2014, p. 232). The two dimensions of creating ease are remembering disjointed story moments and flow in the midst of anchoring. Remembering disjointed story moments connects events in time, as health story fragments sort and converge into a meaningful whole (Smith & Liehr, 2014). As the story unfolds, the nurse helps the person illuminate the issues, values, ideas, and context, uncovering the meaning of the life experience (Smith & Liehr, 2014). Flow is "an experience of dynamic harmony," and anchoring is "an experience of comprehending meaning" (Smith & Liehr, 2014, p. 233). As patterns are discovered, named, and made explicit, anchoring and flowing coincide.

As disjointed stories come together, a whole story surfaces, encompassing moments of juxtaposed realities that characterize every whole story. No story is one-sided. During the COVID-19 pandemic, the ER nurse experiencing fear and isolation may also be experiencing acceptance and connectedness by working as a team to help others. When story sharing becomes a vehicle for healing, embracing the story happens. Embracing the story releases the storyteller from the confines of a disjointed story where story moments are scattered, making it difficult to

discern a plot. Through discerning the plot, ease ensues and makes human development possible (Smith & Liehr, 2014).

Story Theory and Qualitative Research

Stories are the substance of qualitative research. As such, traditional approaches to qualitative research, such as narrative inquiry, can be used when synthesizing stories gathered with the guidance of story theory (Smith & Liehr, 2014). Clandinin and Connelly (2000) propose narrative inquiry as a research methodology when the researcher wishes to understand the lived experience in a social context over time.

Narrative Inquiry

As previously mentioned, narratives are a fundamental and universal mode of human expression (Holloway & Freshwater, 2007). Historically, narrative has been acknowledged in nursing practice to acquire knowledge and understand the patient experience (Joyce, 2015). More recently, narrative has also been used as a qualitative research method, which "aims to interpret the meaning people attribute to their world and gain an understanding of it" (Joyce, 2015, p.36). Essentially, narrative research is concerned with studying and thinking about stories told. As such, the narrative research approach is well-suited in a nursing context.

The word 'narrative' comes from the Latin word '*gnarus*,' meaning knowing, while 'story' comes from the Greek and Latin word '*historia*,' which also means knowing as an account of events (Holloway & Freshwater, 2007). The terms' narrative', 'story' and 'storytelling' are often used synonymously by researchers who seek to gain understanding through listening to participants' stories (Holloway & Freshwater, 2007; Joyce, 2015). Clandinin and Connelly (1990) clarify this as: "Narrative refers to the making of meaning through personal experience by

way of a process of reflection in which storytelling is a key element and in which metaphors and folk knowledge take their place" (as cited in Holloway & Freshwater, 2007, p5.).

Similarly, 'story,' 'narrative,' and 'plot' are closely related and are often confused and conflated in the literature (Holloway & Freshwater, 2007). Although these three aspects of narration blend together in a pleasing way, they are fundamentally different (Holloway & Freshwater, 2007). 'Story' is "all the events which are to be depicted" or, more simply put, the 'what' of the narrative (Holloway & Freshwater, 2007, p.10). 'Plot' is the "circumstances that bring the character to life through a specific series of events" or the chain of causality that creates meaning (Holloway & Freshwater, 2007, p.10). Finally, 'narrative' is the "showing or the telling of these events and the mode selected for that to take place" (Holloway & Freshwater, 2007, p.10).

Narrative Inquiry as a Research Methodology

Narrative is a multi-faceted concept that is difficult to define (Joyce, 2015). In storytelling, the participants' story is told in several ways. Therefore, narrative is a complex term that may relate to the research method, the phenomenon and process, or just the phenomenon of interest (Joyce, 2015). Narrative may refer to the participant telling their story or may refer to the story being told; it is a unique research method and a means of delivering an individual's story (Joyce, 2015).

Narrative is socially constructed and may be personal and focus on the individual or may be used to narrate stories to explain behaviours and context (Joyce, 2015). It is important to note that narrative research does not necessarily reveal the plot in sequence. Since narrative concerns the events deemed critical to the storyteller, the storyteller may be selective in their choice of events, emphasizing certain aspects over others when retelling their story (Joyce, 2015; Wang &

Geale, 2015). While the presentation of narrative is generally linear (beginning at a particular place and moving forward logically with a beginning, middle, and an end), the story is shaped by the storyteller in a way that is logical and meaningful, both to themselves and their respective audience (Connelly & Clandinin, 1990; Holloway & Freshwater, 2007; Joyce, 2015). In other words, the narration may not precisely match the sequence of events that occurred in real-time. However, through the telling and retelling of stories, individuals can make sense of their experiences.

Narrative researchers help facilitate this process by inviting individuals to tell their stories and by listening to them. Although stories may develop as a self-narrative with no input from the listener, it is essential to note that the stories told may be constructed with the researcher as the researcher asks questions (Joyce, 2015). In this sense, the researcher collaborates with the participant, helping them develop both an understanding and meaning of their experiences. Furthermore, it is the meaning participants make of their experiences that narrative researchers interpret (Joyce, 2015).

Narrative inquiry is a way of understanding experience "through collaboration between the researcher and participants, over time, in a place or series of places and in social interaction with milieus" (Clandinin and Connelly, 2000, p. 20). Clandinin and Connelly frame narrative inquiry within what they refer to as a three-dimensional space - temporal, social, and place– and ascertain that attending to experience through inquiry into all three commonplaces is what distinguishes narrative inquiry from other methodologies (Clandinin & Connelly 2000; Clandinin & Huber, 2010; Hutchinson, 2015). Through attending to the commonplaces, narrative inquirers can study people's lived experiences and imagine the future possibilities of these lives (Clandinin & Huber, 2010).

Temporality. Temporality is central to narrative research. It reminds us that experiences cannot be seen in isolation and that each experience has a past (a look backward to remembered experiences), present (a look at recent experiences, feelings, and stories related to an event), and future (a look forward to implied and possible experiences) (Clandinin & Huber, 2010; Wang & Geale, 2015). As participants situate their experiences in time, they integrate them into the ongoing narrative of their lives. Additionally, there is a temporal flow of experience and its meaning. Therefore, the meaning and interpretation that participants give to their experiences may change with time. As narrative inquirers, we do not predict or determine what experiences the participants may follow but recognize that multiple futures are possible (Hutchinson, 2015).

Furthermore, Clandinin and Connelly (2000) remind us of the temporal nature of our own research experience. As researchers, we enter the participants' lives amid living their stories and must remember that both researcher and participant existed before the study and will continue afterward (Hutchinson, 2015).

Sociality. Narrative inquirers attend to both personal (internal) and social (external) conditions that influence each experience (Clandinin & Huber, 2010; Hutchinson, 2015). Personal condition refers to feelings, hopes, desires, aesthetic reactions, and moral dispositions, while social condition refers to the cultural, social, institutional, and familial environment in which people's experiences are unfolding (Hutchinson, 2015).

Also included in this social commonplace is the inquiry relationship between the inquirer and the participants. Narrative inquirers cannot subtract themselves from the inquiry relationship and must recognize and embrace the subjective reality inherent in the process (Wang & Geale, 2015). As such, narrative inquirers must reflect inward and outward throughout the research

process and document these findings in researcher journals or as interim texts in their field notes (Clandinin & Connelly, 2000).

Place. Clandinin and Connelly (2006) refer to place as "the specific concrete, physical and topological boundaries of place where the inquiry and events take place" (as cited in Hutchinson, 2015, p.14). The physical environment and locations in which the events occur are essential to provide context to the storied experiences. Stories nested within 'place' help construct meaning around a place, experience, and people (Hutchinson, 2015). Therefore, researchers and participants cannot understand or ascribe meaning to an experience without knowing the context in which it occurred.

Pragmatism

Pragmatism and social constructivism are the two paradigms embedded within narrative inquiry. Both pragmatism and social constructivism's epistemological and ontological underpinnings are based on the assumptions that multiple truths exist, and that knowledge is derived from personal experiences, and there is personal meaning within those experiences (Creswell, 2013; Doane & Vargo, 2005; Holloway & Galvin, 2017). However, pragmatism takes this a step further. Pragmatism converts knowledge into action. Given that the purpose of my study is not only to describe, interpret, and understand the thoughts, feelings, and problems facing ER Nurses in Toronto during the COVID-19 pandemic, but also to look for instructional messages and develop solutions to problems for future pandemics, I believe that my research is better suited to the pragmatic paradigm.

Origins of Pragmatism

The term pragmatism is "derived from the Greek word meaning action, from which the words 'practice' and 'practical' also come" (Doane & Varcoe, 2005, p. 82). Pragmatism

developed out of the work of Charles Pierce, William James, and John Dewey. It first emerged as a philosophical movement in the 1870s in the post-civil war United States of America (Younas, 2020). Pierce, an experimental scientist, is "widely recognized as the founder of the ideology" (McCready, 2010, p. 193). His initial writings focused on "theorizing the logics of inquiry and articulating the important role of clear articulation of concepts and thoughts and their application in the actual world" (Younas, 2020, p. 2). Although Pierce is recognized as the founder of what would later become pragmatism, James is credited with its name and popularization (McCready, 2010). James, a psychologist and medical doctor, reintroduced and expanded upon Pierce's ideology in 1898, focusing on what pragmatic beliefs might mean for individuals confronted with difficult personal and philosophical dilemmas (McCready 2010). Dewey, a psychologist and philosopher, further developed this ideology emphasizing the social, political, and educational aspects of pragmatic thought (Morgan, 2014). He looked to human experiences as the means of resolving the philosophical debate, rather than abstract truths (Morgan, 2014). Dewey's version of pragmatism focuses on the experimental inquiry for practical applications (Morgan, 2014).

Pragmatism in Nursing, Healthcare and Research

Pragmatism is not committed to any one system of philosophy, truth, or reality (Creswell, 2013). It accepts single or multiple realities derived from or guided by experience or experiment (Doane & Vargo, 2005). Instead of asking the question 'is it true?' pragmatism asks, 'what difference does it make?' (Doane & Vargo, 2005, p. 82). For a practice-based discipline like nursing, this question is imperative. The goal of nursing is to care for and improve the health of others. By allowing nurses to critically reflect on existing practices, explore factors affecting practice, generate research problems from experiences, and develop actions and approaches to

addressing them effectively, pragmatism can be seen as a philosophical tool for addressing and solving problems in actual practice (Kaushik & Walsh, 2019; Younas, 2020).

In today's complex healthcare environment, evidence-based nursing knowledge development is needed to guide practice and move the profession forward. Nursing research creates new knowledge or truths in order to improve nursing practice and is often referred to as 'evidence-based' practice. It is important to note that 'evidence' is determined by that which is 'best-available' at the time. The concept of 'best-available' is similar to the pragmatic belief that "reality can ever be determined once and for all" (Kaushik & Walsh, 2019, p. 3) and that "truth is what works at the time" (Creswell, 2013, p.28). Truth is considered fallible and is only considered truth when it works best (McCready, 2010). With pragmatic philosophy, knowledge is understood as being constructed based on the reality of the world we experience and always occurs in social, historical, and political contexts (Creswell, 2013; Nowell, 2015). Therefore, knowing, in a complex reality such as nursing work environments, requires multiple perspectives to be considered (Nowell, 2015). Additionally, pragmatic researchers have the freedom to choose their methods, techniques, and procedures that will best address the problem being studied and the questions being asked about the problem (Creswell, 2013). As such, pragmatism as an approach to research inquiries is favourable when addressing nursing concerns in an ever-changing healthcare environment.

Pragmatism and Narrative Inquiry

Narrative inquiry is an approach to research that encompasses many, if not all of the principles of Deweyan pragmatism (Clandinin, 2019). In fact, Clandinin and Connelly define narrative inquiry as "an approach to the study of human lives conceived as a way of honouring

lived experience as a source of important knowledge and understanding" (Clandinin, 2019, p. 219), inspired by Dewey's pragmatic understanding of experience (Clandinin, 2019).

Dewey's Concept of Experience. Throughout his career, Dewey promoted pragmatism by turning away from the abstract concerns of the philosophy and instead reoriented it towards emphasizing human experience (Morgan, 2014). For Dewey, human experience was based around two key questions: "What are the sources of our beliefs? And, what are the meanings of our actions?" (as cited by Morgan, 2014, p. 1046). From Dewey's point of view, these two questions are linked together in that we reflect on our beliefs to choose actions and then reflect on our actions to choose our beliefs (Morgan, 2014). In this sense, experiences create meaning by bringing beliefs and actions together. Additionally, Dewey argued that experiences always have an emotional element, in which feelings provide the link between beliefs and actions (Morgan, 2014). From this perspective, feelings are often both the source and outcome of a human experience. Unfortunately, using feelings as a description for experience alone can make it seem as though experiences are individualistic (Morgan, 2004). For Dewey, experiences are also shaped by others, and therefore are always social (Morgan, 2014).

Ontological and Epistemological Commitments. Drawing on Dewey's concept of experience helps make visible the ontological and epistemological stance of narrative inquirers.

Dewey believed that:

> In an experience, things and events belonging to the world, physical and social, are transformed through the human context as they enter, while the lived creature is changed and developed through its intercourse with things previously external to it (cited in Clandinin, 2019, p. 216).

As such, Dewey's philosophy of knowledge relies on a problem-based approach, in which inquiry is the defining process (Morgan, 2014). As Clandinin and Rosiek (2007) note Dewey's ontology is not transcendental but rather transactional with revolutionary epistemological implications. They describe transactional ontology as one in which:

> the regulative ideal for inquiry is not to generate an exclusively faithful representation of a reality independent of the knower. The regulative ideal for inquiry is to generate a new relation between a human being and her environment – her life, community, world – one that "makes possible a new way of dealing with them, and thus eventually creates a new kind of experienced object, not more real than those in which preceded but more significant, and less overwhelming and oppressive" (Dewey, 1981b, p. 175). In this pragmatic view of knowledge, our representations arise from experience and must return to that experience for validation (p.39).

Dewey's pragmatic approach highlights that we interact with the world in order to know the world. Similarly, Clandinin and Rosiek (2007) present narrative inquiry as a means of seeing the world and exploring experiences through the narrative process. Specifically, "narrative inquirers study an individual's experience in the world and, through the study, seek ways of enriching and transforming that experience for themselves and others" (Clandinin & Rosiek, 2007, p.42). Viewed in this way, we can see that the pragmatic ontology of experience is a fitting framework for narrative inquiries and that narrative inquiry is, in essence, a pragmatic methodology.

Research Methods

Research Setting

The study took place in Toronto, Ontario, Canada. This geographical location was chosen for three reasons: first, Toronto was the site of the first COVID-19 positive patient in Canada, second, Toronto was identified as a 'hotspot' for COVID-19 positive cases in Ontario (Covid-19 in Ontario, n.d.), and third, Toronto nurses had already faced the SARS epidemic of 2003.

Research Participants

Participants were selected through purposive sampling. Purposive sampling is a non-probability sampling method where the researcher deliberately chooses participants according to the study requirement (Polit & Beck, 2008). In selecting participants, representative and productive individuals are invited to enhance the diversity and richness of captured information (Polit & Beck, 2010). Thus, participants of different characteristics such as age and work experience are chosen by the researcher to establish a wide range of information.

Individuals were considered eligible if they:

1) are employed as a Registered Nurse (RN) in Toronto, Ontario, Canada

2) consider the ER as their primary place of employment

3) are directly involved in the care of suspected or positive COVID-19 patients, and

4) worked for a minimum of one year during the COVID-19 pandemic.

Exclusion criteria included:

1) nurses who did not work in the ER in a "frontline" capacity, i.e., Nurse Educators, Advanced Practice Nurses, managers, during the COVID-19 pandemic, and

2) those who worked less then one year during the COVID-19 pandemic.

Recruitment Strategy

Recruitment for this study began after the University of Ottawa's Office of Research Ethics and Integrity had granted ethics approval (see Appendix E). ER nurses in Toronto were

recruited by members of the research team, who presented the study through the online social media platform, Facebook © (see Appendix F for a copy of the recruitment poster). The recruitment poster directed potential participants to contact the researcher.

Following an expression of interest, I contacted each individual to ensure that they met the inclusion criteria. The eligibility criteria were listed on the recruitment poster linked to the Facebook © posting. Ineligible participants were notified as such. After confirming eligibility over email, I sent interested participants an additional information letter providing details about the study to provide potential participants an opportunity to review the study. In my information letter, I included the research question around which the initial conversation would be molded: Can you tell me your story, the events, and experiences of working as an ER nurse during COVID-19 that are important to you? The letter also explained the purpose, significance, time commitment, and voluntary nature of the study. Potential harms and benefits of participating in the study and assurance confidentiality were also included. (Please see Appendix G for a copy of the information letter).

I invited participants who continued to express interest to set up a brief telephone call to discuss the study, answer any questions, and obtain informed consent. I asked participants their preferred method of obtaining a physical copy of their consent form. All participants chose email to receive their consent forms. (Please see Appendix H for a copy of the consent letter). Once consent was obtained, I arranged for the participant's first in-depth interview. The recruitment process was repeated until the desired sample size was achieved.

Sample Size Determination

For qualitative research, no absolute rules determine the number of participants. Recruitment should continue until data are saturated with recurrent ideas yielded and no new

information is anticipated (Polit & Beck, 2010). Many narrative studies only examine one-to-two individuals. For this study, I recruited three ER nurses in Toronto to allow for a robust understanding of the lived experiences of ER nurses in Toronto during the COVID-19 pandemic.

Data Collection Methods

Interviews. Once consent had been obtained from participants, I organized and conducted two individual in-depth interviews with each participant. Each interview lasted approximately one hour. Due to the COVID-19 pandemic restrictions, interviews were conducted over the secured video conferencing platform Zoom ©. As such, participants could choose a location suitable to their needs to partake in the virtual conversations.

Interviews were recorded using Zoom's © recording capability. Video recordings helped me obtain accurate conversational data (verbal and non-verbal) with complete wordings from participants (Polit & Beck, 2008). Recording was paused as necessary to allow for participant breaks. Although participants were informed that they could turn off their video feed, all participants chose to keep their video feed on throughout the interviews. Likewise, participants were informed that they could refrain from answering questions that they did not wish to discuss, however, each participant chose to openly answer all questions.

The initial interviews followed an unstructured format. During this time, I invited each participant to share their story about working in the ER during the COVID-19 pandemic. I asked each participant the following open-ended question: Can you tell me your story, the events, and experiences of working as an ER nurse during COVID-19 that are important to you? This question lead to subsequent questions based on the stories shared.

The unstructured interview format allowed each participant to fully express their personal stories, beliefs, and feelings (Polit & Beck, 2017). In Narrative inquiry, the researcher's role is to facilitate the conversation rather than ask leading questions (Clandinin & Huber, 2010). By inviting the participants to 'tell their stories', the participants themselves decided which events and experiences were of most importance to them (Joyce, 2015). The participants were provided with the initial question in advance of the interviews via electronic mail to allow them time to reflect and prepare.

Each participant was interviewed on two separate occasions. The second interview allowed for both the verification of the preliminary interpretation of the original interview by participants, and for a deeper exploration of the narrative from the first interview. The second interviews were held approximately three months following the initial interviews. The timeline of subsequent interviews was twofold: 1) to provide sufficient time to transcribe the initial interview, review the accuracy of transcription with my research supervisor and complete an initial interpretation of the data findings; and 2) to accommodate the participant's schedules. The second interview followed a semi-structured style to allow for follow-up discussion. Questions during the second interview were tailored to each participant to explore previous discussions further and clarify any misconceptions.

Field Notes. "Field texts assist memory to fill in the richness, nuance, and intricacy of the lived stories and the landscape" (Clandinin & Connelly, 2000, p. 80). As such, field notes were recorded before, during and after the interviews detailing observations from informants' physical expressions and gestures to enhance exploration of the participant's verbal and non-verbal information. Additionally, field notes were used to document my feelings of sadness, fear, anger, and excitement. Field notes were used when transcribing the interviews and analyzing the

participant's stories to help provide a detailed description of the participant's experiences and perceptions of working in the ER during the COVID-19 pandemic.

Participant Journals. Upon completion of the initial interview, I provided each participant a journal with instructions. Journals were mailed to the participants to maintain social distancing. The journal instructions encouraged the participants, if they chose, to use their journal to record any emerging thoughts, feelings, memories, or stories about their work experiences during the COVID-19 pandemic (See Appendix I). The journal was not mandatory but rather an optional source for participants to share their reflections. Although one participant made a few notes to discuss during their subsequent interview, all three refrained from documenting in the provided journals.

Researcher Journals: Reflexive and Process. Throughout the entire research process, I documented journal entries in a researcher's journal. The researcher journal served as a source of reflexivity by documenting my personal assumptions, thoughts, and feelings about the stories told. Moreover, by detailing my emerging thoughts and interpretations, the researcher journal assisted in data analysis while supplementing the audit trail. A process journal was also created to document decisions made throughout the research process.

Data Management

Each participant was offered the use of a pseudonym to assign to their narrative. Pseudonyms were used to protect the privacy of each participant and their institutions by association (Polit & Beck, 2021). I did not write or disclose the participants' names in any of the information collected.

Participant interviews were transcribed verbatim by the primary researcher into a Microsoft Word electronic document. Electronic documents were stored on the researcher's

password-protected computer and onto an encrypted USB for backup. The hardcopies of the consent forms, research documents, researcher notes, and the encrypted USB are stored in a locked filing cabinet in the researcher's personal locked office. Consent forms completed electronically were sent to the researcher via electronic mail and were saved on the secure University of Ottawa network in a password protected folder. Only the researcher, thesis supervisor, and committee members have access to the information collected.

Upon completing the research project, all data stored on the researcher's computer will be deleted, and print copies of materials will be destroyed using a professional confidential shredding service. One encrypted USB with all study-related materials will be kept in a locked filing cabinet in the thesis supervisor's office at the University of Ottawa School of Nursing building for five years.

Data Analysis

Narrative analysis was used as the method of analysis for this study. Narrative analysis is "the procedure through which the researcher organizes the data elements into a coherent developmental account" (Polkinghorne, 1995, p.15). In this type of analysis, the researcher's task is "to configure data elements into a story that unites and gives meaning to the data as contributors to a goal or purpose" (Polkinghorne, 1995, p.15). The process in discussed below.

Analysis of Initial Interview and Preparation for the Second Interview. Qualitative data derived from the in-depth interviews was independently transcribed verbatim. After each transcription, the transcript was checked against video recordings and field notes to ensure correctness. Corrections were made to the transcripts as needed to ensure accuracy. To reinforce the accuracy of the transcripts, as well as maintain trustworthiness throughout the data analysis process, video recordings and transcriptions were sent to my research supervisor for checking

and advice. Afterward, I watched the video recordings, noting verbal tone and nuances not accessible in the transcripts. Significant observations from participants' physical expressions and gestures were noted in the researcher's journal and comments added to the transcripts.

Comments made to the interview transcripts were tracked and used as interim texts. Additional analysis documents and interpretive notes were also saved as interim texts. Interim texts are notes built into the inquiry process and serve to facilitate the trustworthiness of the data by providing an audit trail and assisting in further inquiry and discussion (Clandinin & Connelly, 2000. Polit & Beck, 2021).

I began my initial analysis by reviewing the study questions, research aims, and purposes. The purpose of this step was to ensure the achievement of study goals and to avoid distractions from other interesting but unrelated narratives. Next, I immersed myself in the transcripts, drawing out the narratives that aligned with the study's aim and purpose.

Two narrative analysis approaches were employed: 1) organization of the data chronologically; and 2) organization of the data into the three narrative dimensions (temporal, social, and place). Arranging the data chronologically helped organize the stories and identify gaps that required further exploration in my second interview. Moreover, organizing the data into the three narrative dimensions allowed for the preliminary interpretation of the data. Interpretive notes were made in the researcher's reflexive and process journals.

Data from the initial conversations was used to inform questions for the second interview, and allowed for the expansion of details and reflections of the stories presented in the initial conversation.

Second Interview Analysis and Merging Transcripts. The process of the initial interview transcription was repeated for the second interview. Narrative analysis was completed

once again, organizing the data into chronological and the three narrative dimensions. Next, I merged and integrated the data from the two interviews into a single file that resembles a plot, possessing a beginning, middle, and an end.

Individual Narratives. The next step in narrative analysis is creating an account of each participant's narrative. Clandinin & Connelly (2000) ascertain that narrative inquiry aims to give voice to the participants and provide meaning to their individual experiences. As such, each participant's narrative account was written as an individual chapter, using direct quotes from their interviews, interwoven with my interpretive meanings.

Inclusion of Grace Notes. A brief note titled a 'grace note' was included after each participant's story chapter. Merriam-Webster's (2022) online dictionary defines grace notes as "a small addition or embellishment." Each grace note was written to reflect the personal impact each participant's narrative had on me as the researcher and included an expression of gratitude and appreciation. Each grace note is comprised of four components: the critical lesson or lasting impression that emerged from their narrative, their strength or most admirable quality, my wish for them, and a quote that summarizes their story.

Narrative Threads. After the individual narratives were told, I identified the narrative threads that emerged across all participants' narratives. A discussion of the narrative threads concluded the analysis of cohesions drawn from my interpretation of participants' stories.

Trustworthiness

Trustworthiness is a criterion that constitutes rigour in qualitative research (Long & Johnson, 2000). Narrative inquiry is a form of qualitative research that is based on the epistemological assumption that reality is subjective and dependent on context. As such, narrative inquirers need to ensure that the re-told narratives of each participant accurately reflects

the participant's experiences and perceptions. According to Lincoln and Guba (1985), trustworthiness is offered in qualitative research by four criteria: credibility, dependability, confirmability, and transferability.

Credibility. *Credibility* refers to the "confidence in truth of the data and interpretations of them" (Polit & Beck, 2021, p. 569). Lincoln and Guba (1985) point out that credibility involves two aspects: carrying out the study to enhance the believability of the findings and taking steps to demonstrate credibility in research reports. Demonstrating credible work was assured by the following four concepts: relevance, triangulation, peer review, and member-checking (Long & Johnson, 2000).

Relevance. *Relevance* is the "evidence that [something] is important to key stakeholders and has the potential to be actionable" (Polit & Beck, 2021, p. 701). As described in the purpose of the study and evidenced by the literature review and problem statement, understanding the lived experience of ER nurses during the COVID-19 pandemic is both meaningful to the participants who want their stories to be shared and relevant to the nursing profession by potentially informing future pandemic preparation and nursing support.

Triangulation. *Triangulation* is the "use of multiple referents to draw conclusions about what constitutes truth" (Polit & Beck, 2021, p. 572). Triangulation was achieved during this study using various sources of data, including follow-up interviews, field notes, and researcher journals.

Peer review. *Peer review* is an external review that involves sessions with peers to review and explore various aspects of the inquiry (Long, & Johnson, 2000; Polit & Beck, 2021). Peer review was achieved by continuously debriefing with my thesis supervisor. Data analysis and

interpretation was reviewed and discussed with both the thesis supervisor and committee members.

Member-checking. In member checking, researchers provide feedback to the participants about the study, emerging threads, and researcher interpretations to elicit the participant's reactions (Long & Johnson, 2000; Polit & Beck, 2021). If the researcher's understandings and interpretations are accurate representations of the participants' experiences, they will confirm their legitimacy (Polit & Beck, 2021). Member-checking was accomplished by conducting a second interview with individual participants. During the second interview, the preliminary interpretation of the original interview was verified by participants. Following the second interview, I invited each participant to read and provide feedback on their written narrative account.

Dependability. *Dependability* refers to "the stability or reliability of data over time and conditions" (Polit & Beck, 2021, p. 569). In simple terms, dependability can replicate research findings with similar participants in a similar context. The best way to ensure dependability is through compiling an audit trail (Long & Johnson, 2000; Holloway & Galvin, 2017). A documented description of both the process and rationale for decision-making throughout the research process was kept. The research supervisor conducted audits of the transcriptions of the interviews to confirm accuracy. Additionally, all work was reviewed by each member of the research committee.

Confirmability. *Confirmability* refers to "objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning" (Polit & Beck, 2021, p. 570). Confirmability ensures that the data represents the participants' viewpoints, not the interpretation of the data invented by the researcher (Polit & Beck, 2021).

Personal assumptions, knowledge, and experiences, and how those may affect the study was addressed in my reflexivity statement. Furthermore, a reflective journal was kept throughout the entire research process to allow for continual reflection of personal feelings. Additionally, a process journal was kept throughout the study. The process journal contained notes, study decisions and rationale, and served as an audit of choices made throughout the study (Holloway & Galvin, 2017).

Transferability. *Transferability* is "the potential for extrapolation, i.e., the extent to which findings can be transferred to or have applicability in other settings or groups" (Polit & Beck, 2021, p. 570). In narrative inquiry, transferability is achieved by providing comprehensive descriptions of the study methods and findings so that someone interested in making a transfer can conclude whether a transfer is possible (Long & Johnson, 2000; Polit & Beck, 2021). Although the research process was made explicit in the thesis, the findings from the research study represent experiences specific to each participant. Therefore, rich detail was provided to allow others the opportunity to determine whether findings are meaningful and applicable to similar contexts.

Ethical Considerations and Dissemination of Study Results

Ethics approval was obtained from the Research Ethics Board at the University of Ottawa. Data collection commenced only after ethical approval from the university had been granted. Written consent was obtained from each participant before their first in-depth interview. At the beginning of each interview, the participants were reminded of the purpose of the study. Additionally, they were reminded that their participation is voluntary and can be withdrawn at any time. Each participant was provided with the researcher and supervisor’s contact information and encouraged to reach out if they had any questions or concerns.

Confidentiality was strictly kept throughout the research process. Storage and access to the participants' information was restricted to the researcher and research committee. Personal identifiers were omitted from all research documents. Data will be stored for five years on an encrypted device that will be securely locked in the thesis supervisor's office at the University of Ottawa. Participants were informed via the information letter of the steps that were taken to maintain their confidentiality. (Please see Appendix F for a detailed outline of steps taken to maintain participant confidentiality).

Participants were also made aware via the letter of information that a report would be written at the end of the research study, and that the results may be published in peer-reviewed journals or presented at conferences.

Chapter Summary

In this chapter I provided an overview of the methodology of narrative inquiry and provided a detailed description of the research methods used in this inquiry. I also described how I addressed the ethical considerations and attended to the study's trustworthiness.

In the following three chapters, I present the research findings as individual narratives. Each participant's narrative has a dedicated chapter in keeping with the narrative approach. Participant stories are retold using a combination of direct quotes from the participants' interviews and my interpretations of the stories told.

Chapter 4: Pandora's Story

Pandora: Participant One's Alias

The name Pandora means 'the one who bears all gifts' and is derived from the Greek words *pan* meaning 'all' and *dora* meaning 'gift' (Hard, 2019). Pandora was the first mortal woman on earth and was created by the gods on the instructions of Zeus (Dougherty, 2016; Hamilton, 1942; Pandora's Box, n.d.). She was created as a punishment to mankind after receiving the stolen gift of fire from Prometheus (Dougherty, 2016; Hamilton, 1942; Pandora's Box, n.d.).

According to Greek mythology, Prometheus and his brother Epimetheus were Titans whom Zeus spared imprisonment after switching sides during Titanomachy (the battle between the Titans and Olympian Gods led by Zeus to gain control of the heavens) that rendered the Olympians victorious (Garland, 2020; Prometheus, n.d.). Following Zeus' orders, Prometheus created humans and animals, and both Epimetheus and Prometheus were given the task of bestowing them with gifts to survive and prosper (Dougherty, 2006; Prometheus, n.d.). Epimetheus liberally spread gifts of swiftness, strength, fur, and wings to the animals, running out of gifts by the time they had gotten to mankind (Greek Mythology, n.d.; Prometheus, n.d.). As a result, Prometheus decided to make man stand upright as the gods did and gave them fire (Greek Mythology, n.d.).

When the Olympian gods and humans ceased to associate directly and eat together, Zeus decreed that mankind would sacrifice animals to the gods and share the meat with them without meeting face to face (Greek Mythology, n.d.; Hard, 2019). While the humans and gods argued over the matter at Mecone, Prometheus settled the dispute favouring the humans by deceiving Zeus (Greek Mythology, n.d.; Hard, 2019; Prometheus, n.d.). Prometheus sacrificed an ox and

then separated the flesh into two piles, one with bones covered in juicy fat and the other with the good meat hidden in the ox's stomach to look unappealing (Greek Mythology, n.d.; Hard, 2019). As Prometheus bade Zeus to pick a pile, Zeus reached for the more appealing pile of bones, thus condemning the gods to receive the worse share of animal sacrifices forever (Greek Mythology, n.d.; Hard, 2019). Angered by the deception, Zeus withheld the gift of fire from man (Greek Mythology, n.d.; Hard, 2019). Once again, Prometheus came to the aid of humanity, stealing fire from the gods and giving it to them (Greek Mythology, n.d.; Hard, 2019; Prometheus, n.d.). Enraged by this mockery, Zeus decided to take revenge and get even with men and Prometheus.

Zeus ordered Hephaestus to create a woman that would appear irresistible to mankind (Hamilton, 1942; Hard, 2019; Myth of Pandora, n.d.; Garland, 2020). Hephaestus molded the woman's body out of clay, and the four winds breathed life into it (Myth of Pandora, n.d.). Then, Zeus ordered all the gods and goddesses to give the woman a gift (Hamilton, 1942; Hansen, 2017; Garland, 2020). Aphrodite gave her unparalleled beauty, grace, and desire (Myth of Pandora, n.d.). Athena clothed her in a silvery gown and taught her needlework and weaving (Hard, 2019; Pandora, n.d.; Myth of Pandora, n.d.). The Charites and Peitho adorned her with jewelry (Hansen, 2017; Hard, 2019). Horai crowned her with spring flowers (Hansen, 2017; Pandora, n.d.). Hermes gave her a cunning, deceitful mind and the gift of speech, and Hera gave her curiosity (Hansen, 2017; Hard, 2019; Myth of Pandora, n.d.). The gods named the woman Pandora, meaning 'all gifted,' inferring to the gifts she had received from gods (Hamilton, 1942; Hard, 2019; Myth of Pandora, n.d.).

The gods also gave Pandora a carved box, a gift from Zeus, with an explicit warning that she must never open it (Myth of Pandora, n.d.). Unbeknownst to Pandora, the box contained innumerable plagues, evils, and miseries for mankind as well as hope (Hamilton, 1942; Hansen

2017; Hard, 2019). Zeus then ordered Hermes to take Pandora to Epimetheus (Hansen, 2017; Hard, 2019). Knowing that Zeus would seek revenge, Prometheus had warned Epimetheus never to accept a gift from Zeus should it bring harm to men (Hansen, 2017; Hard, 2019). When Epimetheus saw Pandora, he was astonished by her beauty (Hamilton, 1942; Hansen 2017; Hard, 2019). Forgetting his brother's warnings, Epimetheus accepted Pandora as a wife (Hamilton, 1942; Hansen 2017; Hard, 2019). After arriving among the mortals, Pandora's curiosity (a gift given to her by Hera) got the best of her, and she decided to open the box, inadvertently releasing all of the evils and diseases that the gods had hidden inside (Hamilton, 1942; Hard, 2019, Myth of Pandora, n.d.). Frightened, Pandora slammed the lid down; however, the bottom of the box contained hope, which did not fly out (Hansen, 2017; Hard, 2019). It is believed that by not allowing hope to escape, hope would live with man forever, giving comfort just when he felt that everything was coming to an end (Myth of Pandora, n.d.).

I chose the name Pandora for participant one because she perfectly embodies the myth of Pandora. Participant one, a young and beautiful nurse, graduated from school in April 2019. She began her nursing career a mere five months before news of a pandemic making its way across the world hit Canada. Curious about nursing in a major hospital in Toronto and naive to the calamities of nursing during pandemics, participant one left her position in a community hospital outside of the city to work in an emergency room in Toronto during the first wave of the COVID-19 pandemic. Once in Toronto, the difficulties of pandemic nursing quickly revealed themselves, causing participant one both physical and emotional harm. Despite all of this, participant one expressed her feelings of hope for nurses and the future of nursing.

Prologue: Meeting Pandora

I met Pandora online on a bright and sunny late-September morning amid the fourth wave of the COVID-19 pandemic. When we had scheduled our first meeting weeks prior, we had no inkling about the significance of our meeting's timing.

On September 1st, the Ontario government announced a new vaccine mandate to help prevent the spread of COVID-19. The mandate asserted that beginning September 22nd, to enter gyms, dine in restaurants, or enter any other non-essential venues, a patron would need to prove that they had obtained a second COVID-19 vaccine 14 days before desired entry, along with photo identification. As such, members and supporters of several organizations planned demonstrations across Canada to oppose the requirement of vaccination and other government public health measures related to the pandemic. In Toronto, dozens of protestors converged on University Avenue (a street dubbed 'Hospital Row' due to the significant presence of hospitals lining the street), contesting the vaccine mandate. Despite being warned by Toronto Police Services not to harass or obstruct healthcare workers or patients from entering or exiting hospitals, protestors did chastise healthcare workers who arrived in counterprotest.

As Pandora joined me online, her bright smile obscured her solemn demeanor. Offering to read from notes that she had prepared beforehand, it was clear that Pandora had carefully contemplated the research question in advance and was eager to share her story. Sitting against a blue background, a nearby window allowed the warm fall sunlight to fall onto Pandora's body, at times casting shadows over her face. Although I did not know it at the time, Pandora's chosen setting for her interview perfectly foreshadowed her experience of providing care in Toronto during the COVID-19 pandemic.

Plotlines in Pandora's Narrative Account

Plotline One: Before They Were Heroes – This is exciting

Pandora began her story by sharing:

I graduated in 2019… in April. And I didn't start really nursing until…June… I started in [another city] … And… really, I didn't know how to nurse at the best of things… I was in emerg, straight out of school. And I was just kind of like, oh, this is how you push a medication… this is what you're going to do for the rest of your life. Yeah, this is exciting!

On why she chose to begin her career in the ER:

[The ER was] all I really wanted to do as a as a student. It's what I dreamed of doing as a nurse… I actually wanted to be an emerg physician, but the, the exam process… I didn't have that in me. So, so I was like, okay, emergency nursing is a good alternative. And then you can switch if you didn't like it. So, I did my consolidation in emerg and then I went to [a rural hospital] because they would accept me.

She continues:

I like the fast pace, and I also like the critical thinking aspect of it. Whereas the ICU is like the critical thinking and the floor is the fast pace… emerge is a nice chaos in the middle… My grandma was a nurse… So, she was pretty good at, like, telling me about the reality of it. And for me, it was because… I wanted to be the best of the best in nursing. And I felt like emerg is where it was at.

Pandora describes what it was like to work in the ER before COVID:

So, the ER before COVID… I was pretty new, and I found that the, the nursing staff, like, whenever I had a question, they were always able to answer it. So, I remember my first patient I had, that was actually pretty sick, he was septic and he… like pressure was in the 80s. He was super febrile, and I hadn't actually ever drawn, like, a septic panel. I didn't know how to start… like what the management was. So I went to the desk, and I was like, "Hey, I have a sick patient. Someone come help me." And three nurses were by my side. Showing me what to do and teaching me. And then, when COVID hit, we were all kind of on the same playing field. And nobody had that extra experience. And everyone was just so busy, that no one could really stay and say "Oh, let's, let's go through this. Let's help." So, it's less of helping each other understand the process behind diseases.

Reflecting on when she first heard about the COVID-19 pandemic:

I started hearing about a pandemic in November, in the hospital I was at… And then all the nurses, were kind of starting to get scared. And I think scared is the wrong word, but, like, you know, how are you rely so heavily on the senior nurses? They started to just, like, "Yeah, I'm going to retire, I'm not going to do this. I shouldn't be nursing in this. Am I gonna have to move out from my family?" We didn't really know how bad it was. But I remember like specifically standing in, like, I guess it's our rapid assessment zone… and our educator like, "Okay… this is going to be bad." Like, "Be prepared." And me, not really… Me kind of finding it exciting. Like, oh, I'm going to be on the same level as

everybody. Like, nobody's gonna know what to do, and like, this is gonna be kind of interesting… Like, so oblivious to everything. (Smirks) Um, and then, it kind of hit me once… in December… I had my first COVID suspected patient. "Oh, this is so nerve racking." It was like, December, I think, eighth, and I was watching contagion overnight, which is… (laughs)

Pandora reflects back on her naivety in regard to nursing during pandemics:

I had no recollection of anything… I've never seen this. I was too young to remember SARS… I was kind of oblivious to Ebola… I just knew… Really nothing. I remember briefly the H1N1 swine flu. That's it. I was in elementary school when that hit…

Adding:

[COVID] completely… turned everything around and it was really just quite terrifying for me. Because I didn't really understand what I was walking into. Like, all these nurses had seen SARS, so they knew like, "Okay, this is what's gonna be like." And then, I had absolutely no idea. Like, I didn't… I didn't even know my ass from my head… in regular nursing. So, you learn… I learned really fast.

Sharing the sequence of events that led to her move to Toronto:

In January of 2020… I… everyone was getting more and more nervous. And I didn't want to stay up in [another city] alone… I knew that if I stayed in [another city], I would have suffered… mentally. And I would not have been able to complete my job. So, it wasn't… the fact that I wanted to move back home… It was the fact that if I stayed alone, then I would suffer. And my health would suffer… I needed the support of somebody… I was living… [with] roommates who… weren't there. So, I needed some sort of outlet, to… I guess vent… [the event that triggered my departure] … wasn't really involving COVID at all. It was… we had a, like, a pediatric code pink. That didn't end well. So, it wasn't… it was in the middle of COVID, but it wasn't directly related to COVID. And then, because of COVID we couldn't do our normal debrief and we couldn't do our outing that we usually do after unsuccessful codes.

Pandora contemplates working as an ER nurse in Toronto at the beginning of the COVID-19 pandemic:

So… I moved back in with my parents, in like, the [Toronto] region. Um, and that's kind of when I started realizing, like, the effective of it… I… got down here to [Toronto]…It wasn't bad at first… I didn't feel it. But it was a busier hospital than the hospital I was coming from. So, I was like, oh, it's just a little busy… everything is gonna be fine. And I would have maybe ten… [or] twelve patients to two nurses when I started. There's really no… low that I that I thought. Right, I was like, oh, I, I guess they're not seeing the small amount of people that we were in [the other city].

Researcher's Field Notes

As Pandora begins to tell her story, she chooses her graduation from nursing school as a starting point. She explains that she began working in the emergency room "straight out of school." Her perspective of 'not knowing how to nurse' suggests that she experienced a steep learning curve as she transitioned from a student nurse to a staff nurse in a hospital. Considering that the emergency department is a highly specialized skill area, I find it intriguing that Pandora entered her nursing career there. Pandora shares how emergency nursing was "all [she] really wanted to do as a student" and describes how her grandmother, who was a nurse, was "pretty good" at "telling [her] the reality of it." This statement suggests that Pandora's interest in working in the ER was not influenced by the perceived glamour of emergency medicine as portrayed by television and movies. Pandora also comments that she "wanted to be the best of the best in nursing" and felt that "emerg is where it was at," capturing how the place and social context of working in the ER elicited personal feelings of pride in Pandora.

Illustrating what it was like to work in the ER prior to the COVID-19 pandemic, Pandora shares a story of taking care of a septic patient and not knowing what to do. She describes how three nurses were "by her side," "showing [her] what to do." She contrasts this to the COVID-19 pandemic, where "no one could really… help," noting that it put all nurses "on the same playing field." It seems like this was a turning point for Pandora, allowing her to finally feel as though she was equal to her colleagues, thus increasing her confidence as a nurse.

Pandora recalls hearing about the COVID-19 pandemic from her nurse educator while standing in her emergency room's rapid assessment zone in November 2019. She seems to have an image of her surroundings in her mind as she talks about it. Despite hearing the threats of pandemic nursing from a more experienced nurse, Pandora describes this time as being "exciting." The temporal position of this event, first hearing about the COVID-19 pandemic,

would have been only five months into her nursing career. She mentions in her reflection of being "too young to remember SARS," "oblivious to Ebola," and only briefly remembering the H1N1 swine flu, so it appears that her lack of nursing experience positively influenced this time. Considering the narrative dimension of time, the way this past event appears to her now is that she was "so oblivious to everything."

In the context of working in Toronto, Pandora states that she moved to Toronto as she "was getting more and more nervous" and "didn't want to stay in [another city] alone." I find it intriguing that she chose to move back in with her parents when she was becoming more fearful of the contagion. It seems that Pandora valued her own need for support over the risk to her family's health and wellbeing. Upon moving to Toronto, Pandora notices the difference in the number of patients being seen in the emergency department when she states, "I guess they're not seeing the small number of people that we were in [the other city]." I am struck by her comment, "Oh, it's just a little busy… everything is going to be fine," suggesting that Pandora was engaging in positive self-talk. It seems as though her self-talk was an early attempt to cope with the pressures of the pandemic and the fear of bringing the contagion home.

Plotline Two: Hero – It was nice to feel appreciated

Pandora shares how the community feared the contagion in the first wave:

> *The emergency department was emptiness. Everyone's scared… the department was empty. And we weren't seeing the stuff that needed to come in... So, we weren't seeing the strokes. We weren't seeing the trauma, the domestic abuse, or the heart attacks.*

Giving an example of how patients avoided coming to the ER out of fear of contagion, Pandora says:

> *[There] was… it was this little… I wanna say… oh, she's was probably mid… mid to late 80s. And her… Her daughter and son had taken her… out of a nursing home in Oakville and brought her up to [a rural city]. And she came in, and she was having a full-blown stroke. Like, right sided weakness, unable to talk… like, devi… like, the whole thing. And she… we asked her when this all started… or asked the daughter when this all started…*

And they're like, "Oh, maybe four or five days ago. We just didn't want to bring her in because of COVID. We thought it was going to get better. We didn't want to get her sick from COVID." And what had happened is… they were trying to get her off the toilet and she fell. She hit her head. And they're like, "Oh, she's awake… She's fine." And they put her bed. And then, when they woke up, she had this weakness. And she actually had a huge hemorrhagic stroke. And that to me exemplifies the fear. Because a) they took her out of Oakville, where she was getting the proper care she needed. And then they… didn't bring her in as well… if she had stayed in Oakville she might have fallen, right? And she might have hit her head… But she would have come in, right? They would have called 911… or if they didn't, when they noticed the stroke symptoms, they would have a 100% called 911.

Pandora proudly shares how nurses were respected by patients in the beginning of the pandemic:

So, there is this, ah, so lovely [patient]. I don't know. Mid 30s. And his… wife was on a business trip. And … he had a newborn, a three-year-old… and I think it was a five-year-old. So… he was looking after these three kids, and he's like, "I just feel like absolute shit… I don't know why." And he comes in, and he… actually failed his walk test, and he was COVID positive. I was like "You're COVID positive, you should stay in the hospital." And he's like, "I can't. My three-year old's COVID positive from daycare and someone's got to look after the other two kids… I can't stay in hospital". And… he's like, "I'm just so tired" and he just started crying. He's like "I'm so thankful… you really don't understand… the appreciation I have… for you guys. I know this is tiring and endless, and… I just I can't imagine it… just thank you so, so much." … And then he left… he actually ended up writing… a letter back to our manager saying, "I just want to thank you guys. You did a great job… I'm doing better. My baby is doing better… Thank you."

Pandora reflects on the support she received from her co-workers:

… the social workers were really good support. Like, the social workers would come around and say, "Hey, how you doing?" Like, "What's going on? Do you want to talk? Do you need to talk?" And… the charge nurses actually… were… quite hands-on. And they were like, "Hey, like, we see that you're… you're like you're swamped. How are you doing? Can we provide help?" … My educators were glorious. That when… stuff got out of hand, they all put on scrubs and were back as floor nurses… And they, they were… spectacular. I can't say enough good things about my educators in COVID.

On feeling supported by hospital management, Pandora shared:

We had our hospital's CEO come down a couple of times. Um, like, "Great job. Thanks so much." But she's also like a… I think all frontline staff kinda hate management. I'm not sure if that's the version of nursing I'm getting at least. From my two years of… I've seen it.

On why she feels "all frontline staff… hate management":

Nurses need somebody to hate. They, they all do. And it happens to fall on management. 99.9% of the time. And no matter how good or how bad your, your manager is, you can … spot the wrongdoings… I feel the like, the job and nursing is so hard and so stressful to begin with, and … the conditions that even now that we're under… you can't, like, there's no one to be mad at, except for management. Even though it's not management's fault. You have to be… like we're… right now operating… nine… ten short. On a night when we're supposed to be fully staffed at 18. So, it's… you have to… you have to be mad at somebody about that. And management draws a short straw.

Circling back to feeling supported by hospital management:

Um, but I think the… it wasn't met with a "Oh, thanks for being so supportive", it was met with a like, "Oh, she's doing this for a publicity stunt." Like, she was one of the first ones to get the vaccine in my hospital. When she had absolutely no clinical job at all… At least our director of the emergency department and our manager, they come in every day at 6am and they're like, "Hey how'd the shift go?" …and then they come back out… at 8am and they're like, "Hey, like just checking in, how's the shift starting?" So, they're way more around. And they're like, "Everything good? Anything bad? Do you need teaching on anything?"

Pandora expressed the support of the community:

So, in [the rural city] specifically, less so in Toronto… a bunch of restaurants gave in food… So it was, "Oh, we got a bunch of candy, here." Like, "There's a huge spread of sandwiches in the back from the from the community. Oh, by the way, this little mom and pop shop is giving all health care workers 15% off… 20% off." … It was that kind of thing. Or like… [in Toronto] … let this… accounting agency, do your taxes for free. That type of thing… Like, Toronto got… Toronto still gets flowers. I think every week someone still drops off flowers for us… I felt super appreciative… Like, we had like an ambulance drive by. Firefighters and police cars all came out. And it was lovely. It was nice to feel appreciated.

On government support:

I don't remember seeing much from the Government. I'm sure they did do something, but I don't… I was too involved in the lower level to even try to comprehend what was going on above me.

Pandora recalls the first time she heard nurses being referred to as 'heroes':

It might not have been the first time, but one of the first times I remember… It's probably around the same time as the… the ambulances and the drive bys and stuff… So it was pretty early on… People were just like gossiping in the back of the break room… and they're like, "Oh, yeah. They're doing a drive-by in five days, or whatever." And they're like, "Yeah, they're calling us all heroes."

Pandora reflected back on the public's perception of nurses as heroes:

I remember… I remember thinking is…why are they calling us heroes? Because we're not… we're doing our job. It'd be better suited if they just helped. That's what I remember. I don't remember ever feeling like "Oh, yeah, I'm like, I'm a hero." Or that pride that came along with it. I don't remember that… In all honesty, I found it, unnerving. …at the beginning of the pandemic we didn't really deserve more than any other day. …our care hadn't really changed, it was more… like, yeah, cool, we're saving lives. But we've been doing that all the time…

In her subsequent interview, Pandora elaborates on her feelings regarding the 'hero' rhetoric:

I think at that point when we were having our first conversation, it was a bit of burnout. A bit of like… I feel like… nurses are deserving of the praise that the community was giving them, but not more than normal. Especially in the first wave, where everything was empty. Because you're doing less work than we normally were. It just brought attention to… a profession that was struggling. And it brought… that little bit of shimmer, where they didn't actually have to… where they weren't struggling. Where we were seeing two patients a day. And then it was gone by the time they were seeing 18… 20… COVID patients a day.

Researcher's Field Notes

Pandora shares how the community feared the contagion during the first wave of the COVID-19 pandemic. She remembers a situation in which she cared for an elderly woman who had a stroke. Pandora recalls how the woman's children had been caring for their mother at home, as they were fearful of leaving her in her nursing home, worried that she would contract the disease. She talks about how the elderly woman had fallen and hit her head and how the children "didn't want to bring her in because of COVID." Considering the temporality and sociality of the COVID-19 pandemic, Pandora appears both helpless and sad, thinking about how she could not help this patient.

Pandora considers her interactions with patients during the first wave of the pandemic. She recalls a COVID-positive patient was so unwell that he required admission to the hospital. She talks about how he refused to stay, citing that he had three children at home that he had to care for. Despite this, Pandora recalls that he was so thankful that he began to cry. Considering

the social dimension of narrative inquiry, Pandora appears grateful for his appreciation. It seems as though the appreciation Pandora received from patients was different prior to the pandemic. It also seems like the patients were appreciative during the first wave because they were so fearful of the contagion.

Reflecting on a past event and how it appears to her now, Pandora describes the support she received from her hospital's CEO. She recalls the CEO coming down to the emergency department to express their appreciation for the nurses. She talks about how nurses questioned the reasoning behind the messages of thanks, suggesting feelings of mistrust. Pandora states, "I think all frontline staff kinda hate management." Between her first and second interviews, Pandora continued to think about nurses' feelings towards management. Her comment strikes me, "Nurses need somebody to hate. They, they all do. And it happens to fall on management… I feel the like, the job and nursing is so hard and so stressful to begin with, and … the conditions that even now that we're under… you can't, like, there's no one to be mad at, except for management. Even though it's not management's fault… you have to be mad at somebody… And management draws a short straw." This statement suggests that nurses have a lot of misplaced anger. In a later reflection, Pandora talks about how it is "unfeasible" to be mad at the Government, as they are "untouchable" and "there is no one person to yell at." It seems like Pandora believes that the misplaced anger nurses feel directly results from not having their voices heard by the Government when discussing healthcare planning and policy. Pandora remembers the support that the manager of the emergency room gave her. I am intrigued by how Pandora starts her reflection by saying, "At least our director of the emergency department and our manager, they come in every day at 6 am…" suggesting that she relied on and trusted her manager.

Reflecting on the public's perception of nurses as heroes during the first wave of the COVID-19 pandemic, Pandora states that she "found it unnerving." She states that "at the beginning of the pandemic, we didn't really deserve it more than any other day," suggesting that nurses were undeserving of this attention. In an earlier reflection, Pandora describes how the community was so fearful of contracting COVID-19 that the "department was empty." It seems like Pandora's adversary to being praised as a hero is related to a fear of being perceived as a fraud. However, in her subsequent interview, Pandora clarifies that she believes that "nurses are deserving of the praise that the community was giving them," but that the timing of the accolades brought attention to a "profession that was struggling" at a time when "they weren't struggling." Concerning temporality, she acknowledges this feeling represents a change in her perspective, occurring over the past few months, noting in a later reflection that "when the appreciation kinda dimmed down, is when we actually needed that."

Plotline Three: Fall from Grace – COVID's not real

Pandora shared:

> *When wave two started happening, all chaos broke loose. Wave two, it wasn't like wave one… We didn't get the lull in patients. We didn't get the… people weren't scared of it anymore. They were like, "Okay, it's a cold. It's a flu. I'm gonna go to a party anyway. I don't give a crap… it's not that bad". Um, and wave two is when we started to notice that our staff was getting sick.*

Pandora recalls the first time she felt a lack of support from the community:

> *[M]y first COVID positive patient that I remember having, was this… little 95-year-old. Completely with it, independent from home. And it was during the lock down. And I remember her… I try my best not to bring my work home with me, but I remember her so specifically because she happened to be an old war nurse… I think [I] partially [associated this patient with]… the nursing aspect of my grandmother, as well as the fact that she was just a nurse in general… if you say you're a nurse in a hospital, there's something inside of every… I believe every nurse, says like, "Okay, I'm gonna give this person exceptionally good care. I want the best for this person." Because she committed herself to do this for her whole life …Um, and she comes in and she's like, "oh I just… I'm just having a little bit of trouble breathing." And I put her on the oxygen. She doesn't look like she's having any trouble breathing, but… she sats around 75% on room air...*

The only medical history she has is [atrial fibrillation]. And I was like, okay, let's, let's put you on some oxygen. And then her demand became… higher and higher and higher. [At] 5am, I had her on a 50% venti. And then at 6am, she was on a non-rebreather and tachypneic at like 35… she was still holding… she's still in [atrial fibrillation], but [her heart rate] was maybe 101, 98… type of thing. And then, all of a sudden… I was sitting at the nursing station, and you know how alarms… you hear alarms from anywhere in emerg? The cardiac alarm just started triggering. So, I look at the monitor and she's at 186. In afib [atrial fibrillation]. And I was… obviously rushing to her room… she looks at me, she goes, "[Pandora], I know I'm dying. And I know I won't get a vent, but… I didn't expect it to hurt this much." Is the only thing she said to me. And like, I really, really liked that patient. Because she was just… this cute little 90-year-old. And she was telling me about the war stories… perfectly. She walked in and she died at… I think was at 7:40am. She died. Her heart just gave out. And then, we called… her granddaughter. And [she was] like, "What you mean she's dead? I saw her yesterday." I was like, "Oh, have you been seeing [her]?" And she was like, "Yeah, we see her… almost every day." And I was like, "Oh… have you guys been really good with isolating then? How have you been ensuring that she was okay?" And she's like, "Oh, COVID. COVID's not real."

Pandora adds:

Do you remember those… massive house parties? …the COVID house parties in… Brampton? She… had gone to one of those, contracted COVID and gone to visit her grandmother. Like, over the next few days. And she had… no understanding that she was the actual person that basically killed her grandmother. Like it's just… it, it…. that kind of just set in the reality of COVID.

Pandora reflected on her feelings of this situation:

I think numb is probably the best word. … I was numb for the longest time. Until I started getting mad. So, this… Like, this woman and this granddaughter just absolutely… I didn't… I've always been emerg, so I didn't really build that close relationships with patients. But she was just so sick, I was just always there. And I felt… I was so mad at the granddaughter. And it was the ignorance, and the lack of health education, and health information that the government was giving out. It just absolutely floored me. And I didn't… it took everything I had not to scream at that granddaughter over the phone like "You know that you killed your grandmother?" Like, "You understand this." And it's still… to this day, it still makes me so, so, bloody angry, that this…. Like, this woman spent the last twelve hours of her life telling me about her war stories and when she was asked if she wanted a vent, she's like "No save it for somebody younger." And like just, her selflessness, that… it just was met with such ignorance and such… Like, you could tell that that's just the way she was, as a human. And then, her family basically killed her. It just… She should have been able to live a little longer. So yeah, mad.

As the fear of contagion decreased in the community, Pandora illustrates that the number of 'sick' COVID-19 patients began to rise in the hospital:

There is one shift that also stuck out in my mind… we were so short staffed that we were just putting them [COVID positive patients] anywhere… so ours is like, R1, R2, then A10. Right. 1-2-3. A10 is like a negative pressure room, R2 and R1 were both negative pressure rooms. Or made into negative pressure rooms for COVID. So, like I was just walking by them, casually. I was so immune to it. The shit show that was emerg, that I didn't even realize that they were intubating somebody in R1. And one of the docs was like "[Pandora]! Go get me this!" I was like, "Alright cool.". So, I'm… running to the ADU [automated dispensing unit], to get, I think it… I don't even know what it was. But it was something for intubation. I go and draw it up and bring it back. And then I keep walking. Two more steps, and someone is being intubated in R2. And one of the docs was like "[Pandora] I need this, this, this and this." And… they didn't have a runner outside. So… okay, I guess I'll be the runner here. And I go back. Go to the ADU and come back and get whatever they needed. And then… five more steps, I'm in front of A10 and there intubating another person in A10. And the nurse was like "Hey can you just pass me the stuff for an IV? I just blew my IV." And so, all the nurses, in all of acute, which usually eight nurses for twelve patients… were intubating in these three rooms… and nobody was able to run. We had one doctor running two intubations, because we didn't have enough doctors. And… they didn't even ask for help because they knew they weren't going to get it from anybody. Because all the other places were just so busy that we just couldn't spare the nurses. But yeah, they were all COVID positive. All mid 40s… to early 60s. And… that was our norm then. And then, when they were all intubated, we had one ICU spot. So, it was the two doctors determining what patient could go to the ICU and two patients could wait to be flown out to the nearest ICU. And we were shipping, we were shipping people to, to Niagara, to Peterborough, to Orangeville… we were shipping people far. And when people started to come in, we used to give them, this referral like, "Hi, we think you have COVID. If you have COVID and end up intubated, you can end up… anywhere in Ontario."

Pandora spoke about the inability to save everyone:

If it was a controlled intubation, we would get the family members on the phone to say goodbye. And I was there when the doc was like, "this is probably going to be the last time you talk to him ever. So, say goodbye and that you love him." And it was just so blunt. And… she was right… the guy never woke up. But… the family didn't understand the ramifications of being intubated. They didn't. It's like these new words that never really crossed their mind.

When asked if Pandora had a lot of experiences of using iPads to help family members say goodbyes, she shared:

I saw it maybe like a handful of times. And each time I was left in tears. Because you can see… you could hear… you know people's voice cracks when their on the verge of tears? You could hear that in the family member. And… the patient was just too sick to really understand what is going on. But he's like "Okay, bye. I love you. Bye. Yeah, we'll talk soon. Don't worry." And like, the family member actually getting nothing. This will be last time they see [them] alive.

On the dwindling amounts of appropriate PPE:

So, we were given level one, level two masks, right? And they were… the majority of them, when you put them on, they hung down to here (uses fingers to demonstrate below the nose) because the ear loops were too small. So, you'd have to tape them to keep them up. We ran out of gloves. We ran out of the disposable PPE. We ran out of visors. So, we'd have to use the same visor.

Adding to this, Pandora remembers the first time noticed a lack of support from her hospital's management:

My manager would come out every day in the level three surgical mask that was… perfectly fitted for her. In a beautiful visor that… we were using the same ones… but hers was new everyday. And you could tell, because she would… you could see her take it off the screen at the beginning of the shift. And, um, in a disposable gown on backwards. That's what my manager would come out in every day. And we were so short on PPE. And she'd parade around the emergency like that. Telling us that we weren't allowed to wear double masks. We weren't allowed to wear N95s… oh yeah, I should probably add, initially, at the start of the pandemic, she told us that we weren't allowed to wear a mask because it was scaring the patients.

When asked if she was concerned about being told to not wear a mask during the first wave, Pandora states:

I was… worried … like, again, I was very new… and the senior staff was worried. Right? So … I was like, okay, they're worried, I'm worried. And for me, the not wearing of the mask… At the time, I was like, "Okay, so maybe it's not gonna be that big of a deal?" Right? Maybe it's going to pass like Ebola passed. Where we got no cases, and it's all hype for nothing. But as the senior staff says… "No like we're wearing a mask." It's like, "Yeah, that makes sense." Like, what if we get sick? Then what? And I felt more exposed at work than anywhere else.

Pandora recalls an account when a co-worker attempted to protect herself:

This woman that I didn't really know… she always wore an N95. Then, I later found out that she had an autoimmune disease, and she was terrified of getting COVID because she had a weak immune system. And my manager blatantly yelled at her in front of all of the nursing staff, all the doctors, about wearing an N95. And she only wore one per shift. Like, it wasn't like she was changing it… she would wear one. So, it's very much like that. We have to either protect ourselves or not get fired.

Pandora adds:

Our CEO came down and was like, "Great job. Thanks for doing all this hard work, you're doing great, but we also need you to work more. If you're full-time, pick-up OT if

you're part time, pick-up full-time hours." That was like the progression of that. It was like, I'm down here for a reason.

Pandora shares her inability to escape:

I was working every day. Twelve hours. The only days I would have off was when I switched from night shift to day shift… I think my longest stretch was 37 day shifts or 37 shifts in a row… my employer basically was so desperate for nurses, that… they didn't really care that I was working 30 shifts in a row. They have no…. like, they fully knew it. They were paying overtime for every one of those shifts that I worked. But they're like, "Okay, she wants to work this much, let her work this much." And I just… I couldn't leave my colleagues and my patients… I couldn't. They were… we closed down, half of our sections a couple nights because we just didn't have the staffing.

Adding:

They're refusing vacations. We just don't have the staff. We're usually operating at around four or five short… so they're refusing vacations.

When asked if she worked so many hours because she felt like she had to live up to the expectations of being labelled as a 'hero,' Pandora says:

I think, without knowing it. Yes, probably. That being said, there's… in my opinion there's this… I don't know… idea in nursing that you always depend on your colleagues. And then, if you short staffed, it's because a colleague didn't pick up a shift. It's not because three people called in sick. It's because a colleague didn't pick up an extra shift. Or a colleague didn't work overtime. Still now, it's that… like that. Or… it's never, "Oh, yeah, we just didn't fill it because we don't have enough staff." Right? So, it's as always put back on, "Oh, it's because your colleague let you down." So, there's still that… kind of understatement. Even within management itself. And nursing in… in the hospitals. So, yes, I probably felt then that it was related to the hero aspect as well, because they're like, "Oh, your heroes." Like, "you must be working so hard, so many hours." So, I was like, "Well, I guess that's what I'm supposed to do. Work hours. Work hard… At the time, I think [my colleagues felt the same way]. Now, no. Cause they're all quitting. But in the time, yeah. I remember, like, I would go six, seven shifts back-to-back, and I would see the same six, seven, people. They'd be some of the docs, some of the nurses, but there's a group of us that would be there almost every day.

Pandora considers the College of Nurses' responsibility for safe practice, and reflects on the internal conflict she felt:

For a unionized hospital, I know you can't work more than six shifts in a row. Unless you schedule yourself as such… and I know I definitely was over it. In the time, [I did not feel conflicted]. Looking back… a 100%. I felt… I remember this one time… I had probably worked 15 shifts on… and it became like a running joke in the department, too. They're like. "Oh, [Pandora] How many shifts are you on now? Like what number night is this?"

Right? Because I was also the youngest and the least experienced. So, I felt like I had to make up for it somehow. And I remember working this one night and this patient fell. And I couldn't help but think that, "Oh, maybe if I hadn't been working so many shifts, I would have caught that. I would have…" Like… it was a fall that I couldn't have caught… looking back at it. But still… that feeling inside. And that's what made me kind of conflict… conflicted.

Reflecting on feeling expendable by her management:

I felt expendable by management, but not related to how many shifts they allowed me to work… I felt more expendable… when they're like, "Oh, we don't wear N95s. Oh, we use the same mask. Oh, you don't really have a choice you have to take these patients. Why did you stop and gown up before doing CPR? You don't have to gown up during CPR. You don't have to wear an N95. You don't have to…" Right? That type of stuff makes me feel… expendable. Whereas allow[ing] me to work more shifts [did not].

Pandora describes how emergency room nurses began to fall ill from COVID-19, resulting in increased feelings of mistrust, fear and isolation:

We had been on outbreak, about three times by now. And so, we had to wear like full PPE to see anybody, and … we're now using reusable gowns, so that was fine, but we had recently run out of gloves. And we were allowed to take our visors off when we hit the nursing station. We would put our visors up on her head. And, we had these…resource team [nurses]…that … were stuck in emergency in this place called flex overflow. Which is… if you can imagine a gymnasium with curtains and 26 beds. And they were in like the center of this little gymnasium, as their nursing station… And … we usually had 26 people in there. It was… A through Z, and we had all the rooms filled. And they, had a COVID outbreak there. So, they had a patient that walked in, with, I think it was… renal colic… something completely unrelated… and he ended up being positive. And … he somehow ended up coding. I don't know why, but he ended up coding in that little flex area. And no one had N95s… they just assumed he was negative… because he was a renal colic. So… they coded him in regular masks, and they all got sick. They all tested positive for COVID a couple weeks later… all six of them, had gotten it. So, it technically qualified as staff-to-staff transmission. And everything shut down… We were telling people at the door… go to another emergency department… because... we were just this uncontrollable spread among the staff. And then… on Christmas … there was no more senior staff available because everybody was sick. And if you weren't sick… you're calling in sick, because you don't want to get it. And you know that if you were, in the…[nursing] station, there's a high chance that you're getting it. And all the doctors were starting to wear N95s, but we… still weren't allowed. And they banned us from eating in the break room. We weren't allowed to take our mask off in the break room… we had to go out in the middle of outside… if we wanted to eat. We weren't allowed to drink water in the break room, because the risk of transmission was so high. Fast forward to now… if your COVID positive, but you're asymptomatic and double vaccinated you can come into work. You just can't eat with us. Like, that's… we just got

so used to it… so now, everyone's gonna be COVID positive. I was… one of the very few people that didn't end up being positive. And I don't… understand how.

Thinking about how the physicians were allowed to wear N95s, while the nurses were being told not to wear masks:

It was like a little bit of like… "Why did they get it, and we don't?" Is kind of like that. But we knew that N95s were what we needed. And we were mad that the physicians as a whole got the choice to wear them, and we didn't. But we never were mad at a specific physician for wearing one. Um, especially because of the fact that we, we knew we all needed it. We knew it was airborne even when they were saying it wasn't. But… I don't think it actually made us hate the …physicians that were wearing it… we did [vocalize our concerns to management]. And there was… it became the same as "No. A level three is sufficient. A level two is sufficient." At one point we were only we only had level ones. So that's what we were wearing… and even the physicians verbalized it. They vocalized that we should all be wearing N95s, and management didn't listen. Or whether management or the organization didn't listen… I don't know which one.

Pandora shares how the actions of a few of her colleagues led to increased feelings of mistrust:

I remember… This would probably later in the pandemic. But I remember a couple of my colleagues going… like, going away. When you weren't allowed to. They had used their nursing ID to say "Oh, yeah, I'm going to nurse overseas." And then went way. Or I guess it wasn't overseas, it was down south. And then they came back, and they didn't tell management that they had gone away. So, they weren't isolating… It was the time where you're supposed to isolate for 14 days or 10 days. When you even had a contact… or a positive COVID exposure you'd have to isolate. It was that time… And they were very… like, they're very open about their travels, and weren't really trying to maintain the safety of the other nurses by them. And it was before we really knew that the vaccine was working. And had all just been through… And I guess this is… their way of coping. But we had all just been through like absolute hell together, and they're like, "Yeah, so I just went to Florida. There's no mask mandate" and, and all that. So, I kind of mistrusted them. But other than that, I found that the nurses, kind of stuck together and like when they got sick, we all supported them. Especially… especially because we thought they got it from us.

Adding:

…most of my colleagues I trusted. And then… it would become, like, "Oh, I'm going to the party. But it's only nurses that are coming." And then I was like, "Okay, but that's still a party, is that still…" …looking back, that's how they were coping. That's how they were managing their stress. Whereas… I had a partner. So that kind of relieves some of my stress there. But, I think that's how they were dealing with their stress. So, it's hard to look back, and say… I hated them for it, even though I know I probably did. And I was

probably a little mad. Now, I [can] see that it was just how they were trying to deal with everything.

When asked if her co-workers actions made her more fearful of contracting the COVID-19 contagion, Pandora says:

I was just a little bit more mad. Because you would always get mad at the patients for not isolating and for spreading it. And then, when one of our colleagues did it the same, we couldn't even say like, "What the hell you're doing?"

On fear and isolation, Pandora reflects:

I have this one experience and it's… my charge nurse… she walks into this room, and she's not talking to me, she's talking to… the woman I work with. She's like, "I don't want to bury another one of my kids, if I get sick and bring something home" is the only thing she said. I had no context otherwise. But she didn't want to bring something home, and… affect family.

Pandora considers her own fear of not wanting to bring COVID-19 home to her family and the impact of isolation:

So, my mom is a recent cancer survivor. She's… had a huge splenectomy. So, she's got absolutely no immune system, so I tried [to isolate from her] initially. And then I just, I found it too hard to be distanced from her… I found it very lonely. And not so much lonely… I found it… if I had kept doing it, I probably would have killed myself type of lonely. Right? Cause I couldn't…go through what I was going through… in the hospital and then come back and staying in the basement, which I was, and not being able to go outside. Because that was work/home isolation. And not being able to talk to my family, because I was scared, I'm giving it to them. So, initially I did try. And then when I couldn't do that anymore, she would sit at the top of stairs and I would sit at the bottom of the stairs, and we would just talk. Because… (Tearing up) I couldn't do it anymore. Um, and then eventually it just became part of the normal. We would sit on opposite sides of the room when watching tv… And then, I'm just like, fuck it… this is not going to end well if I don't just do something. So, I faked symptoms every two months and got swabbed to make sure I was negative … as soon as I came in, I kind of stripped in my garage and I went straight to shower. And I hoped for the best. And then… when I got… a positive exposure that was really bad… like we had a… an 18-year-old. That we resussed for COVID. And, I was like, okay, like I wasn't… I was doing compressions and CPR on this guy because… there's an 18-year-old. I wasn't gonna go mask up first. I was like… I'm gonna get a swab in a week and I'm gonna stay in the basement for the time being. And we just kind of went back and forth like that. And then when it got really bad, I sent my parents up to the cottage. And I was like, "don't come home." (crying)

Reflecting on why she chose to perform an unprotected code blue on an 18-year-old patient:

The… benefit outweighed the risk. Right? Like… I took… the risk onto myself. If I could get to that child two minutes sooner, and do two minutes of active CPR, when their kid has no blood to his brain… right? As opposed to gowning up for two minutes and making sure I don't get sick. Like that, I would… probably get better from. And I think every other nurse in that situation would probably make the same choice… I'm just gonna help this kid. Like, we still do it, even now. Like… there's been a string of code pinks. Never once have I gowned up fully. I was… been in just my mask. No gloves. Nothing. It's just… because it's such a young person. Like, you never really think about yourself. You're like, "Oh, crap." ...

Adding:

At that point, like… that was later in the pandemic itself… And so… became kind of like this, "Oh, it wasn't a huge deal" with my family. Whereas if it was beginning of the pandemic… it would have had a different impact. But I was still always… like, "Okay, I'm gonna just try to separate from my family. I'm not gonna go near them." Like, "I'm not gonna eat with them." So, I stayed… I basically became a basement hermit. And I stayed in the basement, just until I know I was clear.

Reflecting on feeling helpless:

But what we found was that… we were again… we're seeing more suicides. More… late strokes. Like, out of the window. Um, and more abuse. But like, not more abuse in terms of like, oh, like, they're coming to tell me that you… you're being beaten. It's more like, okay, you're beaten to a pulp. Because you're stuck at home. Um, and I think right now, that's what people aren't talking about. Is that you have COVID, and then we have this whole other pandemic of mental health that was just left untreated. So mental health, domestic abuse, sexual assault, all the stuff you just… just spiked. Because they're stuck at home. They can't do anything. They can't go out. And it… like we, we're starting to see… in the second wave we were starting to see, like eleven-year-olds, taking toxic doses… lethal doses of Aspirin, Tylenol. There was this little twelve-year-old and she... she clearly didn't understand what she was doing, but I think she kinda did. She took an entire bottle of 500 milligram Aspirin. She took about 20 grams of Aspirin. And she like, she got sent down to Sick Kids ICU… and I asked her when she came in… She came in like, an hour after ingestion. We just saw her go downhill. There's something… like, we couldn't fix it in time. And I asked her, like, "Why did you… why did you try to kill yourself?" And she's like, "I just couldn't be stuck at home with mom's drinking anymore." And I guess I started to realize that it wasn't just… like, the pandemic sucked for me, because I couldn't go out drinking with my friends. But for some people, it was like, they can't escape who they're at home with. And that was, like the, the second time… I was really broken by what just continued to get worse and worse over that pandemic.

Pandora continues:

... if they had come in two hours sooner or a day sooner or they reached out for help, it would have been completely different. That always leaves me feeling a little bit… shattered… Like, your heart just completely breaks for that whole situation. And especially with something that's caused by the isolation of COVID. You know that… but

> *they don't understand what COVID really is. And it's just like… the complete opposite side of the isolation is not doing great for society. It's actually destroying it… I don't think I… if I had done everything right in that situation, I don't think I could have saved her. But I think that the feeling of… I hoped I could save her… Or somewhere along the line, we have let her down. Us as health care. Us as a society, has let down this child. And I think that's kind of the… what breaks my heart as well.*

Researcher's Field Notes

Reflecting on past events and how they appear to her now, Pandora describes wave two as when "all chaos broke loose." Pandora recalls that as the pandemic persisted throughout the winter and spring, the community no longer feared the contagion, ultimately leading to nurses' 'fall from grace.' Following the temporal narrative dimension, Pandora presents a string of defining moments, demonstrating a shift in the public's perception of nurses from 'hero' to 'villain.'

Pandora reflects on caring for her first COVID-19 positive patient, an older woman who ultimately died after contracting the virus from her granddaughter. Describing the death of her patient as the moment when the reality of COVID set in, Pandora reflects on her personal feelings and perception of community support. Pandora recalls feeling "so bloody angry" and admits that "it took everything [she] had not to scream at [the] granddaughter." Considering the social position of this defining moment, Pandora states, "I remember her so specifically because she happened to be an old war nurse," mentioning that she saw her patient as a mirror image of her grandmother. It seems like Pandora's comment, "…her selflessness, that… it just was met with such ignorance…" reflects her perception of how nurses are now being disrespected and disregarded by the community. It also appears that Pandora's expressed feeling of anger is an outward expression of her unprocessed feeling of sadness, resulting from the loss of a patient that she "really liked" and believed "should have been able to live a little longer."

Continuing to ground her experience in the social context, Pandora elaborates that as the fear of contagion decreased in the community, the number of 'sick' COVID-19 patients began to rise in the hospital. She reflects on a shift where the emergency department was so short-staffed that they put COVID-positive patients "anywhere." Feeling the weight of her words, Pandora recalls participating in multiple patient intubations and witnessing family members' last goodbyes. This reflection captures how the place and social context of the emergency room during the COVID-19 pandemic elicited personal feelings of fear, sadness, and helplessness that evolved over the narrative dimension of time.

Pandora describes the second defining moment as the decrease in support from her hospital's management. Reflecting on her experience, Pandora considers several events across time, beginning with the dwindling amount of appropriate PPE. Pandora recalls that during the second wave, the emergency department had run out of disposable PPE and that nurses were required to wear poor-fitting masks that had to be taped in place while caring for COVID-positive patients. Pandora juxtaposes the safety measures being afforded to nurses with a description of how her manager "paraded around the emergency" department in PPE that was "perfectly fitted for her." This reflection gives the impression that Pandora internalizes the contrast in protection between management and nurses as a feeling of being dispensable. Indeed, in a later reflection, Pandora confirms that not being allowed to wear a proper fitting N95 made her feel "expendable." Remembering an incident where a fellow nurse was ridiculed for wearing an N95 mask to protect herself, Pandora portrays her feelings of moral distress, stating that she had to "protect herself or not get fired."

Considering her safety further, Pandora recalls that at the start of the pandemic, nurses were told that they "weren't allowed to wear a mask because it was scaring the patients."

Although Pandora appears frustrated while sharing the inability of nurses to wear masks early on, her delay in revealing this information suggests that the initial hero rhetoric enabled her to feel safe, as though she was invincible to the disease. This reflection includes all of the narrative dimensions of time, social, and place. Pandora felt safe at the beginning of the pandemic because the hospital and the community supported her. She was not worried about not wearing a mask until the senior staff with pandemic experience began to vocalize their concerns. Her perception of this event now reflects her frustration with helping a community that does not feel the need to reciprocate the favour to nurses.

Pandora reflects on working "37 shifts in a row" during the second wave. She recalls when the emergency department was "so desperate for nurses" that they had to close half of the sections due to lack of staffing. Pandora expresses feeling as though she "couldn't leave [her] colleagues and [her patients]," suggesting that if she had not worked, she would have let her colleagues down. Pandora admits that she felt this way because of the 'hero' label. Indeed, Pandora acknowledges that she felt as though the functionality of the emergency department rested on her shoulders and was dependent on whether she was working. In an earlier reflection, Pandora recalls the hospital CEO coming to the emergency room to provide the nurses with accolades, followed by requests "to work more." It appears as though this led Pandora to believe that the support she was receiving from her management was conditional based on her ability to work more. I find it interesting that Pandora comments that her management "didn't really care that [she] was working 30 shifts in a row." Although one could assume that Pandora would internalize this as feeling expendable to her employer, she denies that this particular action made her feel that way. In a later reflection, Pandora states, "I was gonna worked until I dropped, and

that was okay with me," suggesting that it was the hero rhetoric – that she felt that she had to live up to – that was causing her destruction.

The College of Nurses of Ontario (CNO) mandates that nurses use their "professional judgment to determine whether fatigue might interfere with their performance and, if so, to refrain from practicing" (Nursing and Fatigue, n.d.). The CNO also encourages nurses who "find themselves in situations where they or their colleagues are working while fatigued to take action" (Nursing and Fatigue, n.d.). Moreover, the CNO demands that nurses in administrative roles are accountable for ensuring that staff can safely provide care to patients (Nursing and Fatigue, n.d.). Given that Pandora had a near-miss with a patient who fell while under her care, it is curious as to why Pandora's management did not step in and mandate that she take a day off. It seems that Pandora and her manager were unaware of the liability should a mistake be made. It also seems like Pandora's manager had no regard for her staff's wellbeing.

Pandora describes the next defining moment as when the emergency department experienced a COVID-19 outbreak. She recalls that a male patient had attended to the emergency department with symptoms of kidney stones, who later ended up coding in their flex area. The six nurses working in the area had assumed that the patient was COVID negative and had resuscitated the patient without taking any precautions, resulting in all six nurses contracting COVID-19. Pandora remembers the "uncontrollable spread among the staff," recollecting that "there was no more senior staff available because everybody was sick." Her comment, "And if you weren't sick, you're calling in sick because you don't want to get it," suggests that nurses were beginning to mistrust patients and other nurses. Pandora recalls that even though physicians were wearing N95 masks at that time in order to protect themselves, nurses were still not allowed. She shares how both the nursing and physician groups vocalized the need for nurses to

be permitted to wear N95 masks to the hospital administration and how their requests fell on deaf ears, making Pandora feel like nurses were expendable yet again.

Pandora elaborates that nurses were not allowed to take their masks off in the break room during the second wave and were forced to eat and drink outside. In reflecting on feeling unsafe while at work, Pandora states that she "got used to it" and assumed that "everyone's gonna be COVID-positive." This reflection captures how the place and social context of working as a nurse during the COVID-19 pandemic in Toronto elicited personal feelings of mistrust, fear, isolation, and defeat.

Pandora recalls how some of her nursing colleagues used their hospital IDs to travel and take vacations "down south" when there was a travel ban and "before [anyone] knew the vaccines were working." She remembers how her colleagues "didn't tell management that they had gone away" and how they did not isolate themselves upon their return. Pandora appears both sad and angry, thinking about how they "weren't… trying to maintain the safety of the other nurses." Considering the narrative dimension of time, the way this past event appears to her now is that this was "how they were coping" and "dealing with their stress."

Pandora reflects on her personal feelings of fear and the impact of isolating herself from her family, specifically her mother, during the COVID-19 pandemic. Recalling a time when she was so scared of infecting her family that she stayed in the basement, Pandora states that she found isolation "very lonely." She further admits that if she had continued isolating herself from her mom any longer that she "…probably would have killed [herself]." Pandora considers how her experience and perception changed over time, explaining that she eventually stopped isolating herself from her family. However, in order to resolve her continued fear of infecting them, Pandora explains that she "faked symptoms every two months and got swabbed to make

sure [she] was negative… [hoping] for the best." Reflecting on a high-risk situation in which she performed unprotected cardiopulmonary resuscitation (CPR) on an eighteen-year-old COVID-positive patient, Pandora comments, "I wasn't gonna go mask up first," suggesting that she felt the need to sacrifice herself for the wellbeing of her patient. Pandora shares how she believes that "every other nurse in that situation would have probably [made] the same choice," suggesting that nurses are expected to sacrifice themselves for the benefit of others. I find it interesting that Pandora does not see her actions at this time as self-sabotaging.

Pandora's final defining moment occurred when she cared for a twelve-year-old who had attempted suicide because she "couldn't be stuck at home with her mom's drinking anymore." Reflecting on her experience, Pandora recalls being unable to "fix it in time," leaving her to feel "really broken." I find her choice of words intriguing, as they suggest that Pandora felt both personally responsible for failing to make the child better and powerless to do so. Given the early rhetoric of nurses as heroes and that our culture is made to believe heroes can save anybody, it appears that she had subconsciously internalized this, believing that she too would be able to save everybody. It also seems that Pandora had a deeper meaning for that statement, believing that if nurses had worked harder to protect the community, the pandemic would have been over, and the child would have never been in that situation.

Plotline Four: Villain - I don't want you as my nurse

Pandora recounted a story of being seen as 'the villain' in the eyes of a patient:

> *I have this patient, and she was in with COVID, and she was an anti-masker. And… she's just… the bane of my existence. It was the first time I actually refused care. It's like, "No. There's other nurses. I'm not going in there". She was COVID positive. On four litres of oxygen…nasal prongs. And needed help to get up. And she refused to wear a mask. So, every time I would go in, I was like, "Hi, can you put your mask on, so I can come in and help you to the washroom?" "Hi, can you… put your mask on, so that I can do your bloodwork?" And she was… grossly symptomatic. There's… the COVID positives that are like, "I've got a fever and like, I'm really cold," and there was her. Actively hacking*

up a storm. Coughing… febrile. Like super, super, symptomatic. And she… puts on her mask, I go in, she rips off her mask and spits at me. And… I have like this huge like spit stain across my mask… it's… disgusting. So, I leave. And then, as I'm leaving, she's like, "I bet you're a nice person, but you're a fucking asshole. So, I don't want you as my nurse." I'm like, "Perfect. I don't want to be your nurse," and I walked out.

Pandora goes on to discuss the support she received from the hospital while caring for abusive patients:

And so, I called the charge [nurse], and charge called COMMS. They are… our communication, which is, I think that's the acting manager. And they're like, "No, you still have to care for her. You can't refuse her care." I'm like "She's… actively… denying to wear a mask. Why can't we charge her with… a fine?" And they're like, "Cause it's healthcare. We can't." And so, I'm like, "I'm not caring for her. I don't want to care for her." She's like, "Okay, that's fine. You don't have to care for her because she refused you anyway." But my partner had to do all the work. Because, like, there was no other nurse to take her. And then, I was so pissed off at that point, like I just wanted to fight anybody that would let me fight them... I couldn't step foot in that room. And… my partner's like "I don't want to go in there." And I'm like, "One of us has to. And I will probably deck her if I go into that room again."

Pandora continues:

So, like I wrote like a huge incident report on it… And I told my dad about it. He's like, "You know, if someone with HIV spits at you, it's considered attempted murder." Right? I was like, Yeah, but it's not the same." And he's like, "Why not? COVID is killing like a mass amount of people. It is the same if you got COVID from that." And so, like, that's what I told my manager. And I was like… "I have the right to refuse unsafe work, because that's deemed unsafe and, it's one thing if she can't wear a mask but she's like in… like, unable to wear a mask. And we're intubating her, and I have the correct PPE on, and if I don't go in she's going to die. But she's not going to die." And my managers like, "Actually you don't have the right to refuse unsafe work, OSHA [Occupational Safety and Health Administration] doesn't apply in hospitals." Which it does. Which it does. Like fully, it does. And she was like… I was like, "So then tell me, why is it if someone's HIV positive and spits on you [they] get… charged with attempted murder, but this person won't…" She's like, "Well, HIV is a different case. You should just be lucky that she didn't charge you with abandonment." That was the end of that conversation.

When asked if her hospital has a zero-tolerance abuse policy, Pandora responded:

No. We… we do… it's like don't abuse nurses, we're all tired type of signs, but it's no it's really not. Like you figure, you figure most hospitals would.

On feeling relieved when the patient decompensated:

She ended up being shipped out. I think it was to Orangeville. She decompensated really fast and ended up being intubated. So… as bad as this sounds, I'm like, I'm glad she's intubated. She's not going to do that anybody else.

Pandora shared a story describing the moral and ethical dilemmas that she faced in providing care during the COVID-19 pandemic:

So, we were all having a super bad shift, and you could just tell because everyone was defeated. We have… in [one] zone, we have 30-37 rooms. And all 37 rooms were… filled with… known COVID positive [patients], that were on oxygen. We only have one cycling room left. That was… used for [another] COVID positive [patient]… We couldn't take anybody more. We were already triaging in our ambulance bay, and pushing them into a corner, and making sure… testing their oxygen to make sure that they weren't desatting. And that was it. And putting them on… a little can of O2 [oxygen] if they were [desatting] wait[ing] for that one room. And there was this… one couple, that came in. And they were Asian, mid 40s… they had gotten COVID, and they were so terrified about this diagnosis…The wife was absolutely fine. She didn't need to be here at all. But the husband… he would get up, and he'd be… short of breath. And then he would become tachy [tachycardic], at probably 110, when he would get up just to go… from the bed… to the sink. Which is… five feet? Ten feet? And… we're like okay, you got to walk around for a minute… to see if you desat and earn yourself a bed. And he went from like 98 to 93 on room air. But he didn't… reach that 92… and as soon as he settled, he went back up to 95. And the doc… is a really good, good doctor, but he's a little bit like, 'all right, like screw off you're fine', kind of doctor. And he's like, "Okay, you're fine. Comeback when you can't breathe anymore. You can go home." ... that was it. It's like, 'come back if you can't breathe anymore.' No… 'you're going to get better when,' 'you're going to get better slowly,' 'here's some steroids,' 'you don't have a fever'… 'Take Tylenol and Advil'. "Come back when you can't breathe". And… this guy… his wife wheeled him out. And she was like, "How am I supposed to take care of him, when I have three children at home, and he can't leave his bed? And I can't have any help him?" And I was like, "I don't know." But I still… walked him to the exit. … we had… I think it was three COVID floors… And they were all full… of people that needed oxygen. We couldn't take someone that didn't need oxygen, cause there was no space. Like it…. Yeah. So, I sound like a really shitty nurse.

Pandora recalled how the community saw nurses as the enemy:

The day the first protest hit, I was actually at work and I'm sitting in the break room... And… one of the nurses was like, "Oh, this is really weird." I was like "What is it?" And she showed me… a meme of like, "Oh, COVID doesn't exist. Let me give you something to worry about." And there's this person with a gun… like, "I'm going to come in and shoot up the emergency department." Like, this emergency department. Because "COVID doesn't exist and I'm going to give you guys something that you need to be focused on." It actually got to the level that we were so uncomfortable, that we closed the department doors. And we had a security guard outside… give everybody a once over before they go in. And… that's what level of security we were on. Because I wasn't sure if

someone's going to come in and shoot up the entire emerg, or it was just like a "Hee-hee, it's the internet, I can do what I want" type of thing.

Thinking about how the Government treated nurses:

I don't think the government… actually… ever said that nurses are the enemy, so I think that's probably a good sign… They might not have seen us as the enemy, but they portrayed us as someone that was to blame.

Sharing how being the Government's 'scapegoat' made her feel angry:

[I wanted to yell at the Government]. But I know that was kind of unfeasible. Like, you can't change the way of the government thinks. Because the government is such a… It's like this untouchable entity. Is what… how it… seems. Because it's a bunch of… people that aren't health care, trying to make decisions… about health care… and not really knowing what they're effecting. So, it's like asking your Uncle Joe what his thoughts are about… I don't know… some disease process that he [knows] nothing about. And so… you can't really get mad at them … You can't really yell at them. There's no one person to yell at.

On fear for her own safety at that time, Pandora shares:

I didn't want to come to work. Like… I don't work in the states for that reason. If I wanted gun violence, I can go down to the states and easily have a mass shooting every week. But I didn't want to work in the States. I don't need an episode of Grey's Anatomy in the emergency department. Right? And it, it terrified me. But… I'm still like a baby [nurse]. So, I look [to] the big, bigger nurses. Right? "Oh, it's cool. [Matilda] isn't scared, so I don't have to be scared. She's got more experience than me, she'll know if we have to be scared. And she's not scared yet, so I'm okay". And then, seeing some of the nurses like, "Yeah, no. I'm not doing work tomorrow. I'm calling in sick." I'm like, "Okay, some of them are scared. This is how it's going to be here for the next time." So, yeah. And that fear is still there, cause that was… two weeks ago, right? Not even. Yeah. So, this is… it's far from over. Um, right now, the issue is, is that we don't have enough staff. So, even if you are scared to come in, you still come in. Because no one else will do that job.

With respect to the protestors demonstrating on University Avenue, Pandora shared her feelings of defeat:

As for the protest, I just…At that time I was just so done, that I was like… "You have fun. I'll see you in three months when you're being intubated in the emerg." … I wanted to scream at them. I wanted to yell at them. But it wasn't… It's like convincing us not to get the vaccine, as my sister said. She's like, "You can't convince someone to get the vaccine, because it's like convincing you to not get the vaccine."

She continues:

And we're starting to get the antivaxxers in now. Like we intubated, this 30-year-old pregnant lady. Who didn't believe COVID was real. So didn't get the vaccine. And got

COVID, we think at one of the rallies. And like, her last words when, like before we… had intubated her, was like, "You guys are just lying to me. I don't have COVID." And like, that was it. It's like "Okay we're gonna, we're gonna put a tube down your throat help you breathe now." Like, so it's still not over.

During her second interview, Pandora shares how being treated as the 'villain' changed nurses' perception of those who do not follow public health measures:

… we're still having a bunch of anti maskers and anti-vaxxers. And they're very… They're still very aggressive to it. And they, they come in fighting, because they're still scared that they're going to get the vaccine. And even now it's… there's still that great divide in COVID. And now, there is even less tolerance with the nurses…to the patients. Whereas before, it was like, "Oh, you're not vaxxed? Okay, there's got to be some sort of reason." Now it's like, "You're not vaxxed. What the hell are you doing? Why are you coming… seeking treatment if you don't want… If you don't want the prevention?"

Adding:

Like, we were so far into it. That it's like, "How do you not know that this is real?" So, the compassion is gone. Like, you try to be compassionate, because you know that they're not going to wake up. And… that baby will probably be born without that mom ever seeing that baby, because she's not going to be un-tubed. That's the reality of it. So, you try to be compassionate, because you're probably gonna be the last person that actually speaks to her. But … the compassion's gone. You know, like "Oh, let me go get your warm blanket. Let me like… "How can I make this more comfortable? How are you doing?" It's like a… "No we're going to intubate you because of this. And whether you believe it or not, you still need to be intubated." Like the… it's very direct. And very… wasn't my best care of a patient… I was doing my job… I was meeting standards. I wasn't going above them. Right? Like, I wasn't… like any other intubated patient that was still conscious enough, I would have been like, "You're gonna do okay." Like, "You're going to get through this. Just keep like… you're strong. Just keep trying to breathe." Like trying to comfort them. With her? No. Like with her, it's like, "This is what we're gonna do and that's it." Like, no like, "Hi how are you feeling?" No pleasantries.

Pandora also remembers caring for a pediatric patient whose parents were anti-vaxxers:

…The one [patient] that just seems to stick in my mind the best… is like this code pink. … I think she's probably three. She comes in, and she's, she's having a febrile seizure and stopped breathing. And all of them, are COVID positive. Because the mom… and it was like right when we were getting our second dose vaccines…And it was the mom the dad didn't believe in vaccinating them. And she had none of her immunizations as well. Like her baseline, her MMR and that type of stuff. And I just… It's probably after we talked. But that one just sticks in my brain, because it's… a) its a code pink. It was unsuccessful at that. But, it was such an interesting way for me to understand that… How… impacts of other people. Right? And how we don't have the health education that we should. Because, like that, kid did nothing wrong. The parents didn't believe in Tylenol, didn't believe in Advil. They didn't believe in any Western medicine. And this child died because

of it. Because, like her fever, which… when we tested her fever, it was 42.8. And we like, gave her Tylenol, but like, what is that going to do at this point? …they're like, "We don't know how to help her." Like, she's blue. And it was… I think [coming to the hospital] was like their last resort. And they're they were, absolutely beside themselves. Which is… what you expect. In absolute hysterics. But, like, it… especially in that moment, you're like, "You kind of did this." And in pediatric resus you always want to blame somebody. Right? Cause kids don't just die. And so, you saw a bunch of the nurses, like, walk away from that, and like, "Why the hell did those parents do that?" Right? There was a bunch of blame on the parents. So that… was the one that's stuck with me the most.

On feeling angry throughout the pandemic:

…the anger raged from anybody that wasn't maintaining the restrictions to anybody that… Like before Omicron, you kind of had to go out and do something to get COVID. Right? Or someone around you had to be doing something wrong to get COVID. The way… that's kind of the way it appeared. Like they had to go to a party. They had to go out drinking. They had to do something to get COVID, and then get you sick. Right? It was a bunch of mistakes. So, it was anger at this one unknown person in each patient's life. Or if they were young, and they're like, "Oh, yeah, I went to a COVID party and now, I have COVID." … that would make you angry at the patients. Angry at management because the way they were handling the PPE. Angry at the Government because of the way they are handling the lockdowns. Even now, like, the Government has taken away all mask mandates, and they probably shouldn't because that's not… like is going to be around forever. You know that now. But it's still… it's still effecting a bunch of people's lives. It's still a strong variant. So, it's anger all around.

Pandora reflects back on the change in community support from the beginning of the pandemic:

When the appreciation kinda dimmed down, is when we actually needed that. Like "Keep going. You're gonna be fine. You can do this." And there's nothing. Right? And it wasn't, it wasn't mixed. It wasn't replaced with like a neutral, like, "Okay, cool like you do what you do, I'll do what I do." It was replaced with… anti-maskers, anti-vaxxers. It's like "You're lying to me, this isn't real." … we're still having a bunch of anti maskers and anti-vaxxers. And they're very… They're still very aggressive to it. And they, they come in fighting, because they're still scared that they're going to get the vaccine…

She adds:

It was nice to feel appreciated [at the beginning of the pandemic]. But it was short lived. And that's to be expected. But at the same time, I just didn't want it replaced with something the exact opposite.

Reflecting on how nurses did not live up to the public's expectations of being the 'hero':

I feel… when I was telling you that… I don't deserve the hero… I felt… as if I… haven't been able to do much… I think it was more of a mental health thing as opposed to a

societal thing. I … absolutely don't think that we deserve the, like, "What the hell are you doing?" Like, "You're the reason we're in the mess." Even though that's kind of what I felt like. It felt like no matter what I did, you couldn't do enough. You couldn't save them all, as the hero aspect would read in. But I don't think we deserve to be the villain in it.

Pandora wants people to know that nurses are not the enemy:

Everybody made sacrifices. Especially in healthcare. Because you were just… You didn't like… no one else could do it. It wasn't like a "Oh, lets go in, like, start a line, you can all do compressions." No. It was like, you need to know medications, you need to understand how to run a code… And that's what people… I think don't get. Is that we all made sacrifices.

When asked if Pandora ever witnessed a situation in which the care she provided led to a positive outcome, she shared:

Not really… There was just so many people and you just… no one followed up… No one was really like, "Yeah… this patient is better. This one got discharged." That type of thing. Um, the one that I do know of… was a nurse… one of my colleagues… she was gone for… a couple months. And she was young. She was probably mid 30s. And she… One day just disappeared. And then through… gossip, we found out she had COVID… And then she ended up in our resus [resuscitation] bay… and she went up to the ICU. And she is the only one that recovered… but when I mean she recovered, she was never really able to… she can't concentrate anymore. Which is what I found weird… she can't concentrate enough to be a nurse anymore. But she came back for a couple weeks… and then she ended up quitting. Like, two weeks later, quitting. She was like, "I just can't." Whether… that was mental stress, or like, trauma? I don't know what it was. But she described it as brain fog. And she's like, "Yeah, COVID gave me brain fog and can't do this anymore. I don't trust myself." So, she ended up quitting. That's really the only one that… I know the ending. Other than the ones that have died… We don't really see the end of it, right? So… the most positive would be, like, "Yeah, you have, COVID. Go home, get better." Right? And the worst off, you die. Or worst off, you get intubated. And then we don't see you. Right? When you go to the floor, we don't see you. And nobody really comes back to "Oh, yeah, like I'm okay." Right? I had a hypothermic COVID arrest that actually survived, so I guess that's positive outcome? But, but other than that, I can't really… We don't really know the ending of our stories.

Researcher's Field Notes

Reflecting on caring for a verbally and physically abusive patient, Pandora considers the social context of nursing, her right to refuse unsafe work, and her obligation to help others. Recalling the first time she refused to provide nursing care to an insolent patient, Pandora seems to feel a tension between her professional responsibilities and her desire to feel safe. Pandora

offers a personal reflection inward as she expresses disgust and anger both for the patient's actions and the lack of support by her hospital administration. This personal expression of feelings suggests that Pandora values supportive working relationships. Pandora describes debriefing the event with her father and feeling justified in her actions. This external validation seemed to give her the confidence she needed to continue advocating for nurses' health and safety. Upon attempting to advocate for nurses when speaking with her manager, Pandora recalls being told that she "…should just be lucky that [the patient] didn't charge [her] with abandonment," demonstrating how nurses' voices are being silenced by their profession. Pandora remembers how the patient deteriorated and required intubation, stating that she feels "glad [that the patient] 's intubated." This statement suggests that Pandora feels that silencing others is the only way to make hearing nurses' voices possible.

Pandora's reflection on caring for a COVID-positive couple discharged home uncovers a significant defining moment for her. Pandora seems to have experienced ethical and moral distress due to the discrepancy between what she wanted to do in this situation and what she was forced to do by the physician, whom she perceived as having more power. This experience changed and transformed her perception of herself as a nurse, allowing her to believe that she is the 'villain' that the community portrayed her as. The emotional impact this experience had on her altered her perception of self and led her to feel powerless and defeated. Considering the narrative dimension of time, the way this past event appears to her now is that she was "a shitty nurse."

Thinking back to the protests on University Avenue, Pandora remembers how the community saw nurses as the enemy. She recalls seeing online messages of people threatening to "shoot up the emergency department." This caused her to feel "terrified," as she did not know

whether the threat was real. Pandora remembers not being able to stay home from work because "no one else will do [her] job," suggesting that only "heroes" can do her job. Similar to her experience with her elderly patient's granddaughter, Pandora describes wanting to scream at the protestors, again demonstrating that nurses have no voice. It seems that Pandora is misguided in her perception of who she is most angry with.

Pandora comments that the Government "portrayed [nurses] as someone that was to blame" for the pandemic, suggesting that Pandora feels like the Government abandoned her. She talks about wanting to "yell" at the Government for not protecting nurses, noting that it was "unfeasible." As Pandora remarks that the Government is "a bunch of… people that aren't health care, trying to make decisions… about health care… and not really knowing what they're affecting," her comment strikes me, "So… you can't really get mad at them," suggesting that their ignorance is excusable. It seems like Pandora is just so defeated that she is trying to justify the actions of others as a method of coping with the betrayal she feels. Despite feeling defeated, Pandora demonstrates her compassion for others by continuing to care for those who have turned their back on her when she recalls caring for a pregnant patient that required intubation after attending one of the rallies. It appears that Pandora does not recognize her strength at this moment.

Pandora remembers caring for a pediatric patient who died from a febrile seizure after contracting COVID-19. Reflecting outward on the social context, Pandora states, "it was such an interesting way for me to understand…. [the] impact of other people… because… that kid did nothing wrong… The mom and dad didn't believe in [vaccinations]… Tylenol… Advil… [or] any Western medicine." Pandora also positions her implicit feelings of sadness, helplessness, and anger in the social context, comparing herself to colleagues who similarly "blame[d] the parents"

for the child's death. Pandora states, "that… was the one [patient] that's stuck with me the most," suggesting that even though time has passed since this event, traumatic events such as this one seem to generate emotional and moral distress and possibly exceed their temporal position by remaining closer to the present than the past.

Pandora reflects on how the level of community support changed throughout the pandemic. While Pandora notes that being unappreciated in nursing is "to be expected," she suggests that the public's attitude towards nurses shifted from ambivalence to condemnation, evoking feelings of sadness and disappointment. Although this description of temporality and sociality are dominant in Pandora's stories, this particular reflection suggests feelings of vulnerability and discomfort in the future of nursing. It seems as though this is why Pandora struggles to recall a situation in which her care during the pandemic resulted in a positive outcome when asked. Her comment strikes me, "We don't really know the ending of our stories." This comment not only suggests that Pandora has not given up hope for the future of herself and nursing, but it is also deeply profound considering the nature of narrative inquiry.

Plotline Five: To be Continued - I was just at the end of my rope

Pandora contemplates how she tried to survive working as a nurse during the COVID-19 pandemic:

> *My coping skills, as bad as it sounds as an emerg nurse, was going out for drinks with my co-workers. And then, in March when the isolation hit, you couldn't do that. And I didn't really… I'd been nursing for less than a year. I didn't have any other coping skills really developed.*

Looking back on the coping skills she used:

> *I worked more. My coping mechanism is diving in… diving into more stress and more work. Um, there's also some really good, like, resources… I could use that were made available because of the COVID pandemic through CAMH [Centre for Addition and Mental Health] … So, I did try that. It wasn't as helpful as I would want. But then again, I'm not really wanting to open up in therapy…*

Pandora comments that socialization with friends was the most helpful:

My friends were a really big coping mechanism… I started calling… my best friend and… I said, "We're just talking about her boy troubles." And it was just so innocent and juvenile, that made it a little bit a little easier for me… And I started to go for walks with friends. Like, specifically it was nursing friends that… nursed with me… So, my one friend was like, "All right, we're going for walks every, every Tuesday. We're going to meet and go for a walk. We can meet… at the hospital, we can meet downtown, we can meet… where you live… where I live, but we're going to go for a walk." And that really helps. Just getting outside on that one day that I wasn't working.

On thinking about how she is coping now:

Like… it's still not over. So… I'm still putting my own health on the backburner to make sure that… (tearful) and I'm eating a lot of candy. Those are how… those are how I'm doing it.

Pandora shares the emotional toll that the pandemic has taken on her:

I definitely, I definitely worried some of the doctors at my work though. Like, so much. At one point, they… one of the doctors was like, "No, I'm not letting you go home." Like, "You're either gonna get seen here or I am going to form you, and you're going to get seen here." Like, "I don't trust you going home." So after, after a 12-hour shift. I had to stay for another six hours just to see psych. And, like, I was discharged. And they're like, "Okay, like, here's some sleeping pills. You're good". (Smirks) So…

Pandora continued with:

…but I needed it. Like, I wasn't sleeping, I was barely eating. Um, yeah, and like, usually I have like a really… I'm like a snack God in emergency. So, I always brought snacks. Um, so like, I'm usually really bubbly person, and then they just like… like, I talked to [one doctor]. She's on mat [maternity] leave now, but I talked to her right before she went on mat leave, and she's like, "You were scaring me." Like, "I thought one day you were just going to go home and come back VSA [vital signs absent]. Cause you were gonna kill yourself." And like, I didn't… I didn't even see it. Like I wasn't having active suicidal thoughts. I wasn't… I was just at the end of my rope.

Pandora adds:

I told my manager, "You can put me as casual, or I'm leaving." And I probably still will also leave the profession, eventually. And when I mean eventually, I mean like, in the next year or two. Because I'm just… still so burnt out by it.

In her subsequent interview, Pandora further explores how the pandemic affected her physical and mental wellbeing:

…in the middle of the pandemic, by all means, I was suicidal. Like, I did not believe I was going to see the end of the pandemic. Like… I was going to work until I dropped, and that

was okay with me. Physical well-being…so I loved sports. And I couldn't do any of that. So that basically, basically, all I did in the pandemic was work and sleep. And then I wasn't even sleeping. So… it's basically just working. And I would give myself, like, these crazy short turnarounds. So, I would do eight hours off and 12 hours on. And so… I'd be working pretty much non-stop. So, like, my mental health, and my physical health just completely went to the wayside.

When questioned how she has processed her emotions, Pandora states:

I didn't. Like, in reality… the entire pandemic I was numb… I broke up with my partner… because she was like… "You're just too emotionally numb." I was like… "Yeah I am." And… she's a nurse too, and she's like, "Labour and delivery saw a bad COVID too." And I'm like, "No… you didn't… You didn't see people say goodbye to other people, and never wake up." So… I just didn't process. Like, slowly I'm starting to… but… you have to be able to come to work the next day, and if you start to think about it you weren't going to come to work.

She adds:

… it's not something we talk about in emerg. Right? You… The shit happens. You go… you move on next patient. Next person. You don't really have time to cope or debrief. Or to, like, almost reminisce on it.

Thinking back to how debriefing happened in her rural hospital prior to COVID, Pandora shares:

…in [the rural hospital] they did [debrief critical events]… They did a lot of it, and it was very… and it was very good for me as a like as a learner, because I would go to all of them. Even if I wasn't involved. And I would understand what it was… it's like "What went right? What went wrong? How are you feeling? What could we have done better?" Right? It was like that. Its usually a hot debrief and then a week later, it would be… like, we'd get together. We'd have lunch, and we would talk about it again. Like… and it's usually… like, it wouldn't have been for all codes, but … the first COVID code we tried to have it. But it didn't… It didn't work out because it was over Zoom. You couldn't hear anything.

When asked if she has a therapist, or someone to speak to, Pandora stated:

Yeah, absolutely. After I went casual… I got into touch with some really good counseling. And… I'm getting better. It's getting better, but it's still… It's a work in progress. If I don't work for four days, I don't ever want to go back.

During her subsequent interview, Pandora reflects further on how her wellbeing has improved over time:

It's definitely improving over time. It still has a ways to go to get back to Pre-COVID times, I should say. But it's definitely getting better. The, the numbness is still… like the

dissociation… The dissociation of my feelings and my work is still very present. … like when I go to work … I don't feel anything. … like we could have an arrest of a young person, and I'd be like, "Okay, that was sad. Next one." Right? And that's… I think that's gonna be a lasting effect from the pandemic. It's like, I'm so used to… as long as I'm not seeing 12, 13, bodies back-to-back, it's a good day. Right? That's still going to be my baseline of what a rough day is. So that numbness will still be there. But it's definitely getting better.

Adding:

I've taken a bunch of time off work. I'm… back to travelling. And so, pre-COVID, I would work six shifts in a row, cause that's what the max was. And then… I would go away for two weeks. And… I'm starting to get back to that. And I'm going out with friends. And, and I'm doing stuff that's not work and not sleep.

On contemplating leaving nursing and considering alternative employment, or taking a break from her job, Pandora said:

I am actually looking to get out of the nursing profession. I actually just got accepted into… I guess it's still in nursing, but extended scope practice. So that'd be going up north, and I'd be working as a nurse practitioner, without becoming a nurse practitioner. It's… a six-week program. So… I get this… certificate, and then I can prescribe, I can cast, I can do… emergency management, if there's an emergency. I can suture. I can do all this… cool stuff. That's not emergency.

In reflecting on why Pandora continues to work as a nurse in the emergency room, she shares:

I like knowing that I make a difference. And I know that if I stay in emerg I can. I also feel like I have the skill set, no one else is going to do it. And, so I want to make sure that I can help someone while I still can. I also like… the cases. The medicine I get to practice, and the skill set I get to use. I don't think I'll find that anywhere else. So, it keeps me going back.

She adds:

The other thing that is keeping me going back is the people I work with. Like, they're slowly changing, but seeing new faces and them being like, "Oh my god, I just performed my first ECG!" It's, it's kind of nice to see… excitement in that. I got one of them to put an IV in me the other day, and they're like, "Oh my god, did I hurt you?" I'm like, "Well you blew my vein, but I'll be fine." Like, "I'll survive." (laughing) They're like, "Thanks for letting me do that." I was like, "You gotta… start somewhere." We were all there. We just gotta… [remember] that.

In thinking further about the new nurses entering the profession of nursing at this time, Pandora describes:

They just… they fill me with such like hope for the profession. … I'm absolutely terrified that they're nursing because I was talking to someone yesterday, and they have one clinical experience and that was in long term care. And now the new grad nurses are in emerg. Like this…this is gonna be a bumpy ride. Like, here we go!

Pandora's advice for the future:

For management [my advice] would be to listen to your nurses. Because even if they're not telling you what's the matter, you can see it. In their actions, and the way they are coping, and the way that they care for patients. So that would definitely be my advice to management. And like, try your best to be as hands on as possible.

For government… you need to re-prioritize healthcare. You need to fix health care because this isn't sustainable. And, right now, I'm one of the most senior nurses in my emergency department... and I have less than two years of experience… you need to refocus and reinvest in healthcare and make some drastic changes. Because our health care system is going to collapse in the next six months if nothing changes.

And for nurses, for new nurses coming on, I would say probably, focus on yourself and work life balance. Don't think you can do it all, because… it will catch up to you. And when it does, it might be too late. For older nurses, be kind. I know we're all burnt out, but those new nurses coming on somehow still have some excitement in their career.

Pandora finishes with:

The whole COVID has been a learning experience, to… I think everybody. And… it's going to happen again. It's just a matter of time. And it's just going to be interesting to see what we've actually learned from this.

When asked if thinks that we have learned anything from COVID, Pandora boldly states:

Nothing that won't be forgotten. Right? Like, we thought we learned something from SARS, and yet all the stuff we had in… storage had expired. So, we couldn't even use it for COVID. So, we will forget most of the stuff we've learned… I think for health care it'll be a lack of… It'll be forgetting. Like, we have a great tendency of forgetting the bad. Right? Like… even now, like, even talking back… not having to talk to you since October, I'm like, "Oh, yeah, I forgot that." … it's just funny what you remember, [and] what you don't remember. Because, like, these [stories] weren't the most traumatic ones. …Like, because we're just… it's onto the next thing. Right? And now, we're having like a huge upswing in domestic violence. Absolutely massive. And so … COVID's out the window. COVID's just a part of our… it's like flu, COVID, RSV, and so on. It becomes part of our… and for government… I don't think the government even knew. Right? Like they knew the stats, but they didn't know… like, having to walk into hospital, having to get into intubate six, seven people on a shift, or having body bags in the waiting rooms… We had… we ran out of stuff in our morgue, so we had six or seven body bags in our little waiting room… all the nurses avoid that waiting room now. Like we, we don't go near it.

Adding:

…the majority of the staff now hasn't even seen COVID… The majority of staff started… I want to say less… like probably December. So, they don't even know… it's already forgotten because they weren't a part of it… we've lost 6 out of 8 of our charge nurses in the… past four months… Some of them have quit nursing all together. Some of them are moving out of emerg, mostly to the ICU. And then some of them have gone to other charge nurse positions in different hospitals. So, I went from being… like in… COVID when I came, I was… more junior… and now I'm probably… there's probably four people in front of me to be charge, and then it's me. And I don't even triage yet… (laughs)

Researcher's Field Notes

Pandora reflects on how she tried to survive working as a nurse during the COVID-19 pandemic, admitting that when the pandemic began, she had been nursing for less than a year and had not yet developed any coping skills. She recalls at that time "going out for drinks with [her] co-workers" as her primary method of coping. Pandora considers how her coping methods have changed throughout the pandemic, mentioning that she began calling friends, going for walks, and eventually got in touch "with some really good counseling." On thinking about how she is coping now, Pandora shares that she is "still putting [her] own health on the backburner" and "eating lots of candy." It appears as though Pandora lacks insight into her own wellbeing.

Reflecting on a past event and how it appears to her now, Pandora describes having "a huge down spiral." She recalls being assessed by a psychologist after a doctor she worked with expressed concerns about her safety. She suggests that this was a turning point for her in her perception of self, stating, "I didn't even see it. Like, I wasn't having active suicidal thoughts… I was just at the end of my rope." Pandora smirks when remembering being discharged home with "some sleeping pills," suggesting that she felt this form of treatment was a joke. I find it interesting that her following sentence is "…but I needed it… I wasn't sleeping," as it seems as though she is trying to convince herself that the medication was enough. It appears that Pandora felt as though she did not need help at that time. It also seems like Pandora lacks insight into how her experience of working during the pandemic has affected her psychological wellbeing.

Between her first and second interviews, Pandora continued to think about how the pandemic affected her physical and mental wellbeing. I am struck by her comment, "…in the middle of the pandemic, by all means, I was suicidal. Like, I did not believe I was going to see the end of the pandemic… I was going to work until I dropped, and that was okay with me." This comment not only demonstrates the depth of the impact that the pandemic had on her, but it also suggests that Pandora has become more aware of the pandemic's effects.

Looking back on how she processed her emotions, Pandora reflects inward on a personal feeling of being numb. This causes her to question how nurses fail to debrief the experiences they encounter while working in the emergency room, suggesting that the lack of emotional processing has caused her to be emotionally distant from others, resulting in the end of her relationship with her partner. She comments that she is working on processing her emotions to manage her work-related feelings and improve her interpersonal relationships. Her perception now is that she is "getting better." In her subsequent interview, Pandora reflects on how her wellbeing has improved over time. I am intrigued by her comment, "The dissociation of my feelings and my work is still very present … like when I go to work … I don't feel anything … like we could have an arrest of a young person, and I'd be like, "Okay, that was sad. Next one." Right? And that's… I think that's gonna be a lasting effect from the pandemic." This comment implies that Pandora has not fully worked through her emotions. I am also struck by her comment, "as long as I'm not seeing 12, 13, bodies back-to-back, it's a good day." This comment downplays the impact of day-to-day traumatic events that Pandora witnesses while working in the ER.

Pandora considers her nursing career over the dimension of time in relation to her perception of self, personal feelings, experiences of trauma while working in her role, and the

support of others. Pandora admits that her experiences during the pandemic have caused her to consider leaving the nursing profession. Pandora states that she plans to go "up north" to take on an advanced nursing role. I find it interesting that Pandora's idea of 'leaving the nursing profession' is taking on another nursing role. This suggests that she identifies strongly with being a nurse. I am also struck by Pandora's comment about being able to "do emergency management if there is an emergency" while working in her prospective role. Her comment indicates that Pandora's perception of self is strongly tied to being an emergency nurse. On reflecting on her current position, Pandora shares, "I like knowing that I make a difference. And I know that if I stay in emerg, I can." Adding, "I want to make sure that I can help someone while I still can." This suggests that Pandora is willing to help others at the expense of her mental wellbeing. Reflecting outward, Pandora expresses her hopes for the future of nursing. She talks about the need for the government to reinvest in healthcare and for management to listen to their nurses, attributing these actions with the sustainability of emergency room nursing. I am struck by her comment, "… for new nurses coming on… focus on yourself and work-life balance. Don't think you can do it all, because… it will catch up to you. And when it does, it might be too late." It appears as though this is Pandora's advice to a younger version of herself.

Pandora reflects on the learning that has occurred as a result of the COVID-19 pandemic. Considering the social and temporal narrative dimensions, Pandora compares the COVID-19 pandemic to the 2003 SARS crisis in Toronto. Her perception of what has been learned from the COVID-19 pandemic is "nothing that won't be forgotten." She talks about how the PPE that had been kept in storage in case of another pandemic, had expired and was deemed unsafe for use during COVID. I am struck by her comment, "we will forget most of the stuff we've learned… I think for health care … It'll be forgetting. Like, we have a great tendency of forgetting the bad."

This comment implies that ER nurses supress the traumatic events they experience in an effort to cope and continue working in the ER. Indeed, Pandora demonstrates the functionality of this coping mechanism when she says, “Like… even now, like, even talking back… not having to talk to you since October, I’m like, “Oh, yeah, I forgot that.” … it's just funny what you remember, [and] what you don't remember. Because, like, these [stories] weren't the most traumatic ones.”

Pandora reflects outward during her second interview to describe how the COVID-19 pandemic has led to the exodus of nurses from the ER. Her comment strikes me, “the majority of the staff now hasn’t even seen COVID,” implying that the COVID cases have decreased significantly over time and that many staff have less than a year’s experience in the ER. Pandora laughs as she says, “when I came, I was… more junior… and now… there’s probably four people in front of me to be charge, and then it’s me. And I don’t even triage yet.” This comment suggests that Pandora believes that having a balance of junior and senior nurses is essential in providing safe and effective care.

Attending to Pandora’s Story

Pandora’s story showcases the emotional toll that the COVID-19 pandemic has taken on ER nurses. As Pandora shares her story, she illustrates how ER nurses became physically and emotionally exhausted as the pandemic raged on and demonstrates how nurses were not afforded the time to deal with the grief and loss they were experiencing. Additionally, Pandora’s story reveals that the lack of real-time interventions to help support the emotional needs of nurses has resulted in many nurses leaving the profession.

Grace Note to Pandora

Dear Pandora,

Thank you for teaching me that it is possible to extend empathy in the most challenging of circumstances, and that with hope, anything is possible. Your story is one of compassion, resilience, leadership, and hope.

I believe the compassion you show others is your most admirable quality. Your ability to care for those who have turned their back on you, shows tremendous strength.

My wish for you Pandora is that you will allow yourself the time to heal from the emotional traumas you have endured. I believe that through healing yourself, you will discover who you are. I hope that you will bring your excitement for mentoring others into your nursing career, seeking out opportunities to mentor and encourage others. You will be the most extraordinary role model to those who are lucky enough to have you lead them on their nursing journey.

"A hero is an ordinary individual who finds the strength to persevere and endure in spite of overwhelming obstacles."

– Christopher Reeve (Superman)

Chapter 5: Kali's Story

Kali: Participant Two's Alias

Kali is a name derived from Sanskrit, *kāla*, which translates to 'black' and 'time' (Fowler, 2012). Known as the goddess of time, change, destruction, and empowerment, Kali is one of Hinduism's most feared yet revered goddesses (Hindu Goddess, n.d.; Oh Baby, n.d.). In the eyes of westerners, Kali is often seen as a goddess of death and destruction and is portrayed as a "terrible mother" (Marsman, 2019). In India, however, Kali is regarded as a manifestation of divine femininity and is mainly seen as a saviour and protector (Marsman, 2019). Kali's early history suggests that she was likely a fierce tribal goddess on the outskirts of Sanskritic Hindu culture (Marsman, 2019). However, Hindu civilization has appropriated the story of Kali over time and has transformed her into a symbol of femininity and female empowerment, thus moving her beyond her earlier marginal identity (Fowler, 2012; van Brussel & Pasty-Abdul Wahid, 2019).

The most well-known story of Kali appears in the *Devi Mahatmya* - a Hindu philosophical text – and describes how the goddess came and saved the world from widespread destruction and darkness (Fowler, 2012; McDermott & Kripal, 2003). Although Kali is not the primary goddess of this text (Durga is), she does make several vital appearances in it, the most important being her confrontation with the demon Raktabija.

According to the *Devi Mahatmya*, the demons and gods had been at war with each other, and it seemed as though the demons were going to win and take over the world (Marsman, 2019; McDermott & Kripal, 2003). Desperate for help, the gods call on Durga – a fierce and powerful goddess – to help render the gods victorious (McDermott & Kripal, 2003). While fighting in

battle, Durga is confronted by the demon Raktabija (Britannica, n.d.). Unlike other demons, Raktabija can reproduce himself instantly whenever a drop of his blood hits the ground (McDermott & Kripal, 2003). Having wounded Raktabija with various weapons, Durga finds herself in a worsening situation as the battlefield becomes flooded with his clones (Marsman, 2019; McDermott & Kripal, 2003). Infuriated by her inability to overcome the demon, Durga summons Kali, who springs forth from Durga's furrowed brow as a concentrated manifestation of her rage (Marsman, 2019; McDermott & Kripal, 2003). Kali turns the battle around by devouring the demon army with her gaping mouth and sucking Raktabija's blood dry—thus rendering him lifeless and saving the world (Marsman, 2019; McDermott & Kripal, 2003). Drunk on blood and rage from her victory against the demons, Kali continues on a murderous rampage destroying the world she is supposed to protect (Marsman, 2019; McDermott & Kripal, 2003).

While Kali is well integrated into the orthodox Hindu tradition as a ferocious, terrifying, powerful death-dealing goddess, she has also developed a parallel relationship in Tantrism (Fowler, 2012). In the tantric tradition, value is placed on one's ability to confront and overcome the prohibitive facets of life (A most misunderstood goddess, n.d.; Fowler, 2012). Due to her association with blood and death, Kali serves as a goddess that one can heroically confront, and through her, overcome socially constructed unlawful provisions (Fowler, 2012). As such, Kali emerges as a gracious and benevolent granter of liberty (A most misunderstood goddess, n.d.; Fowler, 2012; Leeming, 2020).

This softer side achieves even greater importance in *bhakti* or Hindu devotional traditions (Fowler, 2012). Here, Kali appears as a symbol of mother nature herself - primordial, creative, nurturing, and devouring in turn, but ultimately compassionate and loving (A most

misunderstood goddess, n.d.; Leeming, 2020). In this aspect of goodness, she is referred to as 'Kali Ma' or 'Divine Mother' (A most misunderstood goddess, n.d.). Indeed, Many Hindu devotees consider her the 'Divine Mother' and worship her in this form (A most misunderstood goddess, n.d.; Leeming, 2020). The Hindu devotee hopes that Kali will ultimately respond to her children's needs, providing them with a complete vision of reality (Fowler, 2012).

Throughout these texts, we see the duality of Kali – the nurturing earth mother who brings forth all life and the destructive power of death. As both the goddess of death and destruction and of transition and renewal, Kali reminds us of the virtue of channeling one's rage into action.

I chose the name Kali for participant two because, much like the Hindu goddess, participant two's story reflected a dichotomy between the words she carefully chose to express outwardly and the anger she tried to mask internally. Participant two, a wife and mother to three teenage boys, began her nursing career in 1992. With over 30 years of experience working as a nurse in Toronto, 28 of which were in the ER, participant two decided to change her status to full-time amid the pandemic, as she was already being asked to work full-time hours without reaping the associated benefits. Participant two's story is not COVID specific. Instead, she shares how the first wave of the COVID-19 pandemic gave ER nurses reprieve from the mistreatment they have historically endured at the hands of the communities they serve, only to find a resurgence of abuse as the pandemic carried on. Through sharing her story, participant two educates others on the sacrifices of nurses in hopes of eliciting change in how nurses are perceived and treated in everyday life, thus achieving Hindu Goddess Kali's central principle of turning anger into action.

Prologue: Meeting Kali

Kali and I met online on a sunny afternoon amid the fourth wave in late October. The bright rays of sunshine offered a welcomed break to the previously cool and rainy days that preceded it. Its presence, much like recent news reports, gave hope that brighter days lay ahead.

Recently reported statistics showed a decrease in the total number of known active COVID-19 cases in Ontario, with a total of 2,978 cases, declining from 3,435 the week prior (Global News, n.d.). Additionally, local news outlets touted that 88% of the eligible population in Ontario had received at least one shot of an approved COVID-19 vaccine, with almost 84.1% having received two doses and considered to be fully vaccinated (CTV News, n.d.). Moreover, with only 215 COVID-positive patients admitted to hospitals throughout all of Ontario and only 66 new COVID-positive cases in Toronto, I was beginning to feel as though the end was in sight and that ER nurses could finally start breathing a sigh of relief (CTV News, n.d.; Global News, n.d.).

I had planned to meet Kali at 1130 for her first interview via Zoom ©. Shortly after 0930, I received a text message from Kali asking if we could push our meeting time by a few hours so that she could attend a yoga class. Acknowledging the importance of self-care, I was happy to concede, and we rescheduled our meeting for later that afternoon. I greeted Kali as she entered the virtual meeting and noticed that she seemed a bit flustered. Running her fingers through her freshly showered yet disheveled hair, she explained that she had rushed home from yoga to shower before our meeting but that she did not have enough time to "fix her hair or put on make-up." She also shared that she had experienced computer difficulties while logging onto her computer and apologized for her appearance and for being late. I expressed my understanding and said that we were in no rush. I validated how challenging it can be to rely on technology to carry out activities that we could once do in person. Noticing Kali's teenage children in the

background, Kali and I chatted for a few minutes to allow the bustling activity to subside. After settling into our virtual meeting space, I hit the record button, and we began.

Plotlines in Kali's Narrative Account

Plotline One: Before They Were Heroes – I'm gonna go full-time, because why not?

Kali shares:

I [have been a nurse for] oh, I think, 27 years… I became a nurse because I liked helping people. Actually, I loved helping people. I love being with people. And I hated paperwork. (laughs) I didn't want to be pushing papers and sitting still… I graduated in '92 [and] started [working] at, um, [a community hospital] on [a medical unit] … I was there… Um, not very long. I think I went to emergency in 1994… Um, yeah, so I went in emerg in '94 in… at [the community hospital] … 'till 1999. March '99… and then I came to [my current hospital] after that.

Reflecting on why she became an emergency room nurse Kali enthusiastically states:

Why did I choose emergency? Because emergency is fast moving. And every day is different. It's spontaneous. It's adrenaline… fulfilling. Um, that's pretty much why I chose emergency. So every day was a different day.

Kali remembers how she changed her employment status during the first wave of the COVID-19 pandemic:

I went full time… just after [the pandemic] had started. Because, well, number one… up until that day, I was working full time hours, part-time, without any benefits. And I wasn't going to the dentist. I wasn't able to do anything for myself. And when the pandemic hit, and then nobody was going to the city, like, literally, I make it to work in an hour and 15 minutes. No problem. Like, that was so easy. Um, I... But… so I was like, I'm gonna go full time, because why not? I can go for massages… When, like, I didn't realize that everything was gonna be closed forever. But I could go for massages, I can go on vacation… What vacation?! (laughs)… Um, but I went full-time because I could get there fast, and I could get the benefits… And the emergency room was lighter. That's actually three reasons. (laughs) Benefits, traffic, and the lighter load.

Considering her decision further, Kali states:

This was my first pandemic actually… I didn't work through SARS. I was on maternity leave.

Researcher's Field Notes

Reflecting on her career choice, Kali recalls becoming a nurse because she "loved helping people." The past tense of this statement makes it appear as though Kali's feelings have changed over time. Although Kali does not explicitly state any external sources impacting a change in feelings towards others, her experiences while providing care throughout the COVID-19 pandemic were likely contributing factors, whether conscious or not.

As Kali shares her story, she explains that she decided to change her employment status to full-time at the beginning of the pandemic. Reflecting back to Pandora's story, where nurses were told by their hospital administrators, "[i]f you're full-time, pick-up OT. If you're part-time, pick-up full-time hours," I am intrigued by the fact that Kali chose to go full-time at the beginning of the pandemic. Having worked for over 27 years in the ER in Toronto, Kali is, in theory, no stranger to the challenges of pandemic nursing. Her comment strikes me, "this was my first pandemic actually… I didn't work through SARS. I was on maternity leave," suggesting that none of the other significant pandemics of the 21st century left a lasting impression on her as a nurse. It is, however, more likely that Kali suppressed her memories of those pandemics to continue to survive as an ER nurse. While justifying her rationale for changing her employment status, Kali considers the temporal orientation of the events and experiences that comprised her choice, discussing the missed advantages of full-time nursing arising from the challenges associated with pandemic nursing.

Plotline Two: Hero – It took a pandemic for the public to suddenly realize it's the nurses that are sacrificing

Kali began her story by sharing that during the first wave of the COVID-19 pandemic nurses were recognized as heroes. She shares:

I guess I could start with… the positive thing, that was great during COVID, is the support from the community. It just felt like the world, or our province, I should say, is finally recognizing our profession, and we were noted as heroes. I think we are.

Reflecting on what being a hero means to her, Kali describes:

A hero to me is somebody that sacrifices themselves for the well-being of other people. In a good way… Somebody that comes… uh… Somebody that comes across as positive. Wanting to help and make a difference in a positive way. Somebody with energy. Um, and they do it because they want to do it. Not for the recognition of doing it.

Giving an example, Kali explains:

I think… anyone that goes out of their way to help other people. In a… in a dire situation. Like, let's say, somebody gets in a car accident… and… A person gets in a car accident. Just the average person who stops on the road, that comes and helps the person out of the car… is a hero to that person. Like, "Oh my god, they got me out of that car. Like, that was so scary." You know… sits them down. Calms them down. I think anybody that goes out of their way to help other people, are in some way, a hero to that person. You know, helping… seeing a little old lady crossing the street. And the lights changing and she's struggling with her bags… If a kid, or someone comes up and says, "Let me take your bags" and watches the traffic for the little old lady, that person is also a hero to that old lady and her family. Right?

Thinking about why she believes nurses are heroes:

I think [we're heroes] because we go to work every day, whether it's a blizzard or not a blizzard. We're there for people when they're infectious. To garb up into don… like, don all of this equipment, so that we can get in a room to see these people. They're sick. They're sometimes… on the verge of dying. And the nurse steps up and recognizes that what's going on and reacts accordingly. A lot of times the nurse is without the physician, right? And she's sacrificing herself and going into the room first. Seeing the patient first. You know, knowing ah… what's coming next. Like, whether they need Levophed… whether they need… you know, like, we're just on the ball. And, you know, we'll keep working. And sometimes we don't get break. So, here we are sacrificing our time, our energy, to save someone's life. Every day. Every day we do it. An example would be in the trauma room. So, you're about to go for break and then in comes a trauma. And you… you know, you're tired. You're hungry. You're fed up. But yet, you put on your lead. You put on your gown. You put on your mask, your visor… all that. And you get… you're there. And you're ready. And you work hard for an hour until the patient goes to CT or maybe… I had to go to CT. Like, this happens often. You're running back because there's another one that's rolling in. And, you know, you're trying your hardest to help someone when you're feeling depleted yourself. So that… so it would either be in the trauma room… in a resus room… Um… COVID. Like, going into this room with COVID. I don't know if you would call yourself a hero or stupid really (laughs). Going into these situations… but as an emerg nurse, we always go into the unknown. And we try to protect ourselves, of course, but we're always going into something unknown. Like, this past

week there was a lady who had sats in the 70s, and we go in there and we help to, you know, resuscitate her breathing. Putting her on Opti-flow. Putting her on bipap. In the meantime, here we are in the room with her. I think that is a sacrifice and that's something… I mean… that's nursing. Some would say, "you're not a hero." But I think we are heroes. Because if you are the family of that person, you would think, "Wow, that person friggin saved my daughter's life." Or "my mother's life."

Kali proudly shares how ER nurses were able to care for patients quickly and effectively during the first wave:

…we treated these, like, patients, as if they were like, high, high, high, risk, which they are, and they were never allowed to wait. EMS would call or if someone walked in, they isolated them right away.

She adds that the fear of contagion within the community during the first wave, helped to alleviate some of the stresses that ER nurses face:

…the best part of [COVID] was emergency was empty. Because nobody wanted to come. It was really a huge relief. So maybe you're dealing with the stress of what could come, what could happen, but you also didn't have that burden of everybody wanting to get in. And "why isn't it my turn, blah..." You know, the usual heavy annoying patient load that you have out there. That you're worried about. That's constantly aggravating you, because they want in, and they're more important than the next person. So, in that event, we were able to get the patients in right away into a room…

Kali shares how nurses were respected by patients in the beginning of the pandemic:

During [the first wave], we got "Thank you. Thank you for being here. Thank you for doing what you're doing. How's it going?" People actually asked us how we are and appreciated and recognized us. "Thank you for being here." Because, you know, we could have not been there.

Remembering back to the first wave, Kali recalls the challenges of caring for patients in the ER:

…you had the doctor and the nurse in the room. And then you had a runner nurse outside. And then you had the charting nurse, and you had these baby monitors… and those were frustrating too because people can't hear you. And it was also more difficult if the patient was in a cardiac arrest situation, or a life-threatening situation, or let's even say a trauma situation. When you have an N95, and then you have a visor, and then you have your hair covered, and then you have your, um, your iso… your lead on, and then your isolation gown on top, and then… It's just like super-hot. After so long, because the doors are shut, and there's no airflow, and you're melting… but… and sometimes you haven't even had a break yet. That's really difficult because you're thirsty and hungry,

and you're hot. And then you're trying to do CPR, and you don't want to hear that monitor say, "Push harder", because you're like, I'm sweating, I'm so hot… but either way, it was difficult in those situations.

She adds:

And trying to wait for somebody to get you something, was another huge thing. Like, standing there and waiting inside a door for someone to look your way or to come your way, to say "Hey…" This is just on a normal patient, not even a resus right… You have to wait for people. It's not like you can go in the room, out the room. Grab what you forgot, go back in there. It's all donning and doffing, donning and doffing. So that was a lot. The donning and doffing is annoying. The wiping everything down… was annoying. Because you would be really… I mean we are supposed to, but it's just so much. It became very stressful, because you knew you had to wipe it really well. You could cross contaminate, or, you know, get, give it to yourself. So, there was that tedious washing of things, besides yourself, constantly.

Thinking about the challenges of pandemic nursing, Kali contemplates her 'duty to care':

I think it is our duty to take care of people, as a nurse. Morally and ethically, it's your responsibility. You went into nursing. Nursing is to care for people. Whether they are pleasant or not pleasant… I can't say "No." You know, people are belligerent. I can't say "I'm not going in there. They're yelling at me." Or, you know, "I'm not going to go and change that lady's diaper because she's beating me up, because she's got dementia." You still have to do it, you know? You're… You can't just leave them, or you're abandoning your patient… You can address the situation and say, you know, "I don't appreciate the way you're talking to me. I'm gonna, I'm gonna leave." But if a patient is really sick, it's your responsibility to look after them. Rude or not rude. That's kind of how I feel… I don't think [working during COVID-19] was a beyond duty.

Kali reflects on the support she received from fellow ER nurses:

I think, as nursing, nursing goes, we counted a lot on each other. To make sure that we were there to be a runner. That the nurse that was charting wasn't getting overloaded with tasks and behind on charting. That's super stressful. Um, but I think we did pretty good when it came to teamwork. And nobody really pawned off anything, and those that were high risk like pregnant or whatever people would always take it for them… I would hope that, you know, if I was taking on your patient, you would take on my… somebody from me. That wasn't infectious. Right?

Kali recalls the support she received from her hospital's management:

I felt like my manager supported me. I felt like… I do feel like the hospital supported us. Um… Emergency wise. I don't… because we weren't really overloaded. Like, it would probably be different if you talk to someone from Scarborough or from Humber River or something. It might be a different story because they had a lot of cases. We didn't have, like, that much going on where like… We had a tent built. But then, they didn't have the

staffing for the tent. And we never really needed the tent. You know? We, we were well protected. Like, we were well supported. There was always extra nurses provided for the ba… like, you know, to make sure that there was extra help. Because it required more nurses to be in a resus room. To be involved in the trauma room. To be involved. That you always had to have more nurses, because you couldn't come out and grab things, right? Once you're in, you're in. So, you needed to have a charting nurse outside, two nurses inside, and a runner. So, each resus had four nurses. So, they overstaffed us.

Adding:

The hospital provided everything that we needed. At [my hospital] anyway. To protect us from COVID-19. Right? We had N95s in abundance. We had visors. We didn't ever go without anything. They always told us to be careful, and to recycle our N95, but I never did. (laughs) And we never did. We never used… reused N95s. They, they did put them in the recycle bin. But we never got them back. Like, we never had to use a second time around. I just thought that was ludicrous. I didn't even attempt to do it. If I had to reuse an N95, then I would have rethought about what I was doing.

On feeling supported by the physician group, Kali shared:

I feel like the doctors realized how much they needed us. Because, you know, we had to depend on each other. We really worked as a chain of caregiving.

Kali comments on the support nurses received from the government in the first wave:

The first wave the government shut everything down… [*they shut] things down so that people would be less exposed, to make it, you know, not as busy hopefully. To keep the numbers down… So, I felt like they were trying to help us.*

Kali expressed the support of the community:

Um, it, it felt good as a nurse to be recognized wherever you went. Um, some places they gave you benefits and rewards for going, like front of the line, when things were a bit crazy. And the community… people from all over were sending us like gifts and food and rewards for the things that we were doing… the sacrifices we were making.

Contemplating the sacrifices nurses made:

I think the sacrifice, um, part comes into play with, you know, putting yourself at risk, putting your family at risk, by going into these rooms. Even though you're with the right equipment, you never know if you're going to contract COVID or not. So, you're sacrificing. Um, you're sacrificing… Like, we're always sacrificing as emerg nurses. As you know, you're sacrificing your break. You're sacrificing drinking your coffee. You're sacrificing water. Because you have to wear a mask all day and they don't let you take it off anywhere in the department. Right? Because it's risky. And even still to this day we're supposed to be wearing an N95 all day.

Adding:

I mean, other people might think… [we're] crazy. Like, living on the edge. Right? Like, we go into situations not knowing what we're going into a lot of times. Like, when Ebola… Oh, I was around for Ebola… You know, you didn't know what you're going into. Is it going to be Ebola? Or isn't it? But you still have to go in it. So, I don't know. I think it's kind of like, some people would say "That's crazy. I wouldn't do it." …Even though we're protected. It's still a scary situation. Right? When COVID came out, everyone was afraid. But yet, here we were… Still working.

Reflecting back on how the public perceived nurses as heroes during the first wave, Kali shares:

At that time, I felt a little bit guilty, because [my hospital] wasn't very busy. And everyone else, like let's say the people in Scarborough were like, or like Humber River, were like, completely overloaded. And my friends that work there were dealing with the scary things you see on TV. And we didn't so much. So, I felt a bit like, wow, what are we missing here? What's going on? And then at the same time, very grateful that it wasn't as bad for us at that moment.

Contemplating her feelings of guilt further, Kali says:

I guess [I felt guilty] because I chose to do this career. I chose this profession. And… knowing what sacrifices were involved in it. And sometimes, you know, you feel like a hero is someone that does something out of, out of their norm. So, I kind of just contradicted myself. But like, I guess, in the be… in the beginning, like, we did go out of their way… out of our norm… to expose ourselves to something unknown, right? With fear that we could con… contract it and make ourselves sick or our family sick. So, that is kind of like what I'm saying. But when I went into nursing, I knew that I'm going to miss… like, especially in emergency… I'm going to miss breaks. I'm going to have to drive in the snowstorm. I'm going to have to work overtime. You know, those are things that you sign up for. So, you're like, well I chose this career. So, I'm not really a hero. But you're hero when you're going into something that you don't know what it is and you're risking yourself. Or, you know, sacrificing yourself… I felt that it's deserved… I think that nurses are heroes. Emerg nurses are heroes, always. It's just then that we were being recognized for it. You know, like, I think we're always heroes as emerge nurses, as ICU nurses, as labor and delivery nurses. Even cancer nurses are heroes to their patients. Nursing is, you know, underrated. I feel. Completely underrated. And it took a pandemic for the public to suddenly realize it's the nurses that are sacrificing. It's the nurses that are out, like, putting themselves out there. We would be with the patients all day. The doctor pops their head in. Writes an order. The nurse tells the doctor all day what's going on, and the doctor tells them from outside what to do. Right? So, I think we're completely worthy of it. I think my statement before was more… like, I felt guilty because there were nurses that really sacrificed. Like, that were really overwhelmed. From what I understand. Like, when you… but you don't know… because the media blows things out of proportion all the time. So, I don't know if it's true. But, from what I understand, there were a lot of nurses overworked and overwhelmed in other areas. It just so happened that our emergency was not like that. Thank God. (laughs). Grateful for that.

Researcher's Field Notes

Having been provided with the central research question in advance and having had some time to think about this interview, and the question of "can you tell me your story, the events, and experiences of working as an ER nurse during COVID-19 that are important to you?" Kali started her story with, "…the positive thing that was great during COVID is the support from the community. It just felt like the world, or our province, I should say, is finally recognizing our profession, and we were noted as heroes. I think we are." Recognizing both the intent and sincerity behind this opening statement, I am struck by the fact that this assertion comes close to summarizing Kali's entire story. The hero rhetoric not only summarizes Kali's desire for the recognition for her profession; it also summarizes her most significant tension as a nurse. Through positioning herself as a "hero," Kali suggests that she not only feels compelled to serve others whatever the cost, but also that the personal sacrifices she makes for her profession are justified. I am fascinated by her comment that a hero is "somebody that comes across as positive." Knowing Kali as I do now, I think that this concept is central to Kali's perception of self; how she presents herself to the world, and how she wants the world to portray her.

As Kali continues to share, she considers both the social and temporal orientation of her narrative's events and experiences. Discussing the "emptiness" of the emergency department and the ability to assess and treat patients quickly and effectively during the first wave, Kali suggests that it was easy for her to fulfill the "hero" role; 'fixing' those who urgently needed her help. Illustrating the gratitude of both the patients and the community towards nurses, Kali states "people actually asked us how we are and appreciated and recognized us," adding, "[they] were sending us, like, gifts and food and rewards for the things that we were doing... the sacrifices we were making." As Kali shares how the patients and community were thankful to nurses for

"being there," I am intrigued by her response of "because, you know, we could have not been there." This statement suggests that Kali not only recognises the temporal nature of the gratitude she received, but also that she feels resentful that the appreciation only existed because of the fear of the contagion at the pandemic's beginning. I also find it interesting that Kali suggests that the small gifts nurses received during the first wave (like free meals and coffees) made them feel valued, denoting that nurses will tolerate and forgive abuse from others when given small gifts.

Kali reflects on both the initial expectations and the challenges of delivering nursing care to patients in the ER during the first wave of the COVID-19 pandemic. Recalling a situation in which she provided resuscitative efforts to a COVID-19 positive patient, Kali reveals the burden of trying to uphold the hero rhetoric. "Melting" under the heat of wearing full PPE, Kali recounts how the real-time feedback of the external defibrillator continued to tell her to "push harder" while performing CPR. Describing the incident as "difficult," I wonder if the patient had died, and if Kali was left feeling as though she had failed as a "hero." I also wonder if the difficulty Kali is referring to is the extreme working conditions or the subliminal messages of the monitor invalidating her best efforts. Considering the extreme working conditions further, Kali personally expresses feeling "stressed" when describing the infection control measures she was required to perform, and the weight of those actions in protecting herself and others.

As Kali thinks about the measures she endured to keep herself safe while providing resuscitative efforts to the patient, as mentioned above, she begins to examine the concept of 'duty to care.' Her comment strikes me, "I think it is our duty to take care of people, as a nurse. Morally and ethically, it's your responsibility. You went into nursing." This statement implies that Kali is steadfast in her belief that she will help others 'no matter the cost' to herself. It also

suggests that she is critical of those who refuse to care for patients who may pose a risk to themselves.

Contemplating how nurses tried to support one another, Kali explains how nurses never "really pawned off anything" and elected to care for additional COVID-19 positive patients when one of their colleagues was "high-risk" or pregnant. Knowing what I now know about Kali, her moral and ethical convictions, and her concerns about bringing the contagion home to her family, I imagine that taking care of additional COVID patients for her colleagues made her feel irritated and fearful.

Pondering the support she received further, Kali proudly shares how her hospital management "provided everything that we needed… to protect us from COVID-19." Despite this, Kali recalls how her hospital management told nurses to "be careful" with supplies and "recycle [their] N95[s]," boldly stating that she thought that was "ludicrous" and "didn't even attempt to do it." I am intrigued by her comment, "if I had to reuse an N95, then I would have rethought about what I was doing," suggesting that she had limits to her moral and ethical beliefs surrounding 'duty to care.' Kali comments that during the first wave, "the government shut everything down… so I felt like they were trying to help us," implying that at that moment in time, she believed that the government was looking out for the best interest of nurses. Kali recalls the support she received from the community during the first wave of the pandemic. She describes how nurses received gifts and rewards for the "sacrifices" they were making. As Kali contemplates how emergency nurses are "always sacrificing" themselves for others, she remembers working through the Ebola pandemic. Given that Kali stated in a previous reflection that the COVID-19 pandemic was her "first pandemic," I am intrigued by the delay of this

memory. The unexpected appearance of this memory affirms that Kali has likely suppressed painful memories and emotions to continue working as an ER nurse.

Reflecting on the public's perception of nurses as heroes during the first wave of the COVID-19 pandemic, Kali states that she "felt a little bit guilty because [my hospital] wasn't very busy." I am struck by how this statement juxtaposes how Kali began her interview, unapologetically stating that she believes that nurses are heroes and that nurses are finally getting the recognition they deserve. As Kali continues, she shares, "everyone else, like let's say the people in Scarborough were like, or like Humber River, were like, completely overloaded. And my friends that work there were dealing with the scary things you see on TV. And we didn't so much." Considering the social dimension of narrative inquiry, it appears as though Kali is embarrassed for the amount of praise she received compared to her comrades, who she felt did more throughout the first wave. Exploring her feelings of guilt further, Kali describes the tension she feels between not being a hero because she "chose this career" and feeling like she is a hero because of the "risks" and "sacrifices" she has made. Considering the temporal position of the evolution of nurses as 'heroes,' Kali states, "it took a pandemic for the public to suddenly realize it's the nurses that are sacrificing." This statement suggests that although she is savouring the recognition nurses are finally receiving, she does not want to bask in it as she believes it is short-lived.

Plotline Three: Fall from Grace – I'm not afraid of COVID anymore

Kali reflects back on the change in community support from the beginning of the pandemic:

> *The first wave, huge appreciation. The second wave. A little less appreciation was… and it's always voiced, right? Like voiced or, you know… The community, of course, was very generous in the first wave The second wave, no generosity. The third wave, no generosity. The fourth wave, no generosity... there's no… not really any recognition anymore for*

what we're doing. And now we're… our medical care is in a crisis. I think. And the people don't thank you… now… in the fourth wave at all. Like maybe one a week will say, like, "Oh thanks for, you know, doing what you're doing through all of this." But it really doesn't happen anymore.

Sharing what she needs to feel appreciated, Kali states:

I think [it's being] verbally appreciative. Right? "Thank yous." Kindness shows their respect and appreciation for you as a nurse. Not taking you for granted. Like, you know, not having this expectation. Instead, being grateful.

Giving an example of a patient interaction that made her feel appreciated, she shares:

…a patient came in, sat down in my booth, and said "First, first of all, I want to thank you for being here. I want to thank you for being here throughout the entire pandemic and for still being here." And I thought that was pretty awesome. That's how they started our meeting. Our triage. So that was pretty good.

Contrasting the aforementioned appreciation to her current situation, Kali says:

I just don't think that they have any respect for us at all. I would say probably seven... I don't even know. I would like to say… that…. I don't even know the percentage. I can't give you a percentage of like, who supports us and who doesn't. I would pretty much for sure say 30% of the population has no respect for us. It could even be higher than that.

She adds:

Um, now, that we're into the, you know, the thick of it and we feel like we're going to see the light at the end, but who the heck knows? I don't even know. Um, it's back to normal. Those appreciative, non-waiting people because it wasn't that busy… They're angry. (Laughs) And I find that people become abusive, and they become angry, and they become impatient, and they question you, and they threaten you. And that's a normal day.

Giving an example of how she felt unappreciated and unsupported throughout the first second and third waves, Kali states:

The people that challenge the vaccine. People in my family, that didn't, you know… People in my circle. Let's say on social media. Putting all these conspiracy theories up on their social media. That's a huge one. I also feel like, some… you would feel rejected. Because people didn't want to see you. Because you're a high-risk exposure. So, it put distance in your relationships. That still carry on. And no longer does it… I think no longer… Like, I'm going to talk from experience. Like, my best friend is taking care of her mother, who has Alzheimer's, and is living with her. So, during the pandemic I didn't see her at all in the first wave. I didn't see her at all in the second wave. Finally in the third or fourth wave she decided she could see me, but by then… a lot of time went by, and I didn't feel supported and I felt distance. Maybe a little resentful that she would do that.

So then, that connection that you had prior to the pandemic is kind of gone. And even to this day, it's like, it's not the same.

Kali reflects on the increasing number of patients in the ER:

There's like, no room. Literally. There is absolutely no room for the amount of people that are in that emergency department on a given day. It's worse than it's ever been. Ever. Is it because people could not see their family doctors and now, they've got… found out, they've got bad things? Is it because everyone has become "Okay, I'm not afraid of COVID anymore, I'm vaccinated so I'm coming"? Or there's that… "I have symptoms of COVID, and I didn't get vaccinated." And then there is, like, just the, everybody that needs to come with their cancer, their heart, their trauma, their heart attacks, whatever, all that. Like, is all back.

Trying to be empathetic to those who have verbally abused or threatened her in the waiting room, Kali shares:

I don't really think they understand, um, the dynamics of nursing, and what, what it entails, and what we actually do. And I think, with, the waiting room they don't understand what triage means, for sure. And, I mean, I wouldn't either. Right? When I as a lay person… triage? What's triage? Unless you're Greek. Um, they do know that they're waiting to go in. But they don't know that it's not a matter of time, it's a matter of, you know, the triage score and the acuity of the presenting problem.

She continues:

And every single day, I have to do like an announcement in the waiting room. At least three times a day to inform the patients of the process. How it works. Where they're going. Why they're going there. Why they wait. Why they don't. Each different zone. Because I don't want to have anybody bothering me. I find if I make an announcement that people stay back and respect and understand and are more patient.

Turning from holding the patients accountable for their abuse towards her, Kali rationalizes:

But I think when…. Like, I go out [to triage] after someone else has been there for eight hours, and I'm there for four, and I have to deal so much backlash from the waiting room that I don't normally deal with. Because I communicate. So, I think communication is key in nursing. With the families, the patients that don't… like every, in every dynamic. But mostly, nurses don't talk to the patients. They take their story [at triage] and then they dismiss them. And then they tell them to go sit down [in the waiting room]. Well then, the people don't realize, that they're [still being] cared for, I think. So, we have to take that time to explain to people, like, this is why you're [waiting] here.

Contemplating the patient experience further, Kali shares the moral and ethical challenges she faced regarding the hospital's visitor policy during COVID:

> *No visitors. That was a big one. [The] no visitor policy. Um, and then, graduating to a one-person visitor policy. So, both of them have their different… like challenges. Ok, so the no visitors, obvious. You know, somebody really sick and somebody is dying. And you can't have a visitor. And it's not COVID related. It's cancer or whatever, like, you can't have… like, it was really awful. I do not like no visitors in the hospital. My friends, however, colleagues… love it. Cause they don't like to deal with the questions. And the people, you know, bothering them. Family members. And I think the one visitor policy really sucks, because they… you got to decide who's going to come in. Right? You have so many kids, and a wife and everyone is crying. How do you decide who can come in? And it would always have to be that same person too. Couldn't be like, [you] today, and then me tomorrow, right? It was brutal like that. And then… now we're at a one visitor policy for three hours. And the visitor can change. As long as they're vaccinated, they can come in. I think. I don't know that for sure. But I know that you're allowed a visitor. But everyone clearly has to be masked, and they're supposed to only stay for three hours. And then they have to go. And then, it's not supposed to change in the day. So, it can be me today and you can come tomorrow. But you can't come for half, and then I come for half. I don't know what's the difference but, yeah.*

Kali describes how she dealt with her moral distress:

> *I just called the family a lot. I'll be honest, I called all of my patients, families, using my own phone because there wasn't a phone. It was always broken. And the old people, they can't hear. And then if I can't hear the conversation, I can't help them. You know? So, I used to take my phone in, and then just wash it down every time I came out, just so that the people could talk to their family members or even see them. You know? I did that. So, I didn't have a lot of problems in regards to conflicts with families, because I don't care how… like, who I talked to. Because I would want to talk to my dad. My sister will. My brother will. You know? I did that. Other nurses didn't. Families were getting angry and annoyed. So, then I believe that [the manager] kind of said, "Listen guys…" she made a meeting, and she made a point of saying, "I'm not asking you to talk to every family member. Tell them that they need to choose who you talk to, and at least make one contact during your shift for an update with your family." She tried to, you know, endorse that. And make people do it. But they… not, not everybody did. And I think it caused a lot of problems. As, um, you know, the partner of that person… because you would always have to take the call, right? On the phone, you'd be like "You know what, yeah, I'll… I'll go in. I don't know the person." You know, having to tell your colleague to talk to them, because, you know… think if it was your family member. How would you feel? That's pretty much it. I didn't have, um… the zero-visitor policy people were pretty respectful of it. Because they were freaking scared, and they didn't want to come in anyway. That's a big thing. People didn't want to come in. Okay. The second phase… people still didn't*

want to come in, but they would come in. You know? But they weren't allowed to come in. But… if something was really life or death, they did. Um, as long as it wasn't COVID related. We would bend the rule and let the family could come and see the person. You know. Like, if someone has cancer, and that's what's killing them, why am I not going to let their family come in? But they had to wear a mask. And they had to stay in the room. And they weren't allowed to leave the room. And once they left the room, they would have to leave [the hospital]. Um, And now, it's a one visitor policy. And it's nothing but a pain. People are now arguing with you. People are calling and asking for updates because they can't come in. Or if certain family members don't talk to certain family members, you know, who gives who the right to go in? So, you deal with that conflict between nurse and patient and nurse and family members. When you're in charge, it's another dynamic. Whereas before, you know, it… the only way they could complain, is by, you know, telephone. Now, it's like people come to you and complain, either about, you know why their wives, their other family members can't come in, or, you know, the care, the nurses, (Laughs) whatever.

When asked if Kali had any experiences of helping patients say goodbye to family members over the phone, she shared:

Um, my patients… no. Not dying patients. Um, I have been present, like, when I guess they were on the phone with their family saying. "Okay I'm at the hospital." And you know… you're hearing them on the phone with your back turned. It hurts. You know, your heart. To think, like, you know, that their families' afraid and they can't come and see them. It makes you feel really sad, um, when somebody old is there and maybe they don't have COVID, but they can't have their family member there. And they're going to get confused and delirium, because nobody's there to keep them entertained, or up to date with the time and date. Um, the COVID ones… I didn't have much experience with a dying phone call. You know, it was… the same conversations kind of go on that aren't COVID. You know, when I would have them phone with their elderly parent or whatever, "Okay, I love you." You know? You hear the emotion between your patients and their families, all the time. And it's, it's difficult. You know, you… You cry. (Laughs) I'll cry. At the time I can't help it. Like, my eyes will well up. But, you do try and push it back, push back, push it back. But you can… for only for so long and then your tears start coming out. And then you're like, "Okay, well I'm not gonna start crying, because that's it for the day." I'll be crying the entire day. So, you just kind of have to, like, think about things. Like, "Okay, when I leave here, I'm going to do this." And… you don't want to listen to their conversation. You just try and like, keep your brain busy and thinking about other things. And blocking out your ears if you can. You can… to a certain degree.

Kali describes the change in support from her fellow ER nurses:

I feel like, they… that team nursing, um, doesn't always apply as much as it did before. I think now, it's like, depending on who it is… like, my junior team, I feel that they would

come, and run, and help you at any time. They can see, like, that you're doing something, they'll come. The older ones will be like, "Oh she'll be fine, she'll be…" You know? Or they'll help each other. Like, you know, that person is really good friends with that one, they see… "Oh I'll come I'll help you." Right? But otherwise, if they see… if the two that are friends are on one side, and the two on the other side are busting their ass… Doesn't matter. (laughs) You know. They don't move to help out. Right?

Kali continues:

You know, like, so you'd be like, "Oh, can you do this for me?" And they're like…"No, I can't." And you're like, "Shit, you would totally make me do that for you. You wouldn't even give me an option." Right? Um, I think that people were like, more relaxed in the beginning of the pandemic with each other than they are now. Nursing wise.

Adding:

Now, um, they're bitching and complaining. (Laughs) So the older ones complain. Right? About those new nurses. And the new nurses…. they don't complain about the older nurses. I find that there's cliques that are very, very apparent. And some of the lines… because I've worked all of them… I'm friends… like through both sides… but holy. Some of the teams are super cliquey, and they will sit around with each other, they will help each other, they will order things for each other, and they exclude others. And then you have the new people… [The cliques] will gravitate to some of the new people. I have no idea how they pick them. What they're picking… You know what I mean? Or if they if it just happens. But they, they will pick someone that they put under their wing to keep close. And the younger ones, they tend to ask everyone. Old, new, newer than them, you know, they mix with each other, and they talk amongst each other more op… like, more in a group on lunch breaks. Um, but you do hear… instead of a 'he said, she said,' it's more of a hierarchy of 'they said, they said.' You know? And you hear them complaining. But you don't hear the littler ones…. the newer ones complaining as you do…. The newer ones, you hear them complaining about the workload. And the older ones, you'll hear them complaining about how the new ones handle their workload. It's annoying.

Kali gives an example of the type of complaint that younger nurses have, by describing a situation in which a newer nurse complained about a patient care process within the emergency:

I have an example (Laughs) of something… Um, the younger nurse, who's working in [the hallway] … There's three nurses [working there] and up to 15 patients in the hallway. So, this nurse is a complainer. (laughs) She's always, like, complaining about things. For example, if you assign the patients five, five, and five, right, and you help each other, but you're in charge of your five, then A, B, C, D, E, should be yours. And blah, blah, blah, blah, and blah theirs… Right? But this girl was confused. I guess when the porters would take the hallway patient somewhere, then they would take [another] patient somewhere, they would return these people to the hall in random spots. So the nurse felt like, you

know, the patient… the board… Because confidentiality schmalady, they would have the patient's last name and their location, um, on the board. But no problems on it, right, just their name. So, they would have that board, and it would be A, B, C, D, E, just like they were supposed to be in the hallway. (Hand signals to show ordering) But because that's hard to maintain, you've got to maintain here (Touches head), who's who. And here (signaling her wrist), right. So, this girl lost it, because, like… doctors would come and say, "Where's patient Johnson?" And then they would be like, "Johnson's in B". And then the doctor would go there, "That's not Johnson" and then… it became such a kerfuffle. This nurse, had to go to management and tell them, "I don't want the board. It doesn't work. Take it down." And because of that one nurse complaint, the board was put off commission. But then, I think it was off commission that day… but they moved the board to a screen. Now the screen is way more complicated. Way, like, there's two computers for three nurses and the doctors that come in. You know, like, it was completely wrong what they did because of this girl… but in the end we opened up that whiteboard and we use it again…So, this girl is complaining about so many things. I don't know why she keeps coming back. (Laughs) But she does. And she's nice. But she's… she's made multiple complaints to, um, management about like, the system and different things.

Reflecting on her feelings of how nurses have been treating one another, Kali states:

It doesn't bother me as much. I know it bothers my colleagues… I don't care. Like, I'm pretty indifferent with people. I'll help, and I won't help. You know, (Laughs) depends. But I hear my colleagues complaining about it. Often. You know, or, the younger generation also tend to be on their phones a lot more. You know, I will say the… Yeah, the 20 to the… 20 to 37, I guess. You can see they're more on their phones than what we would be, like, as mature or older adults, I guess. And older, senior nurses, you're not going to catch us on our phones as much. You know, if I… if you're working, you're busy and I'm not, I'm going to get up and help you. But a lot of [the junior nurses] are like, "Okay, my patients can be in a kerfuffle in their room and I'm going to be on my phone." That's a difference in the age as well. And I think when you have an imbalance of senior and junior, it can be difficult. Like, you can get frustrated when people are on their phones. But you just have to interrupt. That's all. (Laughs) You know?

Adding:

I don't have any problem with the younger nurses. To be honest. I was there once. So, I know what it's like, it's hard… You know…But people just have to… I don't know. The young ones sometimes they complain (Laughs) about stuff. But rightfully so. But you know after so many years, you're like good luck.

Kali recalls the first time she felt a lack of support from hospital management:

I guess there was the whole preparing for this pandemic. The, um, stress between what to do and what not to do, was difficult. You know, you have like the lead CBRN [Chemical,

Biological, Radiological and Nuclear] doctor telling you "This is what we need to do." And then [the medical chief of the ER] is saying, "Oh no, we're not doing that." And you're thinking, like, "Okay, who knows more about this? What's going on?" Because this woman… this [CBRN] doctor is phenomenal and is in touch with China… is in touch with other countries across the world. And here's this [medical chief of the ER] who just took over, telling us, "No, you don't need to wear an N95. No, you don't need to do this." Um, it caused a lot of tension. I guess, between, you know, as a nurse… toward her… because I was leaning towards the [CBRN] doctor… and then there's that tension of not knowing… like… and the stress of not knowing what, what you're supposed to do, I guess.

Kali recalls the support she felt from the government as the pandemic progressed:

…the government… they weren't really doing anything to support us, to be honest. At some point, I don't know which wave it was, we did get like a little bonus of money. And, in reality, it was nice. But in reality, I don't think that that bonus is what nursing needs. What nursing needs is a larger pay scale for what we do. At least a tiered pay scale. Like, so I don't feel like the government really appreciates nursing for what it is. Or at least emerg nursing. Like, if you go to America, you know emerg nurses make… make a lot more money than a floor nurse is going to make. Right? An obstetrical nurse should make more money than a Gen Surg nurse. You've got people's lives in your hands. Like, in risky situations. And you're exposing yourself too. And you're having to take courses and educate yourself. So, the government really didn't do anything for us. I don't think.

In response to the question of whether she felt that the compensation nurses received was the government's way of genuinely trying to make things better for nurses, Kali says:

I felt grateful for the money. But I didn't feel like… I don't feel like it's enough. I would have sooner received a raise for the rest of my career. Like, I don't think that that little bit of money you know, made that much of an impact. For what we've been doing… Especially because, you… we're still driving. We're still commuting. And working. All the time. And everyone else is collecting, like, I don't know how much money… every two weeks or however they paid that money. I'm not sure. You know, for just staying home? So, they can pay their bills. But people were getting it that didn't even need it. And if the government doesn't take the money back from these people. Oh my God, then ask me how I feel. (laughs). You know, if you're off for a reason, then okay. But if you're just, you know, people running their own businesses and stuff like that, were collecting the money… Yeah. (Laughs) That pissed me off. Still does. (Laughs)

Continuing to reminisce on the confusing safety messages, changing hospital policies, and decreasing support, Kali shares:

In the first phase… it was all over the map. They were changing what kind of precautions… Like, how many times did they change that in the first phase? I don't know. And then, it was, you had to wear an N95. No matter what. And then, you needed to wear a visor-mask. Um, like before it was, a visor and an N95. No matter what. And then it

was, a visor-mask is fine. Like, they were… for the first phase, it was constantly changing. Like, literally, by day. You didn't know what to do by day. Triage, same thing. You know? They had to go in a room. They had to be out of the waiting room. But then, when the numbers piled up, it became… they can't go to the waiting room… they can't go to private rooms… Where are they going to go? So, they ended up making a back hallway where they could pile them up. And then, they ended up, over time… "That's not working. We're going to use [minor], and we're going to change [minor] to a COVID hotspot. So nobody cut through. Nobody come in. Only people in there are going to be, like, strictly COVID patients." And… like you… again… Like you have to wear your masks. And you have to wear your PPE. All day... But those nurses were donning and doff… like, putting on a new gown… clearly their mask always stayed on. And then, that went away. And it became "No COVID patients to [major]." Um, then "No COVID patients in the department." They had to stay outside. Unless they were sick. Like, if they're really sick, then you brought them into a room. Otherwise, they went into the family room and the back hall, and they waited their turn with everyone else in the waiting room. To now... um, they are just… we try… you try and put them in the back hall. Or you try and put them in the family rooms. But everyone is still together, and they wait their turn. You do put the sicker ones in the family room… because there's a door. And you can, like, keep them in there. But then, who's watching them? Right? The EMS [Emergency Medical Services] nurse. Who in the middle of it all, is trying to like, triage all the ambulances that are incoming, and take care of her offload. So, you can't really... you know, yell at them, "Get back in there!" "Shut the door!" "Get back in there!" Um, It's not a safe or ideal environment for anybody. Like, now I triage everyone the same, too. So, yeah, everyone's wearing a mask. Um, but… and, you know… but… I don't like… I triage them in the same booth. And I just wipe the booth down in between the patients. Like, I'm not going to get up, go freaking over there, and triage them in a back hallway. It's so inconvenient. Right. But I can just do it in my own booth. Some nurses still prefer to go over there. (Points to an area away from her) I don't. I'm done with it. And the barrier. Oh yeah, this stupid barrier. At the beginning of COVID they put these plastic… this plastic barrier, with the cut out on… in between you and the patient at triage. And it was the most ergonomically non friendly frigging thing, you can ever imagine. Number one, you have the door open. You have a Plexiglas. (Uses arms to demonstrate barrier between herself and the patient) So now [the patients] have to yell even louder why they are there. People [in the waiting room] can hear. And then you have to like, deform and like twist your body and all awkward positions to try and get the [blood pressure] machine on the person. You know? That stupid barrier was more of a pain. More nurses had shoulder, and neck and back pain in this past two years then you've ever seen. Like, honestly. They should do a study. I guarantee… the pain was so bad. And people were going on, like, modified because of it. Like… and it's not modified friendly at all. Right? Because like, you still had to work there, but you couldn't. Because it hurt. I would just always get up and go on the other side, do the [blood pressure]. So now, I'm even more exposed. But the privacy part… like, mental health for example… There's no privacy there. "Can you speak louder?" Like, I can't hear on a good day. Now we both have a

mask, and we have a glass between us. So, so… um, not personal at all. I don't think I'd want to open up to you [if I was the patient] with all these barriers. It's stupid. Now, when I go to work, I take that glass barrier and I put it in the hallway. I don't want to see it. I don't want it near me. My patient will sit in front of me, and I will face them, and they will face me, and I'll use my equipment, and when they're done, I wash everything down. If I think they have COVID, I put a yellow gown on. That's the difference. Otherwise, it's much better now.

When asked about the hospital policy regarding isolation patients in the hallway, Kali shared:

You can put isolation [patients] in the hallway. Like, um, as long as it's not something that [others are] going to catch, like coughing. But if it's, you know, diarrhea, but they haven't had diarrhea today, you can put them in the hallway. MRSA [Methicillin-Resistant Staphylococcus Aureus] you can put in the hallway care. VRE [Vancomycin Resistant Enterococci], ESBL [Extended Spectrum Beta-Lactamase], can go in the hallway. Um, fever, but COVID swab negative, can go in the hallway. I believe. You know, um, because you need the spots. Actually, maybe not the fever with the COVID negative… but maybe. I… and we've had fevers in the hallway. Whether you can or not, I don't know. But we do…Yeah, airborne/droplet [isolation patients]… you can't. But contact [isolation patients] can go out there. So, you're not going to put shingles in the hallway. Definitely not. You're not going to put COVID in the hallway. Um, if somebody has something, and they've been… I guess 24 hours, I think it is, to 48 hours without symptoms, then they can go in the hallway. But a lot of times you have to move things to the hallway... Because you need the rooms inside for the people that are sick. And really, it's like… it's like a fruit salad out there. I think you can do anything you want, but you don't want to put anything that could be COVID out there.

Adding:

That's what it's come to. And it's awful. The lights don't go down. It's not conducive to anybody to be there. And the things that they witness… That's a whole other thing. And privacy. And how are you gonna get better in a hallway with all this action and no sleep?

On fear and isolation, Kali reflects:

I know a couple of people [who got COVID]. And they were not as sick, but they were sick. You know, not as sick as, um… I don't know. Like, I feel like genetically, it depends on how COVID affects your body. Some people get it really horrible. Clearly… and they die. And then some people would get COVID, and just be like a really bad flu. Fevers, body aches, you know, like, a really bad flu in your body that like takes you down for a week straight. Right? And then, you're tired after. And then by the 14th day you're, like, jonesing to get out.

Feeling helpless, Kali continues:

I know a nurse that got it after we'd all been vaccinated. They just are getting over it. And it's hit them pretty hard. They're very sick, even after that second shot. Yeah, she's, like… came back to work. Like, 16 days later or whatever. And her hands are shaking so bad, and she looks really sick. And they made her go home. Because she couldn't keep working like that. Still, you know, sick. Residual sickness. Imagine if she didn't have that vaccine. I wonder if she would have got worse. Because she seemed like, systemically, like, this is something bad. Um, so yeah, I don't know. (laughs) I've seen people with it. And I feel like we need to kind of… I don't know what's gonna happen with it… It's kind of scary.

Kali considers her own fear of not wanting to bring COVID-19 home to her family:

…you start to hear about your friends parents that died. And you start to think about that. And you think, "Oh my gosh, did they give it to their parent?" But no, they didn't. They got it from something else. And then I had a couple people's parents die. One was at the very, very beginning in a long-term care, so right away I knew, like, this can kill my dad…And then, um, you know… then there was that fear that came over you. Like, oh my God, if I catch this thing… And all I kept thinking is of my dad and how he's in his 80s, and if I catch this, it's going to kill my dad. And that would be on me. That's stressful… Right, so that it… all stems with my dad, my life revolves around him. And probably next would be my kids and my family. Right? But, yeah, my dad was my priority.

She adds:

I also thought I don't want to bring it home, because of my teenagers. Although my teenagers did not self-isolate, so if anyone was going to give me COVID, it would probably be them. But they didn't. Thankfully.

Reflecting on why she felt she would be the person to bring COVID home, Kali says:

I figured it would be on my clothes. On my body. Because you're, you're being overly careful, but it's still everywhere. Like, you know, it's the back of your uniform. Or the leg of your uniform. Like I don't know… your hair. If your hair wasn't covered.

When questioned about her feelings regarding her children's blatant disregard for following public health measures, Kali rationalizes:

I was nervous, but I wasn't that afraid because we live in a really small town and their circle is very small. So, I felt like, I'm not really threatened by their activity. Because I thought if anyone was going to bring it home, it will be me before them. And our community, didn't… I think it had like one or two cases throughout the whole pandemic. So, it just shows you, like, our town is pretty small. And because people were obeying the guidelines. Despite the teenagers and of our town. Um, we managed to keep it clear. And I never got angry at my kids. Because they're, they're teenagers, and they need to explore, they need to move, they need to breathe, and they're healthy. I felt like my kids are healthy. They should be okay, and our community is small. Now, they didn't go anywhere.

Like they literally went to their friends house, or they met at a park or wherever, but they didn't really… they never ventured out of our town. So, and none of them did. Like none of them left town, ever. These people. So, I didn't feel angry, or, or threatened by my kids at all.

Kali describes how isolating from others in hopes of protecting her family took an emotional toll on her:

The one thing I can say is during COVID, you know, everybody needs… like in life, we all need people. And as health care givers, we depend a lot on our outside life, to, to bring us away from the sad things that we see… whatever. And, um, COVID has put a lot of distance in our lives. When we as… needing that outlet, and that relief, it's been hard. You know, for me anyway. Like, I didn't get to see my best friend for a year. She wouldn't see me. People didn't want to see me. Um, and you shouldn't see people either. And that wasn't good for me because that's my… that has always been my release. Going out. Right? Having drinks with my friends. Getting together as couples, or as girls night, or going to the mall. Like, I couldn't do anything to get rid of the stress I was having because I had stress at work and then I had stress here. I think like, man, that was really hard. Not being able to see the people that you wanted to see. You know? That make you feel better and give you the will to feel good about yourself.

She continues:

I think that's a big thing. Like, touching on that with, with nurses. Like, how did it affect you, not being able to see your family? Those people that don't work with the public probably don't even care. Everybody was building decks and doing home improvements. Right? But we were all busting our ass. And stressed out. And we didn't get to go build anything or redo our kitchen cabinets like everyone else did. There was that stress. Man, like, holy… my house needs to be cleaned. And… all those, like, frigging people on Instagram, telling you, like, how you should clean your cupboard… or how to renovate this or how to do that… and I'm thinking… fuck off. I just want to shut off. Like, I wanted to look at my phone to relax and escape, and instead it was causing me again more stress. (laughs) So, I needed something. And what I needed, was to see my friends. And then finally, in the third phase, I got to see my friends and the first visit was awkward. I felt kind of out of place. Do you know what I mean? Like, you haven't connected with these people, so you feel like that closeness, that bond, is kind of gone a little bit. For some reason… even like my very best friend I felt disconnected. I felt like I wanted to go home. And that's not me. I felt like I don't, I don't want to be here. I don't feel good, I didn't feel good about myself. So, I didn't want to be there. I think I was depressed.

Despite Kali's best efforts to prevent the transmission of COVID-19 to her family, it was ultimately her husband (who, like her children, disregarded public health measures) that brought COVID-19 home:

> *[My husband] got it… [from] somebody who he worked with… his girlfriend had it. But he still continued to go to work. And then, um, he was coughing, and he wasn't wearing a mask when they were working… the guy, and neither was [my husband]. Because they thought that they were in a safe nit work community. But I don't know why [my husband] didn't say anything to him. I guess because the guy said his wife didn't…. I don't know. Anyway, long story short, he had COVID and gave it to [my husband]. So, I remember clearly the day. [My husband] was like, getting, going to work. And he's like, (clearing throat sounds). And I'm like, "What's wrong?" And he's like, "My throat kind of feels funny." And I'm like, "Oh. Well, what do you mean by funny?" Right? And then you flip into nurse mode. And then he's like, "Well it kind of hurts." And I'm like, "Well [husband's name], you know, maybe you have COVID." And he's like, "No, I don't have COVID." And then I go "Well you should go get swabbed just in case." And he's like, "Well… I'll see." So, I think he went to work, and ended up coming home, not feeling that well that day. And then the next day, he had… he was achy… and it just went on like this…*
>
> Pausing for a moment, Kali shares:
>
> *I cared for once. (laughs) Cause as a nurse, I'm usually pretty like… "Oh get over yourself." But I was really concerned. I'm like, oh my god, this thing kills.*
>
> Returning back to her reflection on her husband's COVID infection she adds:
>
> *So, he got it from work, and I locked him in our bedroom… and it has an ensuite with lots of room to roam. I moved myself out of the room. And I said, "You're going to the room, and you don't need to come out. You have a TV. You have a computer. You have everything you need in there. You're not coming out for 14 days." And literally, he didn't. And, cause, like I said, I had the three boys here and myself and nobody got COVID. We really kept him in there. Like, I said to my kids, if he's… you know, when you go to get a snack, remember [husband's name]. Ask him what he wants. Ask him if he needs anything. I also bought, like, um, vitamin D, multivitamins, vitamin C, um, like emergency drinks. And I made sure I cooked like super healthy food to make sure I fed him well. And vitamins and water and liquids and drinks, like, all the time. And he slept a lot. Oh, I got cold medicine [too]. And he just slept for the first five days to seven days. And then he went stir crazy. But I think he was happy… to be like, lying around, and sleeping, and being catered to I'm sure. But not the fact that he felt sick, of course.*
>
> Continuing on, Kali states:

So, in the end, he got better. And he thanked me. Because he recognized [that] I took good care of him. But I wanted to, for once. Because normally I'm just like, "Get over the man cold here guys, and let's get to work."

Comparing how she cared for her ill husband to how she cares for herself when she is ill, Kali shares:

Because you know we always work. Right? When we don't feel well. Because we don't get paid if we don't. And now that I'm full time, I still feel a lot of guilt when I don't feel well to not go to work. You know? And that's one thing that COVID has, um, has been good for us as nurses. Is like, you cannot go [to work]. I can lie, which I think like, "Oh I should lie," because I used to lie a lot and just go to work sick. Right? And now with COVID, you can't. If you have a red eye they're going to be like "[Kali] why is your eye red?" "Oh, I have conjunctivitis." "GO HOME." But before, you could be like, "Um, you know… Oh my cream got in my eye." And try not to touch your eye all day. Like, I literally lied so much to work because I needed to. Back then. Now I feel a little bit of relief that I can put it on occ [occupational] health (laughs) and say they said no.

In response to the question of how her family and friends supported her throughout the pandemic, Kali says:

Well, my… under my roof, my kids, they were like, oblivious, really. They didn't… my two older ones they weren't too… actually my kids were not COVID feared right. We live in a small community and there wasn't any COVID here. So, my kids didn't really feel that there was any kind of threat. (Laughs) So my house kind of ran normal. Which, in a weird sense, made me feel normal. And… you know what I mean? Supported, because I didn't feel stressed out. They weren't pushing me away. Right. [My husband] wasn't pushing me away, like I'm some kind of virus myself. Right? People still wanted to be close to me. Intimate with me… in my house. My father still wanted to see me. He didn't care. He was like, "Come and see me." And he'd be like, "Why are you wearing that mask? You're okay. I'm okay." So, he made me feel like I was wanted around. Whereas my best friend didn't. My friends were afraid of me… It just made me feel terrible and unsupported by them. Even though they'd say "Oh, I'm… I don't know how you do…" You know, they messaged you and stuff. But it's not the same. If you're not going to see me and give me the person-to-person contact. Like, I… if you're giving and giving to people, you need to receive, right? You're… you normally receive… right? From your best friend. You see your friends; you give each other a hug… you're like… you know… you smile. You share conversation. You hit each other on the shoulder. There's like, contact. All of a sudden you go from like, contact with people, to nothing. And it keeps going and going and going. And then you're not even seeing people smiles because you go out and everyone is in a mask. Even today. Right? It's annoying. I'm done with it, really.

Kali comments how her relationships with others have changed as a result of the pandemic:

I haven't seen my family. A lot of my family in a long time. Because for the first, you know, year, you were kind of cut off from your family. And then finally we had a family get together and you got to see people. But there's also, like, you know you don't want to get involved in those conversations about vaccinations. Because (Laughs) then you're gonna end up in some kind of major debate. Like, I don't want to chall… I don't want to be challenged or challenge anyone about their decision to vaccinate or not vaccinate. So, um, there are people that I unfollowed on my social media, because I couldn't take their stupid posts about COVID. (Laughs)

When asked if the pandemic resulted in a change in her relationship with her husband or kids, Kali says:

Not really. Although, maybe, in a sense, you're better to ask... Not my kids… but you better to ask [my husband] that question. (Laughs). But I don't know if it's COVID, or if it's just emergency nursing. Like, you became short fused. You know? And tired. So, you're more irritable. You know, you're going… like, if you're going to work every day, and they're not, then you shouldn't have to come home to shit needing to be done. So yeah, you would become a little more demanding I guess? With the right… I think you have the right to be more demanding. Because you're working all day, and they're home. So, you become less tolerant. Your tolerance is down. During the pandemic. But I also think emergency nurses' tolerance are down already as it is. (Laughs) Right? On a normal day. It's kind of why I want to get out of it. (Laughs) I'm tired of it now.

Researcher's Field Notes

As Kali continues to share, she elects to present her story as a sequence of temporal events, each one influencing and leading to nurses' 'fall from grace.' She begins by reflecting on how the support in the community changed as the pandemic progressed, noting that by the time the fourth wave hit, nurses were no longer being recognized by the community for their sacrifices but, more concerningly, were actively being abused. Describing the abuse of nurses by patients as being "back to normal," Kali shares how patients are "once again" "questioning" and "threatening" her in the waiting room. Considering the social position of the triage area, Kali states, "I don't think [the patients] understand, um, the dynamics of nursing, and what, what it entails, and what we actually do… and, I mean, I wouldn't either," suggesting that she is not only empathetic to those who have verbally abused or threatened her but that she feels as though their actions are justified. Given that Kali values being respected as a nurse, it appears as though

the empathy she shows abusive patients is a coping strategy she has employed to deal with the lack of control she feels while working in the ER. It also seems that the years of mistreatment as an ER nurse have resulted in her 'giving up,' thus allowing patients to abuse her further. I am intrigued by Kali's comment, "every single day, I have to do, like, an announcement in the waiting room… to inform patients of the process," implying that no one is listening to nurses. This gives the impression that Kali feels that her voice as a nurse has been lost in favour of patient and family complaints and concerns. Her comment also strikes me, "I find, if I make an announcement, that people stay back and respect and understand and are more patient… when… I go out [to triage] after someone else has been there for eight hours, and I'm there for four… I have to deal with so much backlash from the waiting room that I don't normally deal with. Because I communicate." This statement, once again, suggests that Kali believes that the abusive actions of the patients are justified. It also suggests that Kali believes that the abuse is a direct result of her co-workers' actions rather than the actions of others.

Continuing to ground her experience in the social context, Kali remembers the moral and ethical dilemmas she faced regarding the hospital's changing visitor policies during the pandemic. Reflecting on a situation in which she had cared for a dying patient who was not allowed any visitors, Kali recalls feeling "awful." In a subsequent reflection, Kali discusses how she later elected to "bend the rules," allowing family members to come to visit dying patients "as long as it wasn't COVID related." Kali's reflections offer a personal insight into her values and beliefs and the importance she places on 'family.' Juxtaposing her experience with that of her colleagues, Kali shares how her co-workers "loved" the no visitor policy because they no longer had to "deal with questions" and "people… bothering them." Kali continues to share that occasionally she would have to "tell her colleagues just to talk to the family members over the

phone," reminding them to "think [how they would feel] if it was [their] family member." This reflection suggests Kali perceived a discrepancy between her principles and theirs, which may have made her feel different from them and wary of them. Indeed, she reflects with great insight on how "team nursing… doesn't always apply as much as it did before." Her honest reflection on the abysmal way nurses treat one another is interesting. Kali suggests that this change resulted from the stresses of the pandemic; however, she gives an example of how cliques and the exclusion of some nurses preceded it. Thinking about her personal feelings about how nurses have treated one another, I am struck by her comment, "It doesn't bother me as much. I know it bothers my colleagues… I don't care," indicating that she feels helpless and defeated. It seems as though Kali's feelings have resulted from the constant messaging and actions of the community and government that nurses are unworthy. It also gives the impression that this is a case where the 'abused' has become the 'abuser.' Where Kali feels strangely at home with the messaging from others that nurses are unworthy and is now unconsciously passing on that messaging to others. I am intrigued by her comment, "I don't have any problem with the younger nurses. To be honest. I was there once. So, I know what it's like, it's hard… You know…But people just have to… I don't know. The young ones sometimes they complain (Laughs) about stuff. But rightfully so. But you know, after so many years, you're like good luck." This statement reiterates Kali's belief that no one has, or will ever, listen to nurses. I suspect that this is Kali's way of warning the younger nurses of the trials of nursing.

Kali considers the lost voice of nurses across the temporal and social dimensions. She recalls when the hospital was "preparing for this pandemic." Remembering the discussions concerning PPE, Kali describes how the medical chief of her ER unilaterally decided that nurses did not need to wear N95 masks in the department, contradicting the recommendations of the

lead CBRN doctor. Kali associates this time with when she first felt distrustful of her hospital administration and conveys the fear she felt regarding the potential of bringing the disease home and infecting her family members and the internal conflict of debating the 'right thing to do.' Kali continues to share how the nursing voice and the support for nurses were lost at the government level, stating that the government "[was not] really doing anything to support [nurses]." Implicitly referring to Bill 124 – a Bill that limits an increase in Ontario nurses' compensation to one percent per year over three years – Kali shares her belief that a pay increase would demonstrate that the "government really appreciates nursing for what it is." I am fascinated by her comment that nurses should have "a tiered pay scale" and that "an obstetrical nurse should make more money than a Gen Surg nurse" because "you've got people's lives in your hands." This comment suggests that she believes there is a hierarchy within nursing and implies that ER nurses are superior to nurses in other specialties.

Kali continues to describe how hospital policies and protocols regarding both the appropriate use of PPE and the care of suspected COVID-19 patients were "constantly changing… by day" and how she "didn't know what to do." Illustrating the changing policies, Kali shares that at the beginning of the pandemic, suspected COVID-positive patients were isolated from others immediately after triaging, to how they now stay in the waiting room with everyone else to "wait their turn." Describing the triage area now as "not a safe or ideal environment for anybody," Kali reveals how she has elected to "triage everyone the same," no longer using the Plexiglas barriers provided to her by the hospital for her safety. Justifying her actions, Kali shares how isolated patients are now being placed in the hallway, suggesting that the contamination of patients and staff is inevitable and that minor infection prevention efforts are futile. The temporal dimension of this reflection and evolution of her perspective of safety

and support over time positions both her fear of contagion and personal safety as a strong focus initially when the pandemic was starting, to not being a focus mid-pandemic, to her current perspective that it is likely she will become infected with COVID-19 regardless of personal safety measures. I am fascinated by Kali's comment, "I'm done with it," implying that this pandemic has defeated her and that she is tired of others pretending to care about her safety. Moreover, her comment gives the impression that Kali feels that the safety measures instilled by the hospital were spurious.

Thinking back to the fear and isolation she felt during the COVID-19 pandemic, the relevance of place is at the forefront of Kali's narrative. It was not her actions or the actions of others that defined her experience; it was the place. The ER, as a practice setting, seemed to overshadow her experience, convincing her that it, almost exclusively, would be the reason why anyone in her family would contract or spread the COVID-19 infection. As Kali shares that she knows "a couple of people [who got COVID]," including a colleague whom she recalls as being "very sick" despite being fully vaccinated, and some "friend's parents that died," she begins to reveal how she feared that she would be the cause of her family's demise. Her comment, "I knew, like, this can kill my dad…And then, um, you know… there was that fear that came over you… if I catch this, it's going to kill my dad. And that would be on me," suggests that Kali felt both personally responsible for keeping her family safe and yet powerless to do so because of her employment in the ER. Her comment strikes me, "I also thought I don't want to bring it home because of my teenagers. Although my teenagers did not self-isolate, so if anyone was going to give me COVID, it would probably be them." This statement demonstrates how no one in her family felt the same stress or fear of bringing the contagion home. I also find it interesting that it appears as though she never tried to enforce the public health measures with her kids.

Comparing the responsibility she felt for keeping her family safe to the actions of her teenagers, Kali states, “I’m not really threatened by their activity. Because I thought if anyone was going to bring it home, it will be me before them.” Reflecting on the personal feelings she had regarding her children’s blatant disregard for not following public health measures, Kali shares, “I was nervous, but I wasn’t afraid,” adding, “I never got angry at my kids.” I am intrigued by her choice of words, as ‘nervous’ is a synonym of ‘afraid’ (Nervous, n.d.). Given that Kali’s primary concern is the health and safety of her father, it appears as though Kali is more concerned about who would be to blame if her father were to get sick rather than if he got sick. This gives the impression that Kali may have previously been blamed for domestic issues due to her job. Therefore, it seems as though Kali “never got angry at [her] kids” to avoid conflict in the home.

However, in her subsequent interview, Kali states that because her “kids didn’t really feel that there was any kind of threat [with COVID]” that her “house kind of ran normal,” which made her feel “normal” and “supported, because [she] didn’t feel stressed out.” Moreover, she states that her “father still wanted to see [her],” that “he didn’t care” about the potential of infection and that “he made [her] feel like [she] was wanted around.” I am baffled by these comments as they appear to be the complete opposite of what Kali had previously portrayed. As time went on, I imagine that Kali suppressed her true feelings, creating new ideas and realities to cope with her truths.

Kali describes how isolating herself from others in hopes of protecting her family took an emotional toll on her. Recalling a time before the pandemic, Kali shares how her primary method of coping with “the sad things that [she] see[s] while at work” was spending time with her friends. Reflecting on how she did not “get to see [her] best friend for a year,” Kali shares how

she began to feel “depressed” and “angry” during the pandemic because she “couldn’t do anything to get rid of the stress [she] was having.” Her comment strikes me, “I had stress at work and then had stress here,” suggesting that the pandemic was taking its toll on her professional life and her personal life. Contemplating how her family relationships have been affected by the COVID-19 pandemic, Kali states, “I don’t know if its COVID, or just emergency nursing. Like, you become short-fused,” implying that Kali’s relationships with her family were strained before the pandemic and that her job as an ER nurse is what had previously caused that strain.

Kali shares how her husband ultimately brought the COVID-19 contagion home from work. Kali talks about how her husband contracted COVID-19 from his colleague, who had continued to go to work even though he was ill. Remembering the morning her husband first started to exhibit symptoms, Kali shares how she tried to suggest that he may have COVID and how she advised him that he “should go get swabbed.” She also shares how her husband dismissed her suggestions and continued to work that day, later testing positive for COVID-19. It appears as though this interaction left her feeling unsupported and defeated, as her husband chose to ignore her concerns, thus putting her family and herself at risk of contracting the virus. Kali talks about caring for her husband at home despite feeling unsupported and defeated. As she shares how this past event appears to her now, I am struck by her comment, “I cared for once,” suggesting that this is one of the few times she cared about her husband’s wellbeing. I am intrigued by her statement, “So, in the end, he got better. And he thanked me. Because he recognized [that] I took good care of him.” It appears that her husband may have regretted not attending to her voiced concerns.

Plotline Four: Villain - I wanted to kick her

Kali shares:

Everyone's fed up… Including us. And now, in the fourth wave, there's so much burnout. There's so much burnout. You can feel it around you. The people are snarky with each other. People are leaving, or their marriages are separating. Their relationships are falling apart. People that you work with are like snapping, and these are people that don't normally. Or people are upset that aren't normally, because of the people that are snapping.

Kali shares her anger and frustration with the community:

Well, nobody out there really knows I'm a nurse, right? In the community. But I can tell you that if I get to… like the plexiglass, and the person, let's go with Costco… the person is behind the plexiglass, and you're in front of it. And you can't hear. It's so noisy, right? And you're trying to explain to somebody what you… you need. And then… So I pulled my mask down, which… she's far… like… (Arm motion of distance) plus the plexiglass… (Arm motioning up and down in front of her face) And I said, "I'm, I'm here because…" And she's like, "Put your mask up! Put your mask up!" And she started yell… like, telling me?! And then I wanted to like, just rip her a strip. I think, if I put one of my other colleagues in that position, for sure… they would have said something. Like, you just want to unload everything. Because you're like, really, it's a… it makes… provokes a lot of anger (Laughs) in me. The one who never had anger. I am so angry at people.

Kali continues:

Like, in a store, I was looking… because you know, when you go to like, Winners…They, they have the big line, but then they have all the like sucker buys, as you're going [towards the checkout]. So, I was looking at the stuff. And then this lady's like "Can you back up? It's six feet. This is not six feet." And I wanted to kick her. "Six feet." (scoffs) Because, I was like, "Oh my god. You have a mask. You have your back to me. I have a mask. I have my side to you. Like, oh, and I'm vaccinated. And I'm dealing with this." And I just wanted to rip her one. But I didn't. So, I have zero tolerance in the community with people. (Laughs)

When questioned why people following public health measures as instructed by Ontario Public Health and the government of Canada makes her angry, Kali shares:

Because of where I am, like… and what I'm doing… because I can't do that at my own work. Like, I'm up there in front of it. I'm also… I'm over it. Like, we have patients in the hallways. And we have rest… like everything is going, like… running, right? Like, you can go to a gym and can do that. So, let's just forget about this. Like, I don't care about the mask. I understand the mask, but the six feet back baloney? It doesn't stand clause. When you go to the emergency and everyone is standing, like, in each other's circle of trust, like, literally, and sitting side by side. I mean, there's Plexiglas, but do you really think that's doing anything? No. It's for show… I think. Cause they're still gonna cough out and it's going to go (large circling motion) beside the person, because everyone's

allowed to sit side by side by side. So, let's get rid of that in the community. The anti-vaxxers, well if they have COVID, we're all vaccinated and we're all in a mask. We should be fine. (laughs)

Contemplating her anger further, shares:

I found, like, in this past two years we're like working. Hard. (Laughs) And everyone else was frigging collecting money from the government and taking it easy. And here we are, busting our asses. Its… You become a bit angry with…. I think that's why I got angry at community, not at my kids. You know? Because my kids… we didn't collect money. They could have. They're old enough. All three of them are old enough to collect money from the government. I am not going to do that. I'm working. I'm making money. I can support them, like I do every day. I'm not going to build a deck with the money that the government gives. You know? That's not fair. But people were doing it. Right? Like I could have had [my husband] do it, but I was like, no, don't do it. We'll make it by. No problem.

Adding:

And… I don't want to hear anyone talk about not getting vaccinated. Like, I'm sick of it. (Laughs) And if you don't want to get vaccinated… I… like, it annoys me. It makes me angry.

Researcher's Field Notes

Thinking about the fourth wave, Kali shares how "everyone's fed up." Reflecting outward, Kali describes how nurses have sacrificed themselves and their relationships to continue working in the ER throughout the pandemic. Following the social narrative dimension, Kali presents two separate events that demonstrate how her feelings of anger, frustration, and defeat eventually led her to embody the 'villain' persona.

Recalling an incident at Costco where she removed her mask to help an employee hear her better, Kali shares how her actions were met with shouts and demands of "put your mask up!" Evoking feelings of anger, Kali talks about how she felt like she wanted "to unload everything" on the employee. This interaction emphasizes how nurses were systematically muted during the pandemic, thus eliciting feelings of helplessness, anger, and defeat. Kali also reflects on an encounter with another woman while standing in the check-out line at Winners. Describing how

the woman had requested that Kali "back up" to maintain the required "six feet" social distancing, Kali once again recalls feeling "angry" and admits she "wanted to kick her." I am struck by the level of reaction that Kali had in this moment. It gives the impression that Kali's unprocessed anger could no longer be suppressed, rearing its head at the most inopportune time.

Considering both the spatial and social positioning of these two events, Kali reflects on her personal feelings and perception of the public health measures. She states that she felt angry "because of where I am… and what I'm doing… because I can't do that at my own work." This statement suggests that Kali is not only frustrated that she is not afforded the same opportunity to follow public health guidelines at work but that she is made to feel unworthy of personal safety due to their profession. I am intrigued by Kali's statement, "I have zero tolerance in the community with people." It appears as though this intolerance is related to the dichotomy she feels between how nurses are disrespected and disregarded by the community and how the community expects nurses to treat them respectfully. It also seems as though Kali's expressed feeling of anger is an outward expression of her unprocessed feelings of sadness and fear resulting from her own family's disregard for public health measures.

Contemplating her anger further, Kali describes how nurses have been working continuously throughout the pandemic while "everyone else was… collecting money from the government and taking it easy." Kali attributes her anger to the "fairness" of the financial support measures, noting that she witnessed others use it to "build a deck." This is similar to an earlier reflection, in which Kali shared how the community was so busy "building decks and doing home improvements" that they "did not care" how nurses were coping. Given that Ontario nurses are currently being subjected to Bill 124, it appears as though Kali feels like this compensation to

others was a slap in the face to nurses. It also seems like Kali feels that this money could have been better utilized in healthcare spending.

Plotline Five: To be Continued - As nurses, we are fixers… We're not the ones that need help

Kali contemplates how she tried to survive working as a nurse during the COVID-19 pandemic:

> *I just…they did offer group support at [my hospital]. They had it… I don't know what day it was... It was one day of the week, every week. They had a group session. Where it was supposed to be therapy and there was a psychiatrist there. And it was like a group thing. And honestly, I wanted to go. They offered it from Zoom, from home. They offered it, like, there. But I didn't go. If I was working, I couldn't go. Like, you can't go, right? Like, you… am I going to take… I guess I should take my lunch break and go, but you never could arrange your lunch to attend. So, I didn't go. And then being traditional when I wasn't…. if I was off the day of that meeting, it wasn't a priority for me to go. Clearly. Or I would have went. I went twice. Okay. (laughs) The first time I went, a nurse cried so hard for so long because she lived through SARS, and now the COVID was coming, and she was frigging freaking out. Because also her daughter is a nurse now, and she's worried about her safety, and her life. And this phase one was very scary for her. So she cried a lot. And I was just like, "woah, I'm lucky I wasn't there for that." So, I was on maternity leave. And um, I just listened, and I thought, "Oh, this could be beneficial". But really, I don't need help with COVID. I think it's just nursing in general and our own private lives in general that I need help with. You know, not COVID. And then the second time I went… Oh my gosh… it wasn't that much later. And it wasn't during this third and fourth pandemic, I can't imagine if it was, what would happen. They talked about the signs of burnout. And then, I was just like, gonna cry. (laughs) They had it, like, on the board… they had all the symptoms. And I was like, "Oh my god, it's me. Oh my god I have burnout." Like, I don't have to be angry to have burnout. You know, and I found it very, very emotional. And I think it's too personal. Like, you can't go to that. Right? And then go, go to work after. Because number one, you're gonna… I would have bawled if I said anything. And then I would have cried all day. Because people would say, "Oh [Kali], are you okay?" Right? And then you're off all day. So, it's not that therapeutic to go when you're working. And sometimes, people don't want people that they work with to see their weaknesses. Or, you know, to hear their problems or whatever. I don't think that's really that great either. I think individual support would have been more productive than offering group therapy.*

When questioned as to how she took care of herself during the pandemic, Kali asserts:

> *I didn't. As you can see… (laughs) I did cut my hair. Not me. Somebody. But I.. man, I need blonde hair still… I need… The one thing I did do… is I bought a new skin product.*

I bought like a collagen product for that you drink, and then you use on your face, and it really helped me to kind of look after myself, like that. Um, I've tried to take vitamins. I did absolutely no exercise. I ate a lot. (laughs) I worked a lot. Right. Because I went full time. So, I did not take care of myself. Except at the beginning. So, I started full time in November, and then I started to go for massage therapy, and to use up all of my massages, because I knew it was going to change over. So I use them all up. So that month of December, I was like getting massages. That was good. But since January, what have I done for myself? Nothing. Zero. Zilch Ola. Zip. Um, I didn't even get to go snowboarding in January, because of the restrictions and the frigging closing of the mountain. Which again, I had like a ski passes for… Blue Mountain. And then, I was gonna just, like, not use them, and then they opened up. I guess in February. Mid-February. So my son and I are like, screw it, let's go. Because we just needed to do something to get out of this headspace (circle hands by head). You know? I tried doing some running, for a bit. But I found it, um, kind of bothered my knees… It did help me, but it's kind of boring. You know? Running is kind of boring. So, I didn't do much for myself. Um, I don't do much for myself. I'm going to be honest. Um, what I do for myself, I buy myself things. But mentally, like physically I mean, I don't do anything for myself.

Reflecting on the emotional toll that the pandemic has taken on her, Kali shares:

I notice, now, with… I would say in the past, like year… not year. The past like three weeks… I'm noticing that my stress level is like… I can go from this zero. Right? Like just a quiver… (hand motion on one side of the screen) to like, the hundred percent, other end of the spectrum. (hand motion on the other side of the screen) In one second. In one second. Whereas, it used to be, a little bit. You know? Like, well… [I'll] give you an example. It's in my personal life. It's not, like, in my, my work life really. Cause nothing really bothers me there. It's my… it's a job. Right. I feel like it's a job. Um, not… not nothing bothers me there. The emotional things bother me. Right? Like, things do bother me, but it's different. Like, if something stressful happens at work, I'm at work, and I'm expecting it. So, I'm like, it's a different part of my brain, I think. Right? But when you're at home, it's a different… completely different thing. And I can go like… I don't know. I don't really have an example, but I literally go from zero to 100 like super-fast in my body. You won't notice. But in my body, I notice. It's like complete utter like breakdown inside. I used to have, resistance, I guess. Like, you know, let's pretend that you have a meter. (two index fingers together). Okay, and what sends me to here now… (moves left index finger far from right and back) Before, it might go like this (moves fingers one inch apart) and bounce back. (puts fingers together) Like this… (same hand motion) and bounce back. But now, it's like this… (fingers together) to this… (fingers wide apart) And it stays there. And then it slowly comes… (moving fingers back together). And then it comes back (moves fingers wide apart again). And, you know, like, it's like this, it's staying up here (fingers wide apart). And then finally, it comes down (moving fingers closer together), but I don't think it ever comes back down (fingers touching). For a while. Like, hours. Maybe days. Like, literally days.

Kali expresses how her relationships have been affected by her unprocessed emotions:

I came back from work on Sunday. I already had a fight with [my husband] within 12 hours of being home. Because of me. (laughs) Because I go like this… (fingers motioned far apart) right? But your brain is like this (circling fingers near head). Because I've been like this (circling fingers near head) at work. And now, I'm like this at home (circling fingers near head). And [my husband] was home. And I got annoyed with the fact that he was home. It was raining and he works outside, so he couldn't go to work. But I felt like, fricking hell, I don't not go to work. Get… go to work! Like, I like, I feel frustrated. Whereas, I used to not feel like that. And I snap at my kids. Like, "Mom!" "What?!" Like, instead of like, "Mom!" "Yeah?" You know.

Continuing, Kali describes how her unprocessed emotions have manifested into physical ailments:

I'm having like a lot of symptoms from my stress. I get these like feelings in my stomach. If you ever had restless leg syndrome, or like a drop stomach when you go on a, on a swing and it's like, woah, your stomach goes. So, I've been getting that in my arms and legs, and stomach, a lot in the past like, month. It started in my stomach for a couple of… probably two months. And now it's spread to my legs and my arms, and it feels weird. It feels awful, and you have to move. It's like, I guess that's restless legs and I think that stress. And also, um, a really nondigested stomach. It's like… you know… Constipation. All the time. Bloated. Uncomfortable. It's like this horrible thing… (Laughs) And then I go to work, and even my colleagues notice… And they're like, "Your stomach is bloated." And every time I tell them my stomach is hurting, they always say "Yeah, your stomach is bloated." But, I know that your stomach gets affected by your stress, the cortisol. It all goes to your stomach… And then I don't sleep, right? Because I'm up in the night because of that shit.

Adding:

I know it's from stress. Because I was off sick last week, and I wasn't in the hospital for seven days, and the day before, Saturday, when I knew I had to go back, all of a sudden… shing! Those feelings are coming in my arms and my legs and my stomach. My stomach is bloated and irritated again. Like I don't… and I'm snappy again. I'm snappy.

Kali identifies another sign of feeling overwhelmed by her emotions:

I also noticed something else. It's super noisy in that hospital. Especially with the overcrowding and the hallways are full again. The noise… it's making me crazy. I can't handle the noise. Like I almost want noise cancelling headphones to wear in there because I can't handle it. Like, I actually want to scream, because of the noise. Because the stress is so high. The stress is like, incredibly high, and the noise is so loud. It's just a huge contributor to, to what you're feeling, like, in your day. And then, when I get out,

there's where I'm going with it, I don't want nothing. Like, I won't put the radio on, I'll drive an hour and 20 minutes, because that's about what it takes, with the nothing. Because I need the quiet. And when I get home, I need the quiet. Like, I don't want the noise, of like, my kid's music, definitely like, zero tolerance for that. (Laughs) Or their hooting and hollering on their games. Like, I'm just like, "Oh my god, just shhhh!" I need quiet. That's a huge thing right now. (laughs) Is quiet.

Recognizing the importance of processing emotions, Kali proclaims:

You have to do it. Because you're going to end up a hot mess. Right? You have to do it. That's why I recognize I have to do it, or I'm going… like, something's happening to my body. It's going to break, I'm going to have a breakdown, probably. Because if I'm having these symptoms in my body, what's going to happen up here? (Touches head)

When asked if she has a therapist, or someone to speak to, Kali stated:

No. (laughs) I talked to my best friend. But I try not to talk to her too much anymore. She's a psychotherapist, so I'm very lucky. But, you know, I don't want to be… I don't like… I don't want our friendship to be my problems. And I also, I want to be a release for her, because her mom has Alzheimer's. So, professional help no. Do I need it? For sure. I think I do. Um, but I haven't. I guess… I think about contacting EAP [Employee Assistance Program]. But you know what? They don't really have anything around the hospital with the number. When you think about it. There's something for your study that I think would be really important. Is that they should make EAP more readily available. Like, a poster in your, um, locker room. A poster on the nursing board… or maybe a poster in the bathroom. You know, maybe a refresher to "Hey, this is available for you if you need it." A friendly reminder. Because, um, as nurses, we are fixers. We're the ones that are making people better. We're the ones that listen. We're not the ones that need help. You know, we feel guilty, looking for help. Like I can handle this. Right? We have pride. And I think I haven't called EAP because I don't know the number, and I have to look it up. But I mean, it's not hard for me to look it up.

Kali describes how she is attempting to cope now:

[L]ast week I decided to go back to hot yoga, because, number one, it's cold. And number two, my… I told you, my stress level is so high… So, I decided I'm going to go back to yoga, because it will increase my mindfulness, and I… it will train me back to how to shut out things, right? And, um, it'll help me to relax my body. And it will also help to relieve… relief, like the toxins from the stress that are in our body, and the thoughts that are hiding in all those joints and in those spots, because of all the things that you put here (touches head). That you don't want to put there (outward motion of space). And I also booked a massage tomorrow. So, I'll go to yoga today. I'll go to yoga tomorrow, and then, you know, I try and cook healthy. But that's pretty much it. I don't really take time for myself. My time for myself is my hour yoga and my massage and I'm going to go for. Otherwise, I'm cleaning, cause I'm obsessive. I'm doing laundry. I don't really do

anything for myself. I'm not a reader. I work for a dentist, once or twice a month, in between all my days off. And then I work for lawyers, as well. So, I really don't… like if I take a time off… over here is going… (touching shoulder like someone is sitting on it) "You have a report due. The lawyer is going to message you. You're taking too long." It's always like that. Which is also why I'm snappy.

Adding:

And that's why today, I'm like, no, I really want to go to yoga because I noticed it releases a lot of negative tension in your body. Like, that you might hold in your shoulders, or your hips…[or] in your mind.

On contemplating leaving nursing and considering alternative employment, or taking a break from her job, Kali said:

…you constantly see the job opening, like the, HR [human resources] window [on the hospital's computers] open. People looking to get out. Because it's a lot. And then the new ones that are coming in, which they just came in the third wave, are already leaving. It's crazy. Yeah, I can't believe that I'm still there. I look though. Now I'm looking again. I'm like, I'm looking. I gotta get out of here before I lose it. It's pretty heavy.

In reflecting on why Kali continues to work as a nurse in the emergency room, she shares:

I love people, and I love my job. I love taking care of people. Meeting people. Making a difference in people's lives. Completely love it. I don't want to stop nursing. Even if I win a lottery, I would still go and nurse people but it would be my own accord. (laughs) I don't want to work full time anymore but I, I'm going to because I've been full time and I still haven't taken a vacation. (Laughs)

Considering the future of nursing and the possibility of forthcoming pandemics, Kali offers this advice to the government:

…increase our wages. Overall. Despite the pandemic. Increase our wages… advertise more about… inform the, the community, the public more about nursing and what it entails. You know, it's not about… It's not… of course it's about holding hands of people. Being there for the beginning. Being there for the end. But it's also about educating yourself. Right? Taking courses. Making life altering decisions for people. You know, a lot of people don't know what nursing does and I think that the government could help to put it out there. And I also think the government should have been… I mean, they didn't know what they were going into. So, to be honest, I don't know… there was just so much out there. I wish they would have limited how much they were putting out there for the general public. One minute it was do this, one minute it wasn't. So, it was all over the place. And it becomes exhausting for everyone.

Kali's advice for hospital management:

Up your staffing. Provide incentives. Retention. Maybe retention incentives? Maybe just, you know, treat of the week? Something to kind of keep you going. Do you know what I mean? Like… I don't know… little things make a difference. They don't make it or break it, but they, they do make a difference when you're feeling… I don't know, for me anyway right? Just having [my manager's]'s office full of candy. If you knew you could go in there and get a sweet treat right? But let's say the hospital gave you gave out free coffee every week to the nurses or something? Like, not every week, but you know what I mean? Like you get your coffee voucher in your email and you could use it when you wanted to. Or a free lunch today or a free dinner? Or something like to kind of help you… or maybe, I don't know… they could have just done more to support you in a sense of... If you want to keep your nurses, like right now, look at the agencies paying $90 to $100 an hour. But yet, those that are still committed are making their $46 an hour… So, they need to like step up to the plate. There should be… If the hospital can afford to pay a nursing agency $100 an hour for a nurse, then every nurse in that hospital should be making $100 an hour. Or even $80 an hour. And then we wouldn't have this retention problem. Wouldn't have nurses changing. Right? The government and the hospitals, need to be aware of that.

When asked if she has advice for nurses, Kali states:

Well, I always have advice. I always talk to people that say they want to go into nursing, I ask them why. And I say, "Please go into nursing to be a nurse." We need people to look after us. Right? We don't need nurses to go into nursing to get out of it. We need nurses to care for people.

She continues:

I think that the way that they're making nursing…They're taking away the, what nursing really is. In regards to even the education system for nursing. Right. Back in the day you went to college to be a nurse, and you actually practice nursing. But nowadays, it's like if you don't have 90s or above you can't get into a nursing program. And then when people go into it. This is from what I… what I hear… the things that they're learning are completely like ridiculous. They should be learning practice. You know, some theory. Yes. Physiology. Science, of course. You know, social and human behavior, of course. But like, why they're having to study all kinds of things that… it's just crazy. Like writing these thousand-word essays on something that is irrelevant. It should be how to take care of people. Because these people finish school with a sense of entitlement. And they don't want to take care of people. They want to go into management or nurse practitioner… run their own little side job. They don't want to be front line, you know, care. Taking care of people anymore. Because they're taking that away from people. And they're tiering off nursing… they're having your practical nurses, and your, um, PSWs. They have all… their going back now. They're going backwards in nursing. You know? So anyone that has an RN is going to be a manager or a nurse practitioner. And now, the people caring for the patients are going to be PSWs and RPNs. That's what I feel like.

Finally stating:

Um… I would never tell people not to go into nursing. Like, I hear other nurses saying, "Oh my god don't let your daughter study it." Or "Don't let your son do nursing." I'm like, "No, it's a great profession." It allows you to be independent, as a woman, right? Like, look at… you raised your son by yourself. You have a home. You're doing great for yourself. You're doing your masters, right? I have a home. I have a car. I have three kids. I raised them by myself. I didn't even get proper child support, and I still have all of this because I've worked hard. So, I think it's a great profession, allowing you to have your independence and not be dependent on someone. Um, I would say to the senior nurse… You know, recognize when you need to tap out. And remember where you came from. You know? We got to remember, like, we didn't always know these things. It's all come with experience. We gotta help each other. Nursing has to help each other, not fight against each other. And, unfortunately, nursing tends to eat their young. And we shouldn't be. Because these are the people that are going to be looking after us one day. Or advocating for us, hopefully one day… We should be sticking together. Like the firefighter's union, like the paramedic's union. We should be sticking together. But unfortunately, for some reason, nursing does not. Nursing eats their young. Attacks their young. Attacks, each other. Like different parts of nursing attack other parts of nursing right? ICU attacks the emergency nurse. Why they did this, and why they didn't do that. And it should be like, "Wow, emerg you kept this personal alive. Great job." not "why didn't you do this, why didn't you do that? Don't come up yet. I'm not ready." You know? Or in reverse emerg saying, "I'm coming up now, whether you're ready or not. I have to." Shouldn't be like that. We should be treating each other with respect.

Researcher's Field Notes

Kali reflects on how she tried to survive working as a nurse during the COVID-19 pandemic, sharing that her hospital offered once-a-week group support with a psychiatrist when the pandemic began. She comments that she "wanted to go" to the sessions but states that she often "didn't go" as it "wasn't a priority" for her. Kali recalls going to the sessions twice while at work, stating that she thought the counseling sessions could "be beneficial." However, after attending a second session, Kali comments that she found it "very emotional" and "too personal" to continue going. I am intrigued by her comment, "people don't want people that they work with to see their weaknesses. Or, you know, hear their problems or whatever." This statement suggests that Kali is projecting her fear of vulnerability onto others. It also implies that Kali is seeking to suppress her emotions to survive working as a nurse in the ER. Her comment strikes me, "I don't need help with COVID. I think it's just nursing in general and our own private lives

in general that I need help with. You know, not COVID," insinuating that she has sacrificed everything in her personal life for her profession and that the pandemic was just the tipping point of self-actualization.

Looking back on how she 'took care' of herself during the pandemic, Kali reflects outward, focusing on her personal appearance. This causes her to question "what [she has] done for [her]self physically to "get out of this headspace" mentally, suggesting that she associates her mental wellbeing with her physicality. Her perception now is that she "[did not] do anything for [herself]."

Noticing that her stress level has risen dramatically over the past few weeks, Kali describes how quickly she reacts to external stressors, stating that she "can go… from zero to 100… in one second." As Kali attempts to give an example of how the pandemic has taken an emotional toll on her, I am fascinated by her comment, "It's in my personal life. It's not like, in my, my work life really. Cause nothing really bothers me there," suggesting that Kali does not attribute any of her current stress reactions to her past work traumas. It appears as though Kali lacks insight into how her experience of working during the pandemic has affected her psychological wellbeing, which has affected her interpersonal relationships.

Reflecting on how her unprocessed emotions have manifested into physical ailments, Kali describes having "a non-digested stomach" and "weird" feelings in her arms and legs. Acknowledging that her ailments are a stress reaction, Kali recalls when she had been off work for seven days, and the symptoms had dissipated. She suggests that this was a turning point for her in recognizing the importance of processing her emotions, stating, "I recognize that I have to do it… something's happening to my body. It's going to break. I'm going to have a breakdown

probably. Because if I'm having these symptoms in my body, what's going to happen up here? (Touches head)."

Thinking about the past two years and how she has yet to process her emotions, Kali reflects outward on the lack of available support. As Kali describes her experience, it seems as though she struggles to admit that she needs help. Indeed, Kali's tension with her personal feelings of needing emotional assistance as a nurse is highlighted in her comment, "as nurses, we are fixers. We're the ones that are making people better. We're the ones that listen. We're not the ones that need help." The social positioning of this comment suggests that Kali's personal feelings on the ability to process one's emotions as an ER nurse are informed by interactions with colleagues. It appears as though Kali perceives needing help as a sign of weakness. It also appears that she fears being ridiculed by her colleagues for needing emotional support. Moreover, it seems like she actively avoids discussing her feelings with others as a mode of survival.

Contemplating how she is attempting to cope now, Kali once again reflects outward, sharing that she is "going back to yoga." Her comment that she has chosen to participate in yoga as it will "increase [her] mindfulness" and "train [her] back to shut out things" implies that Kali is choosing to continue to avoid processing her emotions in an attempt to continue working in the ER. Indeed, despite admitting that her experiences during the pandemic have caused her to consider alternative employment, Kali has no concrete departure plan in place. When asked why she continues to work as a nurse in the emergency room, Kali states, "I love people, and I love my job. I love taking care of people. Meeting people. Making a difference in people's lives." I am struck by her comment, "even if I win a lottery, I would still go and nurse people," suggesting that Kali stays in the ER because her self-identity is tied so heavily to being an ER

nurse. I wonder if Kali believes that she would have 'nothing left' of who she is if she left the ER. Finally, I wonder if Kali feels as though she has sacrificed everything for her profession and that giving up on nursing in the ER would mean that all of her sacrifices were for nothing.

Reflecting outward, Kali expresses her advice for improving the future of nursing and pandemic planning. To improve the outcomes of future pandemics, Kali chooses to focus on the government, stating that the government needs to stop giving confusing messages to the public about public health measures, that they need to educate themselves and others about what nurses do, and that they need to reinvest in healthcare. Finally, to improve the future of nursing, Kali turns her focus to nurses stating that current nurses should encourage young adults to enter the nursing profession, urging them to take frontline positions as bedside nurses. She also recommends that nurses "stop eating their young," suggesting that nurses must "stick together" to support one another. She also states that hospital management needs to work on retaining nurses, offering incentives to stay within the organization.

Attending to Kali's Story

Kali's story is not COVID specific but rather that of nursing in general. She talks about how poorly nurses were treated prior to the COVID-19 pandemic and how the first wave gave nurses some reprieve from the abuse that they previously endured as the community started to appreciate the profession of nursing. However, as the pandemic has begun to wind down, Kali demonstrates how the abuse and mistreatment of nurses have come back with a vengeance.

Kali's overall story can best be compared to an abusive relationship where nurses are the abused, and everyone else is the abuser. In this situation, nurses enter the profession (relationship) to help others and make a difference. As they continue in the profession, they begin to notice that they themselves are not cared for and that the frustrations of the patients,

hospital administration, or the government (abusers) are taken out on them by their abusers. Feeling their value being questioned, nurses try harder to appease their abusers, often making personal sacrifices to the detriment of themselves and their families. Despite nurses' best efforts, their abusers begin to act out, harming nurses physically and emotionally using threats, insults, physical abuse, manipulation, and intimidation (e.g., wage freezes). Eventually, the abusers admit they were wrong and promise to make things right again (hiring new staff to help with the workload and paying bonuses). Nurses accept their abuser's assurances, and things remain calm for a while. Eventually, the cycle continues, and nurses begin to see and hear that they are unworthy all over again in the actions of their abusers. Despite this continuing vicious cycle, there is an underlying sense of deservedness by nurses who comment that they 'chose to enter the nursing profession' and therefore 'chose to put themselves at risk.' Moreover, there appears to be a fear of leaving the nursing profession by nurses who identify and define themselves as such, as leaving the profession would lead to a loss of personal identity.

Grace Note to Kali

Dear Kali,

Thank you for showing me the power of a positive mindset. I have seen through your story that by having a positive mindset, one can overcome almost insurmountable challenges.

I believe that your most significant attribute is your desire to help others and the compassion you show those in your care. Your propensity to identify and grasp onto the positive in every situation shows incredible strength and perseverance.

My wish for you, Kali, is that you feel safe and secure enough to share your innermost thoughts, feelings, fears, and experiences with someone who has the strength to share your burdens. Allowing yourself to be open and honest with those you trust will help you feel heard and supported. I hope that you can continue to focus on yourself, nourishing your mind and body with your yoga practice. It is not selfish to refill your cup so that you can continue to serve others.

"True heroism is remarkably sober, very undramatic. It is not the urge to surpass all others at whatever cost, but the urge to serve others at whatever cost."

– Arthur Ashe (Tennis Player)

Chapter 6: Nyathera's Story

Nyathera: Participant Three's Alias

The name Nyathera is primarily a female name of African origin and means 'she survived' (Nyathera, n.d.).

I chose the name Nyathera for participant three because her story is one of survival. Participant three was the most seasoned nurse in my study with over 30 years of nursing experience. Having already worked on a SARS unit during the 2003 SARS crisis in Toronto, participant three was no stranger to the trials of pandemic nursing. However, unlike SARS, the COVID-19 pandemic caused participant three to endure several losses, including the loss of her father and the loss of enthusiasm for a profession she once loved. As participant three continues to tell her story, it becomes apparent that as the COVID-19 pandemic progressed, participant three began to disengage from her surroundings in hopes of surviving as a nurse.

Prologue: Meeting Nyathera

I met Nyathera online on a warm October morning amid the fourth wave of the COVID-19 pandemic. While the province continued to wait to see the full impact of Thanksgiving gatherings on the rate of COVID-19 infections, I felt cautiously optimistic. Morning news outlets reported only 328 new COVID-19 cases in Ontario, 52 in Toronto, continuing to drop the seven-day average (Ontario COVID-19 cases, n.d.). However, despite these encouraging reports, I could not help but be drawn to a different account of the day.

In the weeks prior, Ontario Premier Doug Ford had asked the COVID-19 Science Advisory Table (a group made up of hospital CEOs and healthcare providers) for their input on a province-wide vaccination policy for healthcare workers. Responding to his questions, the Table had just presented a letter to the Premier outlining the reasons why they believe vaccines should

be mandatory for all hospital staff (CP24.com, n.d.). Their reasons included: protecting vulnerable patients from COVID-19, ensuring that hospitals can continue to function, and protecting the health and safety of staff (CP24.com, n.d.). With the public release of their recommendation for a province-wide vaccine mandate for healthcare workers, I noticed an explosion of differing opinions being shared by nurses across my social media accounts. It had become clear to me that as the pandemic waged on, its effects were not only causing a divide among communities, but they were also causing a divide amongst nurses.

As Nyathera met me online, I noticed that she had an authoritative yet reassuring presence. I could not help but think that she would have an excellent bedside manner in the ER and imagined how she would likely remain calm, even in the face of adversity. Her openness and energy were such that I could tell she had many experiences and was ready to share.

Plotlines in Pandora's Narrative Account

Plotline One: Before They Were Heroes – I worked through SARS

Nyathera reflects back on why she became a nurse:

> *When I was in high school, a friend of mine was in a car accident. And ended up with a Halo…So… I guess it kind of piqued my interest then… [prior to that] I always thought I would be a phys ed teacher… There was no nurses in the family. I didn't, you know, like… come from a line of them. Right? …There was nobody… in health care. I'm supposed to be a gym teacher… that was really what I thought I would end up doing… health related… but way better hours… and no Bill 124… There's days I wish I was [a gym teacher]. You have your weekends, your holidays, your summers off. I wish that. You give up a lot being a nurse. You give up an awful lot…*

Nyathera talks about her career as a nurse and how she ended up in the ER:

> *I graduated in '91, so, there wasn't any full-time jobs available when we graduated. I started with an agency, placed at [a rehabilitation facility] … So spinal cord injury [patients]. Worked mostly nights, with a nonregulated healthcare professional… They taught, you know, these non-regulated's how to assist people with catheterization, it was very interesting. And you would pour meds for the following shift. So, if I'd work nights, I'd pre-pour all the am meds for days… Yeah, it was a really good environment actually… It was very positive. Then I went to [the hospital], where I've worked for 31*

years now. So, I started off… it was chronic care at that time… stayed there for quite a few years… and then they removed the chronic care portion of it… And then it became a medical unit… from there, that medical unit incorporated… a three-bed step-down ICU. Still runs today, but they call it critical care level two… we used to call it an Acute Medical Unit. And that would be, you know, your chronic trachs. You know, anybody that's had a long ICU stay. It was a transitional bed until they got to the floor. So uh, lots of complex needs, but still had the higher acuity than what a floor could manage. Like bipap… good things like that. They then instituted art lines, central lines… So, it was just a mini-ICU. The only issue was they weren't intubated. That was the only difference. But they could be on pressers as well. So, um… so, I worked primarily there, for quite a few years… [In 2003] they turned it into the SARS unit… you didn't have to work there if you didn't want to. You were given the option… So, I did volunteer… Then went to patient flow, and I did that for about 10 years. Oh, in between there, I did a little stint as a manager when one was off. So, about 6 months worth of a patient care manager…So patient flow... And then, I got bumped at 20 something years of seniority (laughs)… after being bumped from patient flow, I had to go back to whatever vacant position there was… So I bumped into a floor… where I could just get my feet wet again. Get your skill level back up. And then they approached me about doing this this trial with this mobile admission team… Assisting the floors to pull their patients a little faster than what they're doing. So, a friend of mine and myself, we did this, along with another emerg nurse. We pulled the patients from emerg and took them up to the floors and settled them in and made sure there was no issue… So, that was based out of emerg. So, of course… then you make new relationships with people that you work with down there, and there you go... I got bumped and went to emerg.

When asked why she volunteered to work on the SARS unit, Nyathera says:

Probably just the newness of it all. And maybe, you know, you could help. And that your fellow co-worker might not be willing to do so, for whatever reason. You know, some were very afraid. And if you're very nervous and scared, the likelihood is you're probably gonna breach with your protective equipment, and that would then put them at risk. I think you have to be very confident in your donning and doffing.

When asked if she was afraid of contracting SARS, Nyathera states:

No, No. I don't think so.

Nyathera shares what it was like to work through SARS:

[During SARS, I worked on] a closed unit. You had basically almost two nurses for every patient at one point, because we had our ICU all combined together. So, it was always a two to one ratio. You were never on your own. There was always somebody there to make sure that you were donning, doffing correctly, um, even adding additional tape on… if you needed it. Um, I don't know it just was so much smoother. There wasn't the chaos. I wasn't in emerg at that time… the SARS unit was very well maintained. You knew what

your roles were. They were clearly defined. Everybody knew. Additional support. Right down to environmental services, you had additional support there.

Nyathera remembers caring for co-workers who had contracted the virus:

I can remember getting a busload in from [another hospital] of SARS patients. And everything was laid out. It was the smoothest transition ever. They all came, via bus and they were escorted to the floor. Everything was pre-planned. And it was sad, because these are, you know, some of them were staff… that worked up there. And they don't know… you know… you could imagine what it was like back then. It's only our eyes that are visible, right, and it's a hard to tell. Some people just can't see a face, through their eyes. So, it's hard. You know? I worked at [the other hospital] at one point… so I was familiar with some of the staff. So, I guess it was comforting for them to see… to be at least acknowledged… like, we knew who they were… I do remember the one girl… she was so thankful that it was a familiar face. Because it was very scary for them.

Recalling how nursing changed during and after SARS, Nyathera shares:

There wasn't any [hallway medicine]. There just wasn't any. They all went right upstairs… [because of the] decreased volume [of patients].

Adding:

I'm trying to remember when we started swabbing, you know, for MRSA, and VRE at ESBL… I'm trying to remember how long ago. Because it's just so part of your routine, right? …I don't remember off the top of my head. And I can remember … dropping the ESBL. That that was one of the things people used to be isolated for, was ESBL. And they dropped that. But, I think infection control, the practitioners, I think their scope of practice, or the requirements I should say, in order to practice as one, greatly changed post SARS. Beforehand, it was just based on their gut reaction. If someone should be isolated or not. And they took their time to get people off, I think there was a quite a pressure afterwards to maintain proper infection control guidelines but also to get them off. Start cohorting. Never heard of that before. But they started cohorting because we had such a prevalence. If there was a nosocomial transmission they really started pushing cohorts. And we didn't do that. And they're still cohorting today.

Researcher's Field Notes

Nyathera begins her story with when she was in high school and discusses her decision to become a nurse. She explains how witnessing the adversity of a high school friend piqued her interest in nursing, commenting that prior to that experience, she had imagined that she would become "a gym teacher." Her perspective of 'not coming from a family of nurses' suggests that her family's ideas or beliefs did not influence Nyathera's decision to become a nurse. Instead, it

seems like her ability to choose her career path is part of why she now identifies so strongly as a nurse. Looking back on how her aspiration of becoming "a gym teacher" appears to her now, Nyathera laments that had she chosen a different path, she would have "better hours" and "no Bill 124," implying that she feels unappreciated in her chosen profession.

As Nyathera recalls her journey of becoming an ER nurse, she chooses to focus much of her attention on her experience working in the SARS unit during the 2003 SARS crisis in Toronto. She seems to have an image of her surroundings in her mind as she talks about it. Describing SARS as being "much smoother" with less "chaos" than the COVID-19 pandemic, Nyathera shares that during SARS, there was "always somebody there to make sure you were donning and doffing correctly," that "you knew what your roles were," and that "you had additional support." Nyathera's perception of her role during SARS appears to be firmly defined by, and oriented to, the narrative dimension of place. She mentions in her reflection that she worked in "a closed unit," suggesting that not working in the ER positively influenced this time.

Nyathera reflects on her decision to work in the SARS unit. She refers to "the unwillingness of her co-workers to work during SARS" as the catalyst for her decision. I am intrigued by her comment, "if you're very nervous and scared, the likelihood is you're probably gonna breach with your protective equipment, and that would then put them at risk. I think you have to be very confident in your donning and doffing," suggesting that she was not afraid of contracting SARS. Indeed, when later asked if she was afraid of contracting SARS, Nyathera boldly states, "No, no. I don't think so." The temporal position of this event, volunteering to work on the SARS unit, would have been twelve years into her nursing career. I am fascinated by her comment that she volunteered to work in the SARS unit because of "the newness of it all." This statement gives the impression that Nyathera found the idea of working during the

SARS pandemic stimulating and is reminiscent of Pandora's description of feeling "excited" when first hearing about the COVID-19 pandemic. It seems like both Pandora and Nyathera believed that the experience of working during a pandemic would validate them as nurses.

Nyathera reflects on receiving "a busload" of SARS patients from another hospital that included some staff she had previously worked with. Considering the narrative dimension of time, this past event now appears to her as "sad." Remembering a particular patient, Nyathera shares her perspective of "it was very scary for them." Despite stating in an earlier reflection that she was not scared of contracting SARS, it seems like Nyathera's perception of the patient's feelings at that time is an outward expression of her feelings of fear of contracting SARS. Given the narrative dimension of time, I suspect that Nyathera's feelings of fear grew throughout the pandemic as she witnessed her peers contract the disease. I also suspect that Nyathera is hinting at her personal thoughts and feelings after contracting the COVID-19 contagion. Finally, I am struck by her comment, "I guess it was comforting for them to see… to be at least acknowledged… we knew who they were." This statement implies that Nyathera values the recognition of nurses. It also insinuates a difference in the support and appreciation nurses received during SARS and the COVID-19 pandemics.

Nyathera recalls how nursing changed during and after SARS, concentrating her discussion on infection prevention and control practitioners and testing measures. I find it interesting that these two actions are at the forefront of Nyathera's recollections.

In the final report released by the SARS Commission in 2007, the SARS Commission makes its final recommendations arising from the story of how SARS devastated Ontario and was not contained until 375 people had contracted the virus and 44 people had died (The SARS Commission, n.d.). Expectedly, in an outbreak where nurses, doctors, and other health workers

comprised the largest group of SARS cases, many final recommendations address worker safety issues (The SARS Commission, n.d.). However, it is noteworthy that of the 79 recommendations, only ten encompass surveillance and infection control measures (The SARS Commission, n.d.). Moreover, many of the final recommendations focus on communication and the importance of ensuring that the voices and experiences of nurses are heard. I am intrigued by the notable omission of any changes to nursing practice regarding implementing such recommendations. Indeed, in a later reflection, Nyathera talks about how her suggestions for improving communication between the hospital and families were ignored by hospital administration during COVID. It appears that if hospital administrators had implemented the recommendations for hearing nurses' voices, many of the challenges faced by my participants during the COVID-19 pandemic could have been avoided.

Plotline Two: Hero – It's not hard to please a nurse

Nyathera begins with:

I think the most important, was it being acknowledged that we were in a pandemic earlier than what we were. [The area of the city I work in] is like, the hot spot… So it… we had… we were… we are a hot spot. Still to this day. Um, a lot of language barriers, ah, new immigrants… I think there's a huge education component to it. A lot of multi-generational family homes. Um, nursing staff are, are well represented, I would think. Different immigration groups are very well represented.

Nyathera shares how the community feared the contagion in the first wave:

[The emerg] slowed down. And all the regular things that we normally would see on a daily basis, disappeared. I don't know what happened to all the heart and the walking MIs [Myocardial Infarctions], like, they just didn't come.

Adding:

I blame media for producing a lot of fear mongering. Because it's a… constant panic 24 is on, and everybody's home all the time. That's what I call CP 24 [Cable Pulse 24] - constant panic (laughs). Because it is… it just it… all it does is highlight bad outcomes. It doesn't say anything that's good that's going on. It's always a negative cogitation to it. Unfortunately.

When asked if she was afraid of COVID, Nyathera states:

No, no, because I figure if I've worked through SARS, no problem right?

Nyathera shares how nurses were treated by patients in the beginning of the pandemic:

The first wave they were, they were good. They were… I'm gonna say more respectful than what they are now. The Delta [variant] brought out the worst of them. Definitely. Actually, COVID's just brought it the worst in everybody. But they were better. The first wave they were much… yeah, they were much better. I think they, they took the, the protocols better. The visitor policies better. We still get the odd person that would kind of bite you on it. But for the most part they were very supportive… Even with the phone calls coming in. They were… They were better. Like, they weren't as… they seemed to just like, "Okay, I understand that I can't call every five minutes" or… I don't know. They were… I think they were just more receptive, I think.

Nyathera reflects on the support she received from her hospital management:

You know, they tried to enforce… pre-planning I guess... for the nursing homes to be sending, you know, residents… they were supposed to call ahead of time. We had a dedicated phone line for the physicians to call in, most of time it was a nurse that called, to gain support for them. For them not to transfer to hospital, to acute care, if it absolutely wasn't required. [The phone] was at the main desk, so you know, no different than EMS calling in right.

Adding:

Um, some of them were very… A lot of them were just simple, or they just needed, um, some support. Because they… a lot didn't know either. That was the other issue. A lot of homes just did not call. And they sent… just kept sending residents in for cold-like symptoms. But if [the patients] are vitally stable. You know, you might as well keep them, right? Swab them and keep them. Like we can't… we're not doing anything additional for them, unfortunately.

Nyathera expressed the support of the community:

Communities, I would say were… most of them were fantastic. You know like… yeah, like, it's not hard to please a nurse. Really, you know, you give them some free food, and nine times out of ten, they're happy campers, right? I hate to say it but some of the restaurants were really good to us. Locally, they were really good to us. But then, in turn, we recognized that, and would then contribute back ourselves, by maybe ordering from them, rather than a large chain. Right? So, we were pretty good. I even know here, where I live… I went one day after work to go get Greek food. And you know, we go, you know, fairly regularly, but he knows that I'm a nurse. So, he's like "Yeah, you do lots for us. Thank you so much. Here's a free meal." Very appreciative.

Nyathera reflected back on the public's perception of nurses as heroes:

I don't know. Like, to me it's still just your job. Like this is what you chose to do. And this is a side effect of the position that you chose to do.

Researcher's Field Notes

Reflecting on past events and how they appear to her now, Nyathera shares how her hospital's community has continued to be a "hot spot" throughout the COVID-19 pandemic. Considering the social perspective, Nyathera illustrates some of the community's challenges to staying safe during the pandemic, including language barriers, educational levels, and familial environments. Nyathera proudly shares that "different immigration groups are very well represented" throughout her hospital's staffing, suggesting that she values the cultural practices of others in health and healing.

Like both Pandora and Kali, Nyathera discusses how the community feared the contagion during the first wave resulting in a decrease in the volume of patients seen in the ER. I am fascinated that all three nurses' stories alluded to the idea that having people avoid the emergency room created a safer environment for nurses and afforded them the time and space to care for those who truly needed their help.

Considering the temporal dimension, Nyathera reflects on the support she received from her hospital management during the first wave. She recalls how her hospital management "tried to enforce" safety protocols for patients coming into the hospital from long-term care facilities. She presents the discrepancy between the hospital's desire not to have patients transferred to an acute care facility "if it absolutely wasn't required" and the long-term care facility's actions because of their lack of knowledge and need for support. Nyathera describes how the hospital did not do "anything additional" for vitally stable nursing home patients and states that she felt as though the nursing homes "might as well keep [the patients] instead of sending them in. It

appears as though the continued dispatching of nursing home patients to the ER elicited feelings of lack of support, frustration, and helplessness in Nyathera.

Nyathera considers the support she received from the community during the first wave of the pandemic. She recalls how she received free meals from local restaurants, noting that one particular restaurant in her hometown gave her free food because "he knows that I'm a nurse." Considering the social dimension of narrative inquiry, Nyathera appears grateful for his appreciation. However, I am intrigued by her comment, "… they were really good to us. But then, in turn, we recognized that, and would then contribute back ourselves, by maybe ordering from them, rather than a large chain." This statement makes me wonder if the appreciation Nyathera received from the community was authentic or under the guise of self-preservation. Her comment also strikes me, "… it's not hard to please a nurse. Really, you know, you give them some free food, and nine times out of ten, they're happy campers." This outward reflection and desire to feel appreciated is similar to Kali's account of receiving gifts during the first wave of the pandemic, suggesting that for many ER nurses, what makes them feel valued is appreciation.

Reflecting on the public's perception of nurses as heroes during the first wave of the COVID-19 pandemic, Nyathera states, "to me, it's still just your job. Like, this is what you chose to do." This statement suggests that Nyathera does not feel like she did anything that would necessitate such accolades. This feeling is similar to both Pandora and Kali's stories, who also vocalized the feeling that working during a pandemic is 'part of the job.' Given the social dimension of narrative inquiry, it appears as though sacrifices in nursing are not only accepted but expected.

Plotline Three: Fall from Grace – Welcome to my life

Nyathera shared:

Emerg has been absolutely chaotic and only simmered down for a very short period of time. And for the most part, it's been horrible. There's no other word. Horrible.

Nyathera describes how the number of patients in the hospital began to rise as the fear of contagion decreased in the community:

[In the beginning] we had that one… lull. Where all you were strictly getting was walk in. A lot of walk in for COVID. It was simple. It was a test and home… then you had the influx where you had the really sick COVIDs and the regular stayed away. You know… the ones that you get all the time. Now that COVID's kind of backed off… it's just right back… like, it could be nothing to see over 200 [patients a day]. It's just jammed… Like, we're kind of getting back to where we were, and we can say, "Oh, Mondays are horrible." Everybody knows a Monday's a bad day… And you'll see pre-COVID numbers now on a Monday not a problem.

Adding:

…the family physicians… they still have their doors closed, and the impact that it has created on our hospital system. It's made a huge impact… I know where my mom's family physician is, that she's been available the whole entire time for COVID. Which is wonderful. And she has all the appropriate PPE there and does everything wonderfully. The other physicians on the floor, the doors have been locked since the beginning of the pandemic and they're still locked today. You think how many patients a family physician sees. That they have to utilize a different modality, to see a physician, either a walk-in clinic or an emerg. Yeah, and most of them just tell them… to go to emerg for everything. And I asked them a triage every time. Have you seen a doctor? "Oh my family physician told me to come here." But these are things that could be easily managed by a family physician.

Nyathera Continues:

…our resus area, our resuscitation area. We have eight beds. One airborne room is included in there. We have two isolation rooms that are both negative air pressure as well. Not in an assignment per se, they're just picked up. Upon, depending on what the acuity is of the patient that's in that room. So, we have three RN's for eight beds. Um, the two rooms, one and two, would be for the sickest. So normally your vented patients are in there… we'd be full. The eight beds are full… we increased our ICU capacity greatly. They went up a huge number of beds, but it just … they were full all the time. And it would be nothing to have a patient intubated and in emerg for greater than 72 hours.

With the increase in patients, Nyathera illustrates the difficulty in trying to maintain safety measures:

I don't think the process… the screening… the isolation… to keep people that maybe screen positive, separated from the ones that screen negative. We have, you know, cancer

as well. A lot of immune compromised people coming in, and it's very difficult, challenging with the logistics of the department to keep them separated.

Elaborating further, Nyathera shares:

There is pre-screen coming into the department. They were pre-screened by screeners just asking them the regular COVID questions. Again, language barrier is an issue. Not everybody speaks English. Um, family members weren't always coming… weren't allowed in, to escort. That was a huge issue. You would find out afterwards that yes, they have had maybe an exposure to a family member. But you couldn't necessarily right from the get-go determine what they were there for unless it was blatantly obvious. Once they were actually triaged, because they didn't… Instead of the mindset of people thinking, everybody's positive, um, just to treat them all as a potential COVID, they didn't. So, you would still have your… Maybe your, your palliative patient, that's not doing so well at home in the community, and the family can't go… they need to be admitted. Um, there would be no reason… cause they would pass the screening tool, to isolate them. But then, in turn, there's no bed capacity. And once you come into the department, there's hardly a division. If you walk in, there's no division. They had… they tried to re-jig the one area. The rapid assessment zone. So that's your' you know, your threes, fours, and fives… mostly go there. And lately a lot of twos end up going there for CTAS scores. Um, but it was hard… we tried to have a dirty area, which never got cleaned in between. There's no, no…. Are you shocked? You're shocked. Right? Welcome to my life. Yeah, so you could have a COVID positive, it may get cleaned it may not. Because that… if you put it in for clean. You gotta wait. You're waiting till the housekeeper, the one housekeeper, for a certain area is available. A lot of times they were putting them in for clean, so I'll give them that. But sometimes no, and it will only if it was a known positive. They would clean for a known positive, but the other ones no. It's just a wipe down on the stretcher. That's it. You would find… you know supplies left in the room. You try to minimalize everyth'ng. Um, try to get them to go out a different door. But at some point in time, once they're in the room, you only have four rooms to play with. That's not a lot of turnover. So, we tried to open up a separated waiting area for them. But then, you're still walking through the department to get there. They're still using bathrooms, because bathrooms are not inside these rooms, so they're using one bathroom. It is very challenging.

Nyathera talks about her feelings regarding the lack of cleanliness:

So frustrating. So frustrating. The only way the surfaces got cleaned, is if you took your Sani-Wipes and wiped down stretchers. Like, you tried to keep equipment at a minimum. Like, even at triage, for myself, I wipe down the chair and the BP cuff and the SPO2 monitor after every patient. I still do today. I wipe it down in between. And the other nurses… they don't. They, they don't get washed. They're still doing it. Yeah that's frustrating. Because you could have one nurse doing it on like… there's two triage bays which are both visible from the waiting room. So, one… you can see myself cleaning it. And the other side not getting cleaned. So, I mean, I know it would send a mixed message out there. It has to.

When asked if this practice has led to a lack of trust in her colleagues:

No, I just think it's what I would want for myself. I think I… if I was coming in, I think I want to know the environment was going to be kept… You're going to decrease the risk for the people coming in as much as possible. Because most people think hospital… they think sterile. Clean. They don't think… they don't think the other way. Right? They don't think "Oh, my gosh I could go get… I can get a nosocomial transmission from going to the hospital today." Nobody thinks like that.

Remembering the lack of space, and how patients had to be placed in the hallway:

It was happening. Yeah, because, again, you know, bed supply was an issue, right? Um, and ambulance… I can remember there must have been ten at one point. At one point we had funded, um, within the department… EMS [Emergency Medical Services] paid 50% of the RN [salary], and the hospital, took up the other half, right? In order to expedite the offload. Cause we're pretty good, I must say. Like, you're not… waiting long there. Normally you're not. You're, you're in, you're out. The crew is released… Um, but during COVID, yeah, we tried. But then... we pulled the nurse into acute to open up four beds there. Use it for the additional stretchers, there. But it didn't work out that way… because nobody was going upstairs fast enough. That was the issue… was the real estate upstairs.

On the dwindling amounts of appropriate PPE:

During SARS it was plentiful. Now this time around, I wouldn't say it's plentiful. I know staff that have been… mask fit tested and require certain masks. Um, the previous PCM, always had a lot of [masks] for them. Like, it was never an issue. She always had them for them. Now, these, these staff members are actually having to go down to Central Supply and beg for their masks because they're not on the floor. I've gone to go run a code… And there's, there's no, there's no mask. No N95s. And then… so you have to put another one on that's not the one that you've been mask fit for. Just so you can go and run the code because you don't have [your mask]. It's not stocked. There's nobody there to make sure things are stocked. And you shouldn't have to be running around the department looking for your mask. It should be readily available. But it's not.

Nyathera continues:

At one point that… it was going into a weekend I believe, and what isolation gowns we had, is all we all we had left for the weekend. Make do. And then miraculously some appeared from somewhere.

Commenting on if she ever had to reuse gowns or masks, Nyathera states:

No, I never re-used a gown. No. No. Yes, they asked you to. Yes masks. To conserve them, yes. And you would see people putting an N95 in a basin, or in a bio bag to wear it again. To the next room. Yeah. Then go in again. I refused to do it…

Adding:

And I don't think giving us three surgical masks in 12 hours is appropriate either. Right? Because that's what you're supposed to wear. Unless it's a, you know, a known case, right? I don't think that's too safe. If you can smell through them? Go to the store with one on! I wear them to the store. You can smell every candle! Like, simple. You can blow a match out. You can blow lighter out. Through them. So, you know they don't do anything for you.

Nyathera shares how as the pandemic went on, the procurement of respiratory devices to treat patients also became and issue:

Opti flow was the... That was the… we ran out of machines one day. We didn't have enough. They had to get… borrow some from [another hospital]. We had to wait for them to come down. In a cab. We ran out. Yeah. Because of what… ICU, you know, if they could get them down, down to Opti flow, they would. They were being used on the floors. And then, the department. And we normally would only have, maybe… you know, we don't keep the Opti flow… We weren't keeping it down there. The RTs [Respiratory Therapists] were bringing it. Yeah, but is it scary. And same thing for them… I can only imagine, you know, being that air hungry. The feeling must be horrible.

Reflecting on her feelings of fear and helplessness:

It's just from how they, they look. They know. I just feel… it's the same as people that are that are dying. They, they know they are. It's, it's a it's a look… they all know, and they have a terrible look in their eyes. Because they're looking for you for anything you can do to help them. But you can't. You can't help them. You don't have the equipment… It's hard to watch. Especially because this is something that potentially you can stop or not have to be intubated. It's a non-invasive treatment that is effective.

Nyathera spoke about the inability to save everyone:

I can remember one [patient] in particular. He was about an 80-year-old gentleman, just returned home. So, again, a very robust, you know, healthy looking 80-year-old man. Just returned from vacation. In Italy, I think. He was in Spain or Italy, just returned. I wasn't sick over there no sick contacts, but he came in short of breath. Had COVID. And I can remember… They wanted to intubate him, 'cause his oxygen level was horrible and his x-ray was horrible. And they tried to explain it to him. Now he had some broken English, but for the most part, um, he understood what was going on. And they told him that he needed to be put on a breathing machine. And he had a cell phone. Of course, no visitors allowed right. And I asked him, I said, "Do you want to call home? Do you want to use your phone and call home?" I said, "because after they do this", I said "you won't be able to talk to your family." So, he said "yes". So, he… I helped him dial on his cell phone, and it was his last conversation that he had with his family. Prior to being intubated. And he passed away, three days later. From COVID. In our ICU.

Nyathera reflected on her feelings of this situation:

It's… it's sad. It's so sad. You know? That they're there by themselves. It's… I can imagine how scary it must be for somebody. You know, and I don't… and he just told them on the phone… He goes, "It's just a couple of days. I'll be home in a couple of days." So, he truly didn't grasp that he wasn't coming home in a couple of days.

Adding:

It was… it's very frustrating. For the ones that didn't understand…. Due to probably language barrier more than anything else… That didn't understand… like, very hard. And then, hard for the families. Um, I recommended at one point, with the amount of modified workers that we had that weren't actually doing hands on care if they could just go and call the families for up… and give them an update. Um, because the communication was huge. And we really lacked… we could have done a better job, communicating with families. Because they would call constantly. Like, I'm talking, you might have five family members calling within an hour for one person. And we… up in that resuscitation area, there isn't a unit clerk. So, it's just nursing answer the phone. But it takes a lot out of your day to try and give a family member an update.

Reflecting back once again to the elderly gentleman, Nyathera states:

You know, he was told he'd be okay. Like, no, you're not gonna be okay. Like why lie? I think they do better with the truth. Too many questions afterwards. Right? And then not allow your family there either. Even worse. I can't imagine being that… you know, so scared… because you have to be, and to be told "You need to go to ICU." That "You have likely have COVID." You have to go to ICU… you're elderly… and not have your family there.

Nyathera describes the moral and ethical dilemmas that she faced in providing care during the COVID-19 pandemic:

I have a… hard time …intubating an elderly person, who is COVID [positive], who would have very little chance of ever coming off of a vent. Or, you know, they're never gonna come off. And that's… I guess I believe that family needs time to adjust to a critical incident with their family member. But I think you're just offering them false hope by providing them a bed in ICU that you're only going to extubate them in two days. Like, you're just going to keep, you know, going towards the goal of extubation and palliation, where you could just bring them in earlier and be very real with them. Most people would understand it. I think, I think most people would appreciate the honesty instead of giving them false hope.

When asked how the family updates went, Nyathera states:

It didn't go well. Because they just want… I guess we weren't just giving…. Giving them what they needed to hear. And really, what they need is to see their loved ones. And they

had iPads, you know, purchased to take into the room, so they could do this one on one. But unfortunately, in emerg, there's just there's no time. There's just no time. You know? Like, you're just dealing with one and you're moving right to the next one. There's no time. You know, and they didn't…. I would have enforced it myself. Like somebody do this. Like, a modified worker go in, and just even let them do the iPad with their family member. It would have made, I think, a huge difference for some people.

Nyathera emotionally adds:

Some of them, you know, they we're too short of breath, a lot of them, to have a full conversation anyway. You know, they can say a couple of words. It's just so they can see their family member… that sometimes… their last time.

Nyathera remembers the first time noticed a lack of support from her hospital's management:

I don't think there was a concrete plan on how to deal with this pandemic within our department. They would probably beg to disagree with me on that one. But we went through a change of management. Change of our CRL, our Clinical Resource Lead, that changed as well. We… they brought on board a new director. Like, there was multi-faceted changes happening. Definitely a lack of support.

Nyathera shares how the changes in hospital management led to her feelings of mistrust:

I'm not sure why they elected to walk out our previous manager. I don't know. I have no idea. Nobody seems to know, like this is someone that was always on budget, and she ran a very tight ship. I know she didn't… I guess there was some maybe issues with the director at that time, I'm not 100% sure, but it was a huge loss I will say. Like the department as much as… it's better to know the devil you know, than the one you don't know. You know, and for the most part, she was very supportive of her staff… you knew where you stood as well. There was no favouritism. Anything like that. And then we have a new one that has absolutely very poor management skills… Yeah… And hasn't had a lot of experience either… And our, our CRL doesn't even have emerg experience. So, it's very frustrating. Very frustrating.

Adding:

…it would be not abnormal to see the manager or the CRL just standing outside of a room, watching. What's going on. I believe people asked them… oh, I can remember asking her to… She tried to help out once. The PCM [Patient Care Manger] did. The manager. No idea. It was a block catheter. All she had to do was irrigate it. She didn't know what to do. It's very frustrating.

Illustrating the lack of support by hospital management further, Nyathera shares:

…you know, the phone would be ringing, like, that's a simple fix. When you're run off your feet, and you've got two or three people crashing at the same time, answering the phone, last thing I'm going to do. No, didn't pick up a phone. You can hear it, right? Don't pick it up. And from bloodwork, I'm sure they could figure that out. No. Didn't do that… no, they weren't overly helpful… They couldn't even answer a call bell. Something simple.

Reflecting on this incident further:

I think… just lost. They're just lost. They should be on board… We are a team. Right? You know, we all have designations. Absolutely. But at the end of the day, you're a team and you look at everybody on your team. That we… they don't feel that… like, the staff do not feel supported in that way.

Nyathera describes the change in support from her fellow ER nurses:

I've had arguments. Absolute arguments that I'm not intubating in a room that doesn't have negative air pressure. I refused. Again, it was bed spacing of course. Because we didn't have the beds. They said it "had to be done now." And I said, "No, it's planned." Anybody, you know, this should be a planned intubation. "We're not doing it during an arrest, be it respiratory or cardiac. So, no, this is a planned intubation. So, you need to move them." You know, "I will go with the patient, but you are going move them". And I refused. I just refused until the airborne room was ready. And unfortunately, I don't know, um, how yours runs or not, but they eliminated the rotating charge nurse in our department, and they have patient care coordinators now… But they don't do patient care. They do administrative work for the manager more than anything else. Unfortunately. Like, the flow has been grossly interrupted. Because they're not there to look out for the flow or the staff anymore. And I can remember arguing with them, because they said "go." You know, they have to be like "No, they're going into an isolation room… you have to be safe here".

When asked if she experienced any repercussions from standing her ground, Nyathera says:

No, no, no, no. But, if I have concerns, in regard to that, I would take it further. If I had concerns. Absolutely. Yeah, and it wouldn't be to the director level or management level. No, you just have to go to the infectious disease doctor. It's the only way to do it.

Contemplating the support she received from other members of the healthcare team, Nyathera states:

Um, just like meal trays. I know it sounds so insignificant, a meal tray coming to a room. But they don't go in. The dietary aids don't go into the room. All the trays are left outside because they're not allowed to go into an isolation room. So can you imagine being busy

with one patient that's unstable, maybe one of your other workers busy with an unstable [patient], and people wanting meals at the same time. When they just… you have to drop everything. Like, its just… just having the extra staff available. We couldn't.

Reflecting on her values and beliefs:

I don't know… the dietary... you know, like, I, I understand at some aspect, but sure, they can't go in every room. I get that. But at the same token, there's been no provision… like you could have five patients that you have to completely don and doff for, in order to go in with a meal tray. And then, you have to set them up. And then there's some that need help feeding. Like someone's getting cold food. At the end of the day, someone's getting cold food. And that's not cool. That's… that's… you know, you deserve better. People deserve better than that… For me, [giving patients their meals is important] … But for emerg in general? I would say that would be the least of their concerns is that they got a meal tray. Yeah… it really is the least of their concerns.

Adding:

It's hard. And you feel like all you can do is apologize. Like I'd like to do more, but I can't. It's, it's horrible because they want more, they need more. You can't give it.

Comparing the support and preparedness she felt during the COVID-19 pandemic to the support and preparedness she received during SARS, Nyathera shares:

I worked through SARS. I worked on the SARS unit, so I was well aware of how things should work, and it was way better during SARS. Like, I know that's horrible English to use, but it was way better. I think we were supported better. There was a definite expectation as to who was working where. Um, this [pandemic]… was just, it was just flying by the seat of your pants.

Nyathera shares her inability to escape:

The home/work life balance doesn't exist too well. [The hospital brought] out a new computer system in the middle of a pandemic. They're trying to roll out 'Epic'. I just call it the 'epic failure'. That's what I call it. But they wanted you to do… you're supposed to be learning modules, while at work. So, do your work, and do their modules, and then get assigned to go to classes. On top of working full time. Like, our full-time lines could have you working 52 and a half hours in a week. And then still get sent for two days for Epic training. Like, come on!

On being denied vacation:

…they denied quite a bit through COVID. Um, but there's a lot of… you know, with like, myself, I'm entitled to seven weeks. Right? So, if you got a couple of girls that are entitled to seven weeks, and three and a half are prime time, and you're only taking two nurses

off at a time, you'll never get vacation as a new nurse. You might get it in October, November… I don't take weeks at a time. So, I'm on vacation right now. But it wasn't denied. Um, 'cause it's October. But, yeah, they denied some vacation for some people, yeah.

Adding:

I can't imagine starting out as a nurse now, and not getting two weeks vacation in the summer, or even a week. They can't get it; they don't get it.

When questioned about being asked to work overtime during the pandemic, Nyathera brazenly states:

I don't work overtime. Yeah, not one of those. Yeah. I'm sure some just capitalized. You could work every day… you know, they can't force you to stay. It's not abandonment, because they've known well in advance there's holes [in the schedule] so…. Do they have a plan? No, no, they would stand there in front of the board… Every day, they would stand there, the three of them… The Patient Care Manager, the Educator, and what they're calling the Patient Care Coordinator, i.e. the charge nurse… Just standing. Staring. Like, what are we going to do with all these holes? Here's a thought, make some phone calls.

Nyathera shares how the pandemic resulted in challenges in staffing the emergency department:

We couldn't staff up even. We have too much absenteeism. Like, the sick time was horrendous. The burnout is massive. Um, and the workload is crazy. It's very unsafe there… So, I think that's just the pandemic. And age… that's part of your shortage.

She Continues:

…we work short quite a bit and have a…. Initially, we… have fairly, I would say a really good team. We had a good core group. But slowly the core group is dissipating. We have a lot of new grads. A lot. Um, this is their very first, very first job. In emerg. Like, it's just not somewhere you start off, I don't think. Unless you've got a really good, solid background coming in. And most of them don't. They don't have it. They don't have the clinical experience. And they're just the pushing them through so fast, from acute or… a stable, you know, fairly predictable area, to going up to resus. Like, they're pushed up there, with… very quickly. And it's scary. Like… I saw… I was… 'cause I've been off. And I seen the assignment. Someone showed it to me. And the people… there was two people working [in resus] and out of the two, one is new... he might have been there… maybe three years now? And the other one's brand new. Pushed up. And there's no other senior nurse around. This is scary. It's very scary.

Nyathera recalls an account of trying to save a patient with limited available staff:

Um running codes… with no staff. Like, I can remember… We ran a code for close to four hours, I think. On one person. On and off for four hours straight. With no relief. I came out of the room soaked. Like, head to toe soaked. It was awful…

She continues:

She came in by ambulance… With chest pain, shortness of breath. So, they just automatically say COVID. But she was young… She was awake when she came in. She said there was something wrong with her. She just knew there was something wrong… She turned out to be a COVID positive, but she had a big PE [Pulmonary Embolism]. Four hours. That's a long time.

Remembering the challenges of working with inexperienced ER nurses, Nyathera says:

…being a senior nurse, like, you're always either at triage, or you're in resus. I think I lived in resus one and two for about a month. Every shift I had was there. So, um… I don't know if they recognize, I don't think they have… because I don't think they can recognize change in a condition… or how… just the physical… they don't have it. They just… they can't see it, they don't… they can't see a sick person. And perhaps somebody that was triaging, and we have some of them, who are experienced nurses, might downgrade I would say it triage, because there are no stretchers available. No monitored beds available. So, they may down triage them and send them to RAZ [Rapid Assessment Zone], which would be the ambulatory area, and they don't belong there. But they are get sent there because of bed spacing. And that prevents the hallway medicine, I guess. It'd be nothing for EMS to offload there, which is not appropriate, nine times out of 10. Um, and they just don't… they don't know… they… they don't see it. They can't tell from bloodwork, um, that somebody just shouldn't be there… And it's bad, because they're normally there with… It could be a new nurse, a new grad, with an RPN. And they will be short for four hours at least… 0730 to 1130. Depending on the day you, don't know how bad… what's walking in… but it's a huge assignment for a very young new nurse… And then you want them to work… we have one nurse who told the doctor that he could get his ECG on the monitor. Yeah. [The doctor] asked for a 12 lead, and she says, "We can see it right there."

Adding:

I know a lot [of nurses] coming out of programs now… like, I'm a college prepared RN. But I've seen a huge difference in the programs, between the you know the diploma program and the BScN program. There's a huge difference. I think it does contribute, perhaps, to the readiness of the new grads, because they don't have the hands-on experience. As much as what a diploma nurse had. Like, when you graduate you can go work. It wasn't an issue. Right now, some of them haven't given needles. Like I don't know how you managed to go through four years of school, and you can't give an IM injection.

On precepting inexperienced nurses during the pandemic:

…they… call it mentoring, that's, that's the nice word today, mentoring. Let's go mentor three brand new grads. Yeah! Yeah, who cannot… you know… they have monitoring capabilities, they should all be able to read a monitor. Do an ECG. Interpret. Um, But again, it's the critical thinking… not there yet. And I can remember asking one girl because she was just off her orientation, and I had her for a couple of days, but she was kind of tossed around, because there was nobody permanent to do all of her orientation with. And I can remember. I asked her, "How is it? How are you coping?" Because she looked… she was like a deer in the headlights. And I said, "How are you coping?" And she goes, "I'm not." I said, "Has the educator discussed this? Have they come back to check in with you?" And she said, "No." I said, "Well then you need to ask." I said, "You need to come forward and say you need some additional orientation time." And she goes, "I can do that?" and I'm like "Yes you can do that". I said, "I'll go do it for you if you want". You know, like, "If you're acknowledging that you feel that you need it, they need to provide it for you." But I don't think they feel the, the um…. I don't know if they know they can do that.

Sharing how she appreciated the help of experienced ER agency nurses:

You know, I eventually asked them. Like, I'm not a big fan of having agency nurses, but we had no choice at one point. We had absolutely zero choice. You had no staff. They weren't coming in. They're tired of doing over time. And they finally… They finally okayed agency. Now sometimes it worked out, sometimes it didn't. It's not easy for the agency nurse either… Um, the one guy was really good. I must say, like, he was, he was good. Like, he's well versed emerg nurse. It was great. You know they had an easier assignment, always. Um, and he was willing to stay longer. It was great. Like, we were so short, and he was willing to work 16 hours that day instead of 12. So, fine by me. I said, "you get approval from your manager and if it's good then we'll go from there."

On how the government is focused on the hiring newly graduated nurses in an attempt to fill the nursing shortages:

You know it's a nice band aid on the dam, but the dam is going to break through. And we're there. We are there. You know, and they should have known this 10 years ago when the average age was 45 then. What's going to happen in 10 years?

Nyathera describes how emergency room nurses began to fall ill from COVID-19, resulting in increased feelings of mistrust, fear, and isolation:

I think there is about eight, I believe. Which doesn't seem like a lot, but I believe there was eight. That I can think of. Off the top of my head. Three of us that were at the same time.

Adding:

…there was more than you know the two, which is what they consider an outbreak, but they wouldn't do it, they wouldn't do it to emerg. We hadn't greater than two, and they wouldn't do it. Wouldn't declare an outbreak… The concern was with the how it would look to our community. I think that's… I think that's where their concern lies. It is more, how do we look to the community that we serve? It would be poor publicity. And I, I really think they think about that before they think about the safety. Cause they should think about the patient's safety. And contracting COVID in a hospital is terrible.

Reflecting on feeling helpless, Nyathera talks about how she contracted COVID-19 from her workplace:

I got COVID from my workplace… probably from flipping from nights to days. Because I normally work just day shift. I managed to partner off my, my nights. But I couldn't partner the one night off. I couldn't find anybody. So, I had to work the night shift. And I do not sleep. So, I'd already been up… from like 5:30-6 o'clock that morning. Then I worked my 12 hour-night shift. And then awake all day. And then I flipped back to days the following day. So, I'm just probably burnt out, just from lack of sleep. And people coming in and not having their masks on.

In a subsequent interview, Nyathera added:

I can remember where I was, and …exactly how it happened… I know where I got it… from a non-compliant patient… He had three trips to the emerg… and [was] taking [his] mask off and coughing. So, I know where I got it from.

Sharing her experience of being infected with COVID-19, Nyathera says:

[I had] muscle aches, fever, um, shortness of breath… and I still have long term effects from it. I have terrible brain fog. Still, you know, still fatigued…. I have bad insomnia from it. And, you know, if I get… it's getting a bit better now. I'm able to sleep…. Beyond four hours… but that's all I'd be getting in a day is three to four hours sleep. So that's why you're confused, or you don't… You can't remember what you want to talk about it sometimes.

Adding:

If you don't have to do anything, it's okay. But if you have responsibilities, it's not so great. And you don't have the drive. Like, you don't have the drive to do much. Sad.

When asked if contracting the COVID-19 contagion made her feel like she was defeated, Nyathera states:

No, I was kind of shocked actually. I guess I probably think I'm invincible. But I'm not. That kind of proves that.

Nyathera reflects on her own fear of not wanting to bring COVID-19 home to her family and the impact of isolation:

I live with my partner. My fiancé. It's hard for him because he's… just a year out of having a spinal cord tumor. It was difficult. I wore a mask, as much as I possibly could. You know. Slept separately. You know, I had to go down and get another bed and bring it up and… it was challenging. Oh, and groceries delivered to our door. My daughter had to go pick up groceries for me. But it was challenging. It was. And now, he never got swabbed. But I just assumed he was positive [at one point]. He slept for five days straight. I just assumed he was positive.

Nyathera reflects on infecting her fiancé:

He doesn't go anywhere. So he was… I kept him very well protected. Because he's a spinal cord tumor survivor. So, you know, he's been very well protected in the house. He doesn't go into stores. Very rare will he ever go out to store. I did everything. So yeah, he got it from me… I'm glad he had a mild dose. But you know, you'd never forgive yourself… if you know, he was critically ill from it.

She continues:

[I was worried] every day. Every day. And my parents, you know, they were elderly, and I lost my father… Um… I was COVID positive in April and I lost him in June. So, I was unable to go up… he was failing in health, but at home with my mom. And I couldn't go up and look after him. I couldn't go and nurse him. Because I was too ill myself. And then, even when I was past my 14 days, [my mom] still wouldn't let me to go up. So, it was closer to a month before I saw him. It was a very challenging time.

Researcher's Field Notes

Grounding her experience in the spatial and social context, Nyathera describes how the number of patients in the hospital began to rise as the fear of contagion decreased in the community. She explains how her hospital's resuscitation room was "full all the time" and that "it would be nothing to have a patient intubated and in the emerg for greater than 72 hours." With the increase in patients, Nyathera describes the difficulty of maintaining safety measures within the hospital. She begins by illustrating the screening process of patients coming into the ER. Nyathera expresses feelings of helplessness, noting that it was challenging to keep the

COVID-positive patients separated from the COVID-negative patients because of "the logistics of the department." I am shocked by her comment, "we tried to have a dirty area, which never got cleaned in between." This statement indicates that the hospital was not concerned about the potential for spreading the infection to others. It appears that this practice made her feel helpless about contracting the disease. It also seems like this practice caused Nyathera to feel moral distress, knowing that she was potentially infecting more patients by allowing them to go into a contaminated area. Finally, it appears that the absence of enforcing the strict cleaning of rooms by hospital management reinforced Nyathera's mistrust of them.

Nyathera recalls how language barriers were an issue in determining the infectious nature of a patient's visit. Nyathera appears frustrated with her co-workers, stating that "instead of the mindset of people thinking, everybody's positive, um, just to treat them all as a potential COVID, they didn't," suggesting that Nyathera began to mistrust both the patients and her co-workers. This reflection captures how the place and social context of the emergency room during the COVID-19 pandemic elicited personal feelings of fear and helplessness that developed over the narrative dimension of time.

Remembering the lack of physical space to place patients within the department, Nyathera describes how some patients had to be placed in the hallway "because nobody was going upstairs fast enough." In an earlier reflection, Nyathera commented that during SARS, "There wasn't any [hallway medicine] … they all went right upstairs." Given that Nyathera remembers SARS and understands the impact of pandemics, it appears that this practice made her more fearful. It also seems that Nyathera internalizes the contrast in protection between the SARS and COVID pandemics as a feeling that her current management sees her as being dispensable.

Contemplating her safety further, Nyathera recalls how the emergency department started to run out of disposable PPE as the pandemic progressed. Considering the narrative dimension of time, Nyathera shares that during SARS, PPE "was plentiful." Contrasting her SARS experience to the COVID-19 pandemic, Nyathera states that staff members had to go down to central supply to "beg for their [N95] masks" because they were not readily available within the department. Moreover, she shares that at one point, PPE was so scarce that nurses were told to "make do" with what was left. This reflection demonstrates how nurses were helpless to protect themselves. It seems as though this messaging sent a solid signal to nurses that they are dispensable. Furthermore, it appears like Nyathera felt abandoned by her management at this moment, as she was required to 'fend for herself.' Remembering how she was asked by hospital management to re-use her PPE, Nyathera exclaims "refused to do it," demonstrating that she is not afraid to advocate for her herself and does not worry about how it will be received.

Thinking back to the fear and helplessness she felt during the COVID-19 pandemic, Nyathera shares how her department ran out of respiratory devices to treat patients. She explains how they had Opti-flow machines sent to them by taxi from another hospital. Reflecting outward on how her patients had to wait for treatment, Nyathera remarks that it "must be horrible" to be "that air hungry." Describing how these patients had "a look" "the same as people that are dying," it seems like Nyathera's fear for her patients not only stemmed from the impact SARS had on her and knowing how bad this disease could be but also from feeling powerless to help them.

Nyathera recalls caring for an "80-year-old gentleman" who had "just returned from vacation… in Spain or Italy" and died from COVID-19 three days after being intubated in the ER. Sharing how the patient needed to be intubated because "his oxygen level was horrible and

his x-ray was horrible," Nyathera describes how she helped facilitate a telephone conversation between her patient and his family to say 'goodbye.' Reflecting on her personal feelings and perception of hospital managerial support, Nyathera recalls feeling "sad" and "frustrated" and admits that her hospital "could have done a better job communicating with families." It seems like Nyathera's feelings surrounding this patient's experience are compounded by her own experience of being unable to say goodbye to her father. Considering the social and spatial positioning of this experience, Nyathera states, "…unfortunately, in emerg, there's just there's no time. There's just no time. You know? Like, you're just dealing with one, and you're moving right to the next one. There's no time." This comment suggests that Nyathera could not provide the kind of care she would have liked to provide, evoking feelings of moral distress, helplessness, and sadness. As Nyathera shares her perspective that hospital management should have "enforced" that a "modified worker go in and…do the iPad with [the patient's] family member," I am struck by her comment, "It would have made… a huge difference." It appears as though Nyathera's comment reflects how she believes that she could have been spared, in part, the moral distress she faced throughout the pandemic. It also seems like Nyathera's expressed anger is an outward expression of her unprocessed feelings of sadness and helplessness.

Nyathera's tension with hospital management is highlighted further as she shares the decrease in the support she received as the pandemic continued. Reflecting on her experience, Nyathera considers several events across time, beginning with the change of her manager and Clinical Resource Leader during the first wave of the pandemic. Sharing her confusion as to why her previous manager was "walked out," Nyathera discusses how her previous manager "was always on budget" and "ran a tight ship." Comparing her perception of her previous manager's support to her current manager's "poor management skills," Nyathera describes the change as a

"huge loss" to the department. Given that Nyathera trusted and felt supported by her previous manager, it seems like Nyathera internalizes the departure as a feeling of abandonment.

Considering the support of hospital management further, Nyathera recalls a situation in which she asked her current manager to assist her in irrigating a patient's blocked catheter. Stating that her manager "didn't know what to do," Nyathera admits that she felt "frustrated" by the lack of what she considers to be basic nursing knowledge. This reflection offers insight into how Nyathera feels personally unsupported by her manager and reveals how Nyathera equates clinical skills to 'being a good nurse.' As such, it seems that the manager's lack of clinical skills has led to Nyathera's increased feelings of mistrust. Offering a further reflection outward, Nyathera states, "…and our CRL doesn't even have emerg experience," implying that Nyathera's mistrust of her new management is compounded by her mistrust of those who have not 'been in her shoes.'

Nyathera reflects on how she considers everyone who works in the ER as being part of "a team." Team dynamics and the helpfulness of other staff members, regardless of their designation, are closely intertwined and connected to her perception of feeling supported. The personal feeling of being supported is most important to Nyathera.

Reflecting further on feeling supported, Nyathera illustrates a situation in which she was asked to help with the intubation of a patient in a room that did not have negative pressure. Knowing the safety risk associated with performing an intubation on a contagious patient without proper protection, Nyathera states that she got into an "absolute argument" with the charge nurse, refusing to assist "until the airborne room was ready." She shares how the charge nurse in her department no longer does patient care and comments that "they're not there to look

out for… the staff anymore." She associates assisting with bedside care with the attentiveness to the well-being of the nursing staff, suggesting a direct relationship between help and support.

Nyathera reflects on the support she received from other healthcare team members. She remembers how meal trays were left outside of patient rooms because the dietary aids were "not allowed to go into an isolation room" and talks about how she would have to "drop everything" to ensure her patients got their meals. As Nyathera shares this story, she appears frustrated and angry. I find it intriguing that the hospital protocols differ between healthcare team members. In this case, the hospital keeps the dietary aids safe by telling them not to go into COVID-positive rooms, but nurses do not have the same respect. Although Nyathera acknowledges the inability of the dietary aids to go into the isolation patients' rooms, she expresses her frustrations with the lack of "provisions" that are required to enable her to attend to all of her patient's needs promptly. Moreover, Nyathera expresses her feelings of moral distress from not being able to maintain her standards of care.

Comparing the support and preparedness she felt during the COVID-19 pandemic to the support and preparedness she received during SARS, Nyathera states that "it was way better during SARS" and that "this [pandemic]… was just flying by the seat of your pants." Given that Nyathera had already worked through SARS, it appears as though she expected how the COVID-19 pandemic 'should have' gone. After SARS, the SARS commission released several recommendations, including that healthcare institutions employ safety programs that include training workers, management, officers, and directors on their roles and responsibilities should a future outbreak occur (SARS Commission, n.d.). The expectation following SARS was that both the hospital organizations and the government would be ready for the next big pandemic. When this proved untrue, I think it left many nurses feeling disillusioned, including Nyathera, who had

already lived through SARS. It appears as though the lack of direction and leadership that Nyathera witnessed at the beginning of the first wave resulted in her feelings of fear and helplessness and her immediate mistrust of her hospital organization.

Nyathera reflects on the challenges of staffing the emergency department during the pandemic. She recalls how her department worked "short quite a bit," noting that they "couldn't staff up" because "the sick time was horrendous" and "the burnout is massive." Reflecting outward, Nyathera shares how several junior nurses were denied vacations during COVID to help with staffing. She expresses that she "can't imagine starting out as a nurse now," suggesting she feels empathetic to those being denied their vacations. However, her comment strikes me, "I'm entitled to seven weeks," implying that she knows her rights within her collective agreement and is willing to stand up for her rights.

In an earlier reflection, Nyathera reflects inward, offering insight into the importance she places on having a work/life balance. She recalls a time when the hospital tried to implement a new computer system that required nurses to attend classes while working full-time, resulting in her "working almost 52 and a half hours in a week." Thinking back on the event, Nyathera appears irritated, later sharing, "I don't work overtime." As Nyathera reflects outward on the number of overtime shifts available, she comments that "they can't force you to stay," indicating that she will not compromise her values for the needs of others. This gives the impression that Nyathera is so defeated by the pandemic that she does not pick up extra shifts in hopes of survival. It also appears that Nyathera is angry that she is being required to work more in her free time and is not being compensated appropriately for that work. Her remark strikes me, "I'm sure some just capitalized. You could work every day…" suggesting that she judges those who do not have the same values as her. I imagine that, similar to Pandora's story, Nyathera's colleagues

feel compelled to work overtime in hopes of helping their colleagues when they are working short.

Given that Nyathera perceives the helpfulness of others as a symbol of support, and the personal feeling of being supported is vital to Nyathera, I am baffled as to why Nyathera is critical of those who are sacrificing themselves in order to help out "the team." Additionally, this reflection contradicts a later reflection where she talks about how she appreciated an agency nurse who was "willing to stay longer," working sixteen hours instead of twelve because they "were so short." Considering the social dimension, it seems that Nyathera's appreciation for this agency nurse was because she felt as though he was a "well-versed emerg nurse."

Nyathera talks about how her department is staffed by "a lot of new grads" and shares her belief that the ER is "not somewhere you start off." Her outward reflection on the narrative dimension of place and the suggestion that a particular sequence of places is most appropriate for all new graduate nurses is that they do not have the clinical experience required to work in the ER and therefore cannot be trusted to keep the patients safe and alive. Her perception of having so many new graduate nurses working in the ER is that "it's very scary."

Nyathera reflects on working with a nurse who was "just off her orientation." Describing the other nurse as appearing "like a deer in the headlights," Nyathera reflects on how the new graduates struggled with beginning their careers during the COVID-19 pandemic. Learning that this young nurse was not coping well with the transition into the ER, Nyathera recalls advocating for her to have some additional orientation time. Considering the social position of this moment, Nyathera states, "I don't think they feel… if they know they can do that," suggesting that she feels the need to protect and advocate for the younger nurses.

As Nyathera considers how the government is trying to help the nursing shortage by hiring more new grads, I am intrigued by her comment, “it’s a nice band-aid on the dam, but the dam is going to break through.” It seems that Nyathera is referring to the exhaustion of senior nurses from mentoring so many new grads that they themselves are leaving. It also gives the impression that she has witnessed that the younger nurses do not stay in the emergency room as they come to understand the realities of emergency nursing, especially during a pandemic, resulting in their departure and more nurses being hired that need to be mentored thus the cycle continues.

Nyathera describes how her emergency department experienced a COVID-19 outbreak with three nurses simultaneously contracting the virus. She recalls that her department “wouldn’t declare an outbreak” because of “how it would look to our community” and that it would be “poor publicity.” Sharing her frustrations, Nyathera states, “they should think about the patient’s safety. And contracting COVID in a hospital is terrible.” This memory highlights how her past interactions with her hospital’s administration have shaped how she mistrusts them now. It appears that this event made Nyathera feel as though nurses were expendable.

Nyathera elaborates that she contracted the COVID-19 virus while at work. Nyathera appears angry as she describes how she contracted the contagion from “flipping from nights to days,” commenting that she “normally work[s] just [the] day shift” but “couldn’t find anybody” to work her one night. This statement suggests that Nyathera believes she got COVID-19 because of a lack of support from her management and colleagues. In her subsequent interview, Nyathera changed her understanding of how she contracted the COVID-19 contagion, stating, “I got it… from a non-compliant patient.” This statement suggests a change in her perception and the meaning of her experience, demonstrating that she now believes that she got COVID from

the lack of support from the community rather than a lack of support from her management and colleagues. Illustrating both the short- and long-term effects that having COVID-19 has had on her, Nyathera states that her condition is "sad." When asked if Nyathera's feeling of sadness is related to a feeling of defeat, she responds with, "No. I was kind of shocked, actually." Her comment strikes me, "I guess I probably think I'm invincible. But I'm not. That kind of proves that," suggesting that any indication that nurses are 'heroes' has been proven false. I am also intrigued by her comment, "I'm probably burnt out, just from lack of sleep." This comment implies that Nyathera has insight into the fact that she is burnt out. However, she equates her burnt out to a lack of sleep rather than the experiences she has been through. I imagine that this discrepancy is related to an attempt to suppress her feelings in hopes of surviving in the ER.

Nyathera reflects on her personal feelings of fear and the impact of isolating herself from her family, specifically her fiancé, during the COVID-19 pandemic. Recalling how she was so fearful of infecting her fiancé that she stayed in a separate room, Nyathera states that she found isolation "difficult." Despite her best efforts, Nyathera shares how she believes that her fiancé also contracted the COVID-19 contagion as he "slept for five days straight." Although Nyathera appears relieved that her fiancé survived his infection, it appears as though she feels some associated sadness and guilt, knowing that she was the cause of an infection that could have been detrimental to him.

Nyathera emotionally shares how she lost her father during the COVID-19 pandemic. She shares how she "was unable to go up… and look after him" because she "was too ill [herself]. And then, even when [she] was past [her] 14 days, [her mom] still wouldn't let [her] go up." Nyathera describes that time as "very challenging," suggesting that she felt both personally responsible for caring for her father and powerless to do so. Given that Nyathera identifies so

strongly as a nurse and that she "couldn't go and nurse him," it seems like Nyathera feels as though she failed her father and failed herself.

Plotline Four: Villain – You have to justify your actions

Nyathera shares:

I should say… you know, family members, don't believe it's real. Right? …they say, "It's not as bad as what we were told". But I, you know, I do beg to differ. Because, you know, I have seen the worst of it. Um, you know, our beds were full. We were, you know, moving… transferring patients… I think as far away as Brockville, the one day. I think that was the farthest transfer we did. Um, so it was real. Um, it's still… they're like, "Oh well." "You did?" "Yeah, I know it's real, but they're sick." Yeah, but no. I've had 20 something year-olds come in, be intubated. You know, Opti flow and intubated because of COVID. And they're healthy.

She continues:

I argue a lot. Yeah. I have… heated discussions, I'd say. With my mom over it. And that's more over the vaccinations than anything else. But, right now, just their, their mindset… I think is all it is. I think, what she believes, and what I believe, I think they're two different things. And [she] just doesn't understand everything. So…

Nyathera shares how the vaccine mandates have also caused a divide among her co-workers:

I would say there's probably only one… one that's very vocal about her outlook towards the, the vaccine mandate at work… the one girl in particular… She said that "people wouldn't want to look after the unvaccinated." And "unvaccinated staff may not want to share the same break room with them." As… Yeah… that's… that's only one person there. And I said "Well, how would you know what their vaccine status was?" If it wasn't a mandate at the hospital or people to be vaccinated, I said, "How would you know what their vaccine status is?" I said, "That's private, personal, confidential information." I said, "You wouldn't know unless you asked them." But she's very, very head strong on "Everybody needs to be jabbed, and as many as you can get to." She's very, very adamant on it. And that's fear based on her part. Right?

Nyathera reflects back on the change in community support from the beginning of the pandemic:

We were heroes in the beginning. Yes. And now it is "You terrible person. You're not vaccinated. How dare you?" Well, we're back to pre pandemic levels now. So, everybody is… it's right back to being called, you know what… See You Next Tuesday… on a, on a daily. That's just what we get. And it's not changing. It just went away for a little while. And now they're all back. Full force.

Giving an example she shares:

The other day at work, now I was only on… I only did four hours, 'cause I'm on modified, returning to work. And I ended up… I'm not supposed to… I was supposed to be in RAZ [Rapid Assessment Zone], but I ended up at triage. Because why? Senior nurse. And I triaged four STEMIs [ST Elevation Myocardial Infarctions] back-to-back. Walk ins… And then the nurses are just like, "Oh my god. Another one. Another one. Another." And then, you've got the [patient] who, you know, in the waiting room, is calling you a See. You. Next. Tuesday. Because you didn't tell… you know, address his concern right away. Yeah, I think it's the just the disrespect from… Not everybody, but some certain individuals, perhaps? …those are normally the ones that are so quick to go and complain. And then, you… feel like you have to justify your actions, [to] someone that can say horrible things to you. I think that's… that's a big part of it now too.

When questioned if she feels unsafe while at work:

Um, there's times, you could. Yes. I know coworkers do. They'll lock themselves, the triage doors have locks, so they'll lock themselves in. The door lock. Yeah. You don't know what you're gonna get there. We have one walk in… somebody walk in a couple years ago and just hit one of the nurses at triage. Smacked her and walked on. You know, [the hospital did] their investigation and then, they asked if… finally asked her, "Would you like to press charges?" But she said no. For sure I'd say yes. Your first reaction is to retaliate, of course. But you know you can't do that so… but your first reaction would be to… It happened again recently, actually, in emerg. Same thing happened. He actually threw feces at her I believe this time… this person. Yeah, like it's ridiculous. And again, this person would not call the police. And I'm like, "You have been assaulted." And I tried to explain to her that you're not just calling for you. But you're calling for every one of us. In this department. In this hospital. In this province. I said that. "This is not tolerated, and it won't be accepted." So, you have to be a voice because if you're just gonna sit back, then. Nothing's going to change, right? [You have to advocate] for yourself and for your profession.

When asked if her hospital has a zero-tolerance abuse policy, Nyathera responded:

Well, they'd like to say they do, but they don't. No, no. Well, you'd have to have like active security in place, rather than… we had a unit clerk end up with a broken nose. From a patient… No one takes them seriously, anyway… you know, you can put two of them, and I'm probably the size of two of them put together. Like, they're very tiny. What's a little girl gonna do? Unless she's got some martial arts. What is she gonna do?

Adding:

Security doesn't even try and take [the patient] out of the room. You have to tell [security] to make [the patient] leave... You have to tell them to escort the patient out of the department... It's sad. That needs to change too.

When asked if she has an example of something good that happened during the COVID-19 pandemic, Nyathera states:

> *No, no. I can't think of… no, I can't... I don't have anything that stands out that was a positive experience.*

Researcher's Field Notes

Reflecting on the support that she received from her family members, Nyathera admits that they "don't believe it's real." As Nyathera begins to describe in vague terms several patient scenarios of what she calls "the worst of it," it seems as though she is genuinely hurt by the lack of understanding or appreciation that her family has for what she has experienced. Her comment strikes me, "I argue a lot… with my mom over it," suggesting that her voice and experience is not being heard. I am also intrigued by her comment, "[she] just doesn't understand everything…" implying that the lack of respect for the nursing experience is justified for those who lack understanding.

Nyathera reflects on the deferring opinions regarding the vaccine mandates amongst her co-workers. She discusses a colleague who is "…very vocal about her outlook towards… the vaccine mandate." Sharing how her co-worker is "adamant" that "everybody needs to be jabbed," Nyathera states that she believes that her co-worker's opinions are "fear based." This statement suggests that Nyathera is not convinced about the efficacy of the vaccine.

Nyathera reflects on the change in community support throughout the pandemic. While Nyathera notes that nurses "were heroes in the beginning," she suggests that the public's attitude towards nurses has always been discouraging but that the first wave of the pandemic offered some reprieve from the cruelty that nurses have historically faced. Recalling a situation in which she was verbally abused for prioritizing one sick patient over another, Nyathera offers a personal reflection inward as she expresses sadness, disappointment, and anger both for the patient's

outrage and the need to justify her actions. Reflecting outward, Nyathera recollects a situation in which a patient assaulted her colleague. She recollects how her colleague declined pressing charges, adding, "I'd say yes." Her comment strikes me "… you're not just calling for you. But you're calling for every one of us. In this department. In this hospital. In this province," suggesting that Nyathera's identity as a nurse and concern for the nursing profession is what gives her the courage and confidence to stand up and advocate for the safety of herself and others. I am intrigued by her comment, "your first reaction is to retaliate… but you know you can't do that." The CNO's code of conduct decrees that nurses "are accountable for their own actions and decisions" and that nurses "must act with integrity to maintain patients' trust" (Code of Conduct, n.d.). Therefore, there is often no recourse for nurses who are assaulted by patients while at work. As such, it appears that Nyathera feels as though she is helpless to abuse while at work and that the only reprieve she feels is to use her experiences to try to advocate for the protection of nurses. Nyathera expresses her sadness while reflecting on the lack of enforcement of her hospital's Zero Abuse Policy. It seems that the lack of enforcement of the Zero Abuse Policy has led to her feelings of mistrust in her co-workers.

Plotline Five: To be Continued – It's like a death before it occurred

Nyathera shares how nurses have been unable to cope during the COVID-19 pandemic:

> *I think it's just additional pressures. We had to adapt to a new computer program as well. Which was a terrible roll out. Awful rollout… I've had my meltdowns myself. So even I… had to go in the supply room and bawl my eyes out because I just could not give the care my patients needed. I couldn't. I was just too frustrated…*

Nyathera contemplates how she tried to survive working as a nurse during the COVID-19 pandemic:

> *I think you just march forward. And I think that's what we do. Like, the ones I've seen break down, which are all friends of mine… You know… and we're all well seasoned nurses, like, because we're all at the 30-year mark… and we've all… are so frustrated. And I think some of its process. Some of its environment. And some of it's just sheer*

volume. But I think the younger ones might… they've done much better with the computer program. They're young. They've got good brains. You know, they're not leading towards the dementia pathway, like some of us (laughs). And us older ones, you know, we're… we're challenged. Right? Like we have to take… it takes… we're different learners, I guess. Is the best way to say it. You… so, I think we all have our… They're overwhelmed with volume and acuity. The younger ones. And probably not knowing what they're doing. I think it's the fear of… they've never seen anything like this. They have no experience. Versus us older ones who have the experience. We can do all the tasks. That's not the issue. We can still see a sick patient. We know that. It's putting it together and being challenged with the volume, and then having to figure out a program on top of it. I think that's really what it comes down to. I think that just culminated our, our level of frustration.

Looking back on the coping skills she used:

I'd like to say I came home and drank. But that would be a lie. So, I think a lot of people probably turned to something like that. I think you vent. You come home and you vent. You know, like after you strip down and showered… um… and you lean on the ones that you're close with… You have relationships with at work. And talk things over on your break. Or you try and have a moment where you can laugh. Which you know ideally, is probably one of the best medicines out there.

On thinking about how she is coping now:

I'm, I'm getting better now. I had a really, really hard time. Um, after [my father] died. I had a really hard. But I'm getting better now. But I'm just so done with it all. I'm just so done with it all. And it's just not going to be... It's not going to end. Like we're going to be like this for next year, maybe the next year after that. I don't see end in sight.

Nyathera shares the emotional toll that the pandemic has taken on her:

I've just never been so… I don't think it's disillusion… but I'm just so… it's just so upsetting to see what towards the end of my career… how heartbreaking it is to see how much change there's been. The quality of care has dropped tremendously. I used to pimp up my workplace like no tomorrow. I thought it was a great place. You know, my mom said that she recently she said, you always said, you know, you have you talked about your workplace in such high regard. And now I don't. Now I'm just… I'm so frustrated. It's sad, and a lot of us senior, senior staff, we all feel the same way. Like, you want to finish out your last few years, kind of like together. Cause there's a group of us, you know, probably five of us, I guess, but around the same age group. And, you know, you want to… the days where you could laugh, you know, have a joke… share a smile… gone. Yeah, it's really… it sucks… no other word… it sucks. Yeah, it's like a death before it occurred. Yeah, yeah. I'm grieving. And it hasn't happened yet. I'm grieving for my loss already.

When questioned if she has processed her emotions, Nyathera states:

…unfortunately, in emerg, there's just there's no time. There's just no time. You know, like you're just dealing with one and you're moving right to the next one. There's no time… as soon as you leave the room, you've got another [patient] to go deal with… doing the same thing. But you don't get time to de-escalate.

Adding:

… if you dwell on it at home, then it interrupts your, your time away… and your time away is to regroup and refresh yourself in order to go back and face it again. I do know, changing my shift pattern has made a big difference. I can tell you that. The working the four on five off makes a huge difference. Your work/life balance is way better. As exhausted as you are for the fourth shift. It's better home length. Yeah, so I think you have more patience too. You have more time to de-escalate the situation. And there's times I come home… You could peel me off the ceiling. I just need to… I just need to vent. No, I don't need solutions. I just need to vent.

Comparing her experience in processing her emotions during the COVID-19 pandemic to the SARS pandemic, Nyathera states:

[During SARS] they would speak about it afterwards. I can remember one. She was I think… she has some severe mental health issues, I believe. But she was intubated and she extubated herself. I can remember that. And I'm telling you, it was the fastest progression I've ever seen in my life… it was just so fast. And then, it was afterwards… you had time to decompress. Once the patient was stable. Sure… they would, you know… you had a discussion as to what could we do differently next time… I think they… from what I remember… It would be, what did you think went well? And what did you think did not go well? It's a process. How can we prevent this from happening again? And then… people were more receptive I think…

When asked if the debriefing she experienced during SARS met her needs as a nurse, Nyathera says:

If they're listened to and acted on, yes. If they're listened to and ignored, no. Every… I'm sure every hospital has an improvement board. You know, we have to right? Part of accreditation. Some of them are very easy fixes, and some of them are very difficult. If it comes down to funding and supplies… not going to happen. Yeah, it can be frustrating when it's something so simple…

When asked if she has a professional she can talk to, Nyathera says:

No. [My fiancé] listens to all of it. For the most part [it is helpful] … Yeah. And for things that really bother me, I'll talk to my coworkers. You know? That… they get it. Yeah. My people. That's what we call each other. My people.

In reflecting on why Nyathera continues to work as a nurse in the emergency room, she shares:

> *I honestly enjoyed my job. I really did. I say I enjoyed it up until the last, oh, probably, maybe, two years… just before the… beginning of this pandemic. I think, yeah, I enjoyed it. I like emerg. I love the fast pace. The autonomy. You know, I think that's huge. Um, knowing a sick patient. You know, just having that gut, that says there's something wrong. Even though the numbers don't tell you there's something wrong. You know, being able to make a difference. You know, in someone's life. Yeah, to make them better. Hopefully. That's the goal.*

On contemplating leaving nursing and considering alternative employment, or taking a break from her job, Nyathera said:

> *I'm looking for another job... Yeah, I don't know if I can do this… I don't know if I can do emerg anymore… but, like, where's there to go? Like, I have to look at my exploring my options. Because I don't want to be bored. I think that's the big challenge there. Change too right. Change. We don't embrace change normally very well. And, you know, we're all… Most emerg nurses are a little bit of a control freak, you know… We are really. We were a unique group of people. Yeah, true ones are. We're, you know, all very like minded. You know? Very like minded.*

When asked to describe an ER nurse, Nyathera states:

> *I think you need to be very confident. Both in yourself and the decisions that you make, or the skills that you're going to perform. You need to be compassionate. You need to be empathetic. You have to have a bit of an attitude… You gotta have a sense of humor. You have to, and you need to be really good at communicating. And you need to be an advocate for your patients. That's the biggest one. You need to be an advocate. Do for them how you'd want done for yourself.*

Sharing how her self-identity is tied to being an ER nurse:

> *I think my family… they identify me [as a nurse] too. I went to my uncle's funeral last week actually, and someone asked me, "Oh, who are you?" Because they didn't know me. And I said, "Oh, I'm [so and so]'s niece." She went, "Oh, you're the nurse." So that's how you're identified. "Oh, you're the nurse."*

When asked how it makes her feel to be identified as a nurse, Nyathera says:

> *It's great. It's wonderful. Sure… I've given 31 years looking after other people. Yeah, it's a good feeling.*

Reflecting on what she feels hospital management could have done to support her better during the pandemic, Nyathera shares:

> *Clean the department. It's awful. Like every supply is… it's I've never seen it…. so, disorganized. It's just, it shows there's no leadership. When you walk in, it's, it's awful. It's awful. Like, you're tripping on things. Like, everything's plugged into a hallway where stretchers need to be pushed down. You have to navigate around things. Equipment is not put away. Finding the equipment… You know, for the monitors if you need anything new, good luck finding it. There's no… it's, it's awful. It is like, a war zone there. You see the pictures on the internet you know the rooms after a code? Our hallways aren't much better. The Verna care. Do you know what they are? None of ours work. None of them. They're all broken because people probably put a blue pad down them again. The bathrooms? I think there was one functioning at one point.*

Nyathera's advice for hospital management for the future:

> *Know your staff. Look for volunteers. Because that's how our SARS unit went. They took volunteers first. They didn't just mandate people to go work there. It was on a volunteer basis. And that worked quite well. You know? And then they offered the incentive for staff to work there. And once they offered a financial incentive, they came out of the woodwork. So, I don't think that's the way to go. I don't think financially compensating is the correct way to attract staff. Um, get your house in order. First, it's no different than if you were at home. And, you know, now we're hearing there's going to be a tire shortage. You know I'm not saying like stockpile of the toilet paper like everybody did at the beginning of the pandemic but get your own… Get your house in order. So, you know what you have. What can you do. What can you quickly implement, with the least amount of turmoil created. Have a plan. Practice your plan. You know,? And have, maybe a team, within your own team. That is a… Maybe a leader… let's say… for isolation? Maybe a leader that does screening, perhaps? Um, one that will do the communication with families when there's no visitors allowed. Things like that. They just need to not do as I say but do is I do. Right? Yeah, that makes an effective leader.*

For the government:

> *Prepare within your own country. Don't rely on external countries to get you through a pandemic. We should be producing our own vaccinations, producing our own PPE. Um, making sure, hospitals, long term care facilities, any kind of health institution, is ready for another pandemic. Cause there's going to be another one. That's just the way life is right. Um like there's some very outdated facilities out there. I happen to work in one. Like we, yes, we have a newer emerg and critical care, but the rest… it's so outdated it's disgusting. Um, yeah, we don't have the negative air capacity. Machines, bringing hepa filters in. That's not true negative air. Um, they closed those rooms even. So, we need to be better prepared. And that would be even retaining staff… keep them happy. Yeah. Um, that's the easiest. Make them feel valued. That's a big one. Make them feel valued.*

Nyathera gives an example of how nurses have been made to feel worthless by the Government:

> *[Bill 124 tells nurses] "You're just not valued." I really believe it's because the majority of us are still women. If there was more men involved… I do think we'd have… a better chance of… having… on par for pay. Like, we're 11% behind. That's a lot of money. And, for what we do, to be responsible for someone's life as you are, especially in emerg. To be paid less than someone that's putting bricks on a house, is terrible. Like, my partner used to do dry wall taping. He would be making… probably $20 more an hour than I am. For taping walls. Like, how do you….? Like it's just laughable.*

When asked what action she would need to see to make her feel valued as a nurse, Nyathera says:

> *We would have appropriate staffing levels. That would be the first one. You can't replace someone… who's retired who has 30 plus years, with someone that just graduated. You know, the, the pressure is it's, it's terrible. There's only a few people… let's say… 5 out of 14 nurses per shift that… can function in the whole department. That's a huge… you know, there's 9 nurses that are incapable. It puts a lot of pressure on the 5 that are there. How do you get them? I don't know. I, I don't know how you get an experienced nurse to come somewhere where you're gonna be run off your feet, and don't have the supplies… You know… the hospital [tries] to give you a… bag for this, a bag for that. Tim Horton's card. Like, it doesn't make up for the fact that you're working short all of the time.*

Researcher's Field Notes

Nyathera reflects on how she tried to survive working as a nurse during the COVID-19 pandemic, admitting that she had "meltdowns." She recalls that throughout the pandemic, she tried to continue to "just march forward," noting that she "vented" her "frustrations" and "leaned on" the "ones [she was] close with." Her comment strikes me, "…you try and have a moment where you can laugh. Which… is probably one of the best medicines out there," implying that Nyathera coped through having positive experiences with her co-workers. However, in a later reflection, Nyathera states, "the days where you could laugh… have a joke… share a smile… gone," suggesting that the pandemic defeated her. On thinking about how she is coping now, Nyathera shares that she is "just so done with it all."

Looking back on how she processed her emotions, Nyathera reflects outward, stating, "unfortunately, in emerg, there is no time," implying that she has yet to process her emotions. This causes her to reflect on how nurses had no time to "de-escalate" from traumatic experiences during the COVID-19 pandemic. Contrasting her experience during COVID with SARS, Nyathera comments, "they would, you know… you had a discussion as to what could we do differently next time." It appears as though her previous debriefing sessions did not include a moment where she could process any unsettled feelings following a traumatic incident. I am intrigued that Nyathera interprets discussions focused on the clinical events of what went well, what did not go well, and what participants need to change in their practice to improve patient care as attending to her emotions. It gives the impression that, like Kali, Nyathera is avoiding processing her emotions in an attempt to survive.

Nyathera considers her nursing career over the dimension of time in relation to her perception of self, personal feelings, and the support of others. As Nyathera shares the emotional toll that the pandemic had on her, it becomes apparent that it has altered her perception of self and made her feel powerless and defeated. Nyathera admits that her experiences during the pandemic have caused her to consider leaving the nursing profession, but quickly inserts "but, like, where's there to go?" implying that she identifies strongly with being an ER nurse. Indeed, in a later reflection, Nyathera comments that it "is a good feeling" to be identified as a nurse. On reflecting on her current position, Nyathera shares, "I like emerg. I love the fast pace. The autonomy. You know, I think that's huge. Um, knowing a sick patient. You know, just having that gut that says there's something wrong. Even though the numbers don't tell you there's something wrong. You know, being able to make a difference. You know, in someone's life. Yeah, to make them better." This suggests that Nyathera holds emergency nurses in high regard.

Contemplating her feelings about leaving the ER further, Nyathera states, “it’s like a death before it occurred… I’m grieving. And it hasn’t happened yet. I’m grieving for my loss already.” This comment indicates that Nyathera’s perception of self is strongly tied to being an emergency nurse and leaving the ER would be the equivalent of death.

Reflecting outward, Nyathera expresses her advice for improving the future of nursing and pandemic planning. First, she describes how hospital management needs to focus on cleaning and organizing the emergency department, stating that the way things are “so disorganized” now “shows there’s no leadership. Considering what makes an effective leader, Nyathera comments, “they need to not do as I say but do as I do.” This statement implies that Nyathera values effective participative leadership and feels as though it is imperative to the future of nursing. Finally, she talks about the need for the Government to reinvest in healthcare, work on retaining current nursing staff, and make nurses feel valued. Nyathera gives the example of Bill 124 to demonstrate how the Government is showing nurses that they are “not valued.” Given that Nyathera places a significant emphasis on the idea of making nurses feel valued and gives a monetary example of how nurses are being shown that they are worthless, I am surprised to learn that “appropriate staffing levels” is the action that Nyathera believes she would need to see to feel as though this requirement has been met.

Attending to Nyathera’s Story

Nyathera’s story is one of survival. As Nyathera shares her story of providing care both during the 2003 SARS crisis in Toronto and the COVID-19 pandemic in Toronto, we begin to see how ER nurses have suppressed their emotions in an effort to cope and how these processed emotions have led to feelings of sadness, anger, and defeat. Moreover, Nyathera demonstrates

how nursing voices are not being heard by their employers, the community, or the government, resulting in the disengagement of nurses from others in hopes of self-preservation.

Grace Note to Nyathera

Dear Nyathera,

Thank you for showing me that there is truth to the adage, “It’s not whether you get knocked down, it’s whether you get up.” Your story is truly one of perseverance, resilience, and strength.

I believe that your self-confidence is your most admirable quality. Your ability to keep going in the face of adversity shows incredible strength.

My wish for you, Nyathera, is that you will take the time to discover who you are outside of nursing. I hope you will discover your passion, goals, dreams, and happiness by walking away from anything that no longer serves you, grows you, or makes you happy.

“There are no heroes on the battlefield, my lady; there are only survivors.”

– Elizabeth Hoyt (Author)

Chapter 7: Understandings of Providing Care During the COVID-19 Pandemic Across the Three Narratives

As described in the first chapter, the primary foci of this narrative inquiry were to understand how ER nurses describe their experiences of working during the COVID-19 pandemic, to look for instructional messages and develop solutions to problems for future pandemics, and to allow for the healing of ER nurses through storytelling. Narrative inquiry methods were used to engage with ER nurses to explore their experiences of providing care during the COVID-19 pandemic, allowing them to share and reflect on their stories in a meaningful way. The data from each participant's story was interpreted within the three-dimensional space of temporality, sociality, and place to discover meaning and facilitate reflection consistent with the narrative inquiry methodology (Clandinin & Connelly, 2000; Clandinin & Huber, 2010; Hutchinson, 2015). After writing the participant's narratives and verifying that I presented their stories in ways that made sense to them, I looked across the narrative accounts to determine what I learned about their experiences of providing care during the COVID-19 pandemic.

I begin this chapter by explaining how the resonances across the participants' narrative accounts were discovered and present the narrative threads that support the understanding of providing care in the ER during the COVID-19 pandemic in Toronto, Ontario, Canada. Next, I discuss the eight narrative threads (mistrust in leadership, fear and isolation, expectations and duty to care, nursing shortages, personal safety and PPE, workload and stress, moral and psychological distress, and loss of voice) that emerged from the participant's storied experiences, integrating the understanding gained from the participants' stories with the current understanding

of providing nursing care during pandemics as demonstrated by the literature. Finally, I conclude this chapter by tying the narrative threads together.

Resonances Across Participants' Accounts

The individual narrative accounts presented in this thesis are organized around the plotlines of *before they were heroes*, *heroes*, *fall from grace*, *villain*, and *to be continued*, representing the story of each ER nurse along a continuum of pre-pandemic to present day nursing. As a way of attending to the resonances across participants' accounts, I purposefully placed the stories alongside one another, looking across each narrative account to discover resonant threads or patterns that I could discern. I did this to gain a deeper understanding of the nurses' stories, an approach consistent with the recommendations of Clandinin and Connelly (2000).

After reading and rereading the stories of Pandora, Kali, and Nyathera, I noticed that each narrative account walks us through both the personal and professional events and experiences encountered, and illuminates the tensions felt while providing ER care during the COVID-19 pandemic in Toronto. As such, eight narrative threads (mistrust in leadership, fear and isolation, expectations and duty to care, nursing shortages, personal safety and PPE, workload and stress, moral and psychological distress, and loss of voice) were identified. As highlighted in the literature reviewed in the second chapter of this thesis, seven of these thematic threads are representative of all other pandemics. Consequently, this inquiry demonstrates the detrimental impact of not listening to the nursing voice, as history has once again repeated itself. Although the existing literature separates the personal concerns and considerations from the professional concerns and considerations, this study demonstrates how these two perspectives are intertwined and cannot be separated. Additionally, this inquiry expands on the previously published work by

examining the specific experiences of working during the COVID-19 pandemic through the interpretation of stories of ER nurses in Toronto, Ontario, Canada.

Narrative Thread One: Mistrust in Leadership

As I examined the three narrative accounts, I found the thread of mistrust in leadership to be central to Pandora, Kali, and Nyathera's stories. For example, Nyathera shares how her mistrust of hospital leadership began when there was a change in her department's manager and CRL during the first wave of the COVID-19 pandemic. She talks about her new manager having "very poor management skills" and "not a lot of experience." She also talks about her new CRL not having any ER experience. Recalling a situation in which she asked her manager to assist her in irrigating a patient's blocked catheter, Nyathera states that her manager "didn't know what to do."

Similarly, Nyathera remembers running multiple resuscitation efforts simultaneously while her manager stood outside of the room watching. She describes how the "phone would be ringing," and the manager would not pick it up. In a later reflection, Nyathera shares how her management elected to have a "dirty area" that "never got cleaned between [suspected COVID-positive] patients." Sharing how this practice made her feel helpless about contracting the disease, and moral distress, knowing that she was potentially infecting more patients by allowing them to go into a contaminated area, Nyathera demonstrates that the absence of enforcing the strict cleaning of rooms by hospital management reinforced her mistrust of them. These stories suggest that Nyathera's mistrust in her management happened gradually, as she experienced multiple breaches of trust over time.

Conversely, Pandora's mistrust of leadership occurred more abruptly. Pandora describes how at the start of the pandemic nurses were told that they were not allowed to wear masks as

they were “scaring the patients” while her manager “paraded around the department” in PPE that was “perfectly fitted for her.” Pandora also recalls how the CEO of her hospital came down to the emergency department to express their appreciation for the nurses. However, she describes how their accolades were followed by requests “to work more.” This comment suggests that the ulterior motive of the CEO’s actions, which on the surface appeared to be entirely complementary, resulted in the continued mistrust of nurses toward management. Like Pandora, Kali describes how her mistrust of leadership started in the first wave when the ER’s medical chief rebuked the lead CBRN doctor’s claims that N95 masks were necessary when treating suspected COVID-19 patients.

Like the mistrust in hospital leadership, mistrust in Government leadership was a crucial issue that spread across all three narratives. For example, both Kali and Nyathera comment on how the Government does not value nurses. They both discuss Bill 124, alluding to how the Government’ cheered for nurses’ at the beginning of the pandemic, only to turn their backs on them when it came to financially compensating nurses for the work they were doing. Illustrating further how the Government turned its back on nurses, Pandora talks about the protests on University Avenue. She describes how the protestors targeted hospitals, even though the Government was responsible for the lockdowns and mandates being protested. She expresses how the Government used nurses as the scapegoat, portraying them “as someone that was to blame” for the pandemic.

Additionally, both Pandora and Kali comment on the inability of the Government to effectively lead pandemics due to their lack of healthcare knowledge. For example, Pandora comments, “the Government is… a bunch of… people that aren’t health care, trying to make decisions… about health care… and not really knowing what they’re affecting.” Similarly, Kali

comments, "…the Government… didn't know what they were going into… I wish they would have limited how much they were putting out there for the general public. One minute it was do this. One minute it wasn't. So, it was all over the place. And it becomes exhausting for everyone."

These stories bring attention to the need for supportive leadership. Moreover, these stories suggest that frontline nurses need to be at the helm of healthcare leadership. This is a finding that previous researchers in the literature have not addressed.

Narrative Thread Two: Fear and Isolation

As I looked across the three narrative threads, I saw fear and isolation as a dominant thread that wove over time, interaction, and place through the individual narrative accounts. For example, while attending to the nurses' stories, I was able to make sense of how their previous experiences with nursing and pandemics informed how they feared contracting the disease, feared transferring the infection to family members, and feared death.

Pandora, Kali, and Nyathera begin their stories with a detailed account of why they chose to enter the nursing profession and how they ended up working in the ER. Both Pandora and Kali share how the COVID-19 pandemic was the "first pandemic" that they worked, while Nyathera explains that she worked as a nurse in Toronto during the 2003 SARS crisis. Pandora recalls hearing about the COVID-19 pandemic from her nurse educator while standing in her emergency room's rapid assessment zone. Despite hearing the threats of pandemic nursing from a more experienced nurse, she describes this time as being "exciting." She mentions in her reflection of being "too young to remember SARS," "oblivious to Ebola," and only briefly remembering the H1N1 swine flu, so it appears that her lack of nursing experience positively influenced this time.

Similarly, Kali reflects on how COVID "was [her] first pandemic," sharing that she "didn't work through SARS" as she was on maternity leave. Having worked for over 28 years in the ER in Toronto, Kali is, in theory, no stranger to the challenges of pandemic nursing. Her statement suggests that none of the other significant pandemics of the 21st century left a lasting impression on her as a nurse. Kali comments that she chose to go full-time at the beginning of the pandemic, implying that, like Pandora, Kali did not fear the contagion in the first wave.

Nyathera also shares how she did not fear the contagion in the first wave. However, unlike Pandora and Kali, Nyathera did work through SARS and attributes her lack of fear to her previous pandemic experiences. It is interesting to note that Nyathera also states that she was not afraid of SARS either. Like Pandora to COVID, Nyathera shares that she was not afraid of SARS because of "the newness of it all," implying that a lack of nursing experience can positively affect the experience of working during a pandemic. In the literature, researchers describe how prior exposures to outbreaks help to enhance nurses' sense of preparedness, thus decreasing the potential fear of unknown contagions, similar to the experience described by Nyathera. However, my study participants provide an additional perspective to the literature, that naivety about providing nursing care during pandemics may also be a protective factor.

All three participants explain how there was a lull in patients during the first wave as the community feared the contagion. Considering the narrative dimension of time, all three narratives illustrate how the fear increased as the pandemic progressed through the second, third, and fourth waves; as the number of COVID-positive patients increased within the hospital, PPE dwindled, and participants witnessed co-workers becoming infected. For example, Pandora and Nyathera experienced COVID-19 outbreaks among the nursing staff. Pandora shares how six nurses became infected after providing resuscitative efforts to a COVID-positive patient with no

PPE. Nyathera recalls that eight nurses in her department had contracted COVID, noting that her hospital administration refused to declare an outbreak because of "how it would look to the community." Kali describes how she had a colleague who contracted COVID even after vaccination, stating that she could not return to work in the ER because of "residual sickness." Likewise, Pandora shares how one of her co-workers had to quit nursing after becoming infected because she could not "concentrate enough to be a nurse anymore."

Like the concern about the safety of oneself, the fear of transferring the COVID-19 infection to their family members was another crucial issue that spread across all three narratives. Pandora feared bringing the contagion to her mother, who is a cancer survivor, Kali feared bringing the contagion to her elderly father, and Nyathera feared bringing the contagion to her fiancé, who is immunocompromised with a spinal cord tumor. To help alleviate this fear, all three participants separated from their families to avoid infecting them. Pandora moved into the basement of her parent's house, Kali stopped seeing her father and extended family, and Nyathera wore a mask in her house and slept separately from her fiancé. In addition to not seeing her family, Kali also illustrates how her friends chose to remain distant from her out of fear of contamination.

It is interesting to note that while Kali attempted to prevent the transmission of infection to her family, her family did not reciprocate the same efforts. As Kali describes how her husband and children did not follow public health measures, it becomes clear that her family did not feel the same stress or fear of bringing the contagion home. Given that Kali's primary concern is the health and safety of her father, it appears as though Kali is more concerned about who would be to blame if her father were to get sick rather than if he got sick. This gives the impression that

Kali may have previously been blamed for domestic issues due to her job. Moreover, it suggests that nurses fear being blamed when incidents of mass infection occur.

Coupled with the fear of infecting family members, both Pandora and Kali describe how they developed feelings of sadness and anxiety as they were isolated from friends and family. For example, Pandora comments that she "found it too hard to be distanced from her" mother. Sharing that she felt "lonely" and "scared," Pandora admits that as time went on, she "faked symptoms" and "got swabbed to make sure [she] was negative" so that she could see her. However, Pandora also comments that when "things got really bad, [she] sent [her] parents up to the cottage," telling them not to come home. Likewise, Kali shares that being shunned by her best friend was the most distressing when it came to feeling isolated. She comments that witnessing her friends purposefully avoid her made her feel "terrible," "unsupported," and "resentful." She describes how not seeing her friends left her feeling as though she "couldn't do anything to get rid of the stress [she] was having." The fear of infecting family members and the resulting anxiety and stress were identified as facilitators to nurses engaging in negative coping behaviours (Cui et al., 2020). Coincidentally, Pandora and Kali both comment that they ate more and worked more in an effort to cope.

These stories illuminate the effects of fear and isolation on the mental well-being of frontline nurses and highlight the critical role that the social and temporal dimensions have in influencing the participants' experiences.

Narrative Thread Three: Expectations and Duty to Care

Considering the social dimension of narrative inquiry, all three nurses reflect on the dichotomy of balancing the duty to care for COVID-positive patients with the rights and responsibilities of nurses to protect themselves and loved ones. The tension between the duty to

care for patients and the duty to care for oneself is present in Nyathera's story and is prominent in both Pandora and Kali's stories.

Pandora reflects on a situation in which she cared for a COVID-positive patient who purposefully spit on her. Recalling how she refused to provide nursing care after the patient assaulted her, Pandora seems to feel a tension between her professional responsibility to provide care for patients when needed and her desire to feel safe. In an American study looking at the impact of working during Ebola on Emergency Nurses, Wolf et al. (2012), found that for many ER nurses, the ethical principle of duty to treat is a professional commitment and a moral obligation (Wolf et al., 2016). In Canada, the Candian Nurses Association Code of Ethics (2017) states that nurses have a "professional obligation to provide persons receiving care with safe, competent, compassionate and ethical care" (p. 38). Indeed, when faced with a similar situation of caring for a belligerent patient, Kali comments, "…it is our duty to take care of people as a nurse. Morally and ethically, it's your responsibility… whether they are pleasant or not pleasant… I can't say I'm not going in there… it's your responsibility to look after them." From this statement, it appears that Kali is critical of those who refuse to provide care for patients who may pose a risk to themselves. Pandora describes debriefing the event with her father and feeling justified in her actions. This external validation seems to give her the confidence she needs to continue advocating for nurses' health and safety. In high-risk situations, the ethical obligation of nurses is to advocate for themselves just as they would their patients (Wolf et al., 2016). Moreover, "there is no obligation for an emergency nurse… to provide care to a highly infectious patient in the absence of appropriate training and protective equipment, especially when the benefit is small and the risks high" (Wolf et al., 2016, p. S36). This ethical obligation is also highlighted in the Canadian Nurses Association Code of Ethics. The code stipulates that nurses

may withdraw from providing care or refuse to provide care when *unreasonable burden* exists (Candian Nurses Association, 2017). Unreasonable burden exists when "a nurse's ability to provide safe care and meet professional standards of practice is compromised by unreasonable expectations, lack of resources or ongoing threats to personal and family well-being" (Canadian Nurses Association, 2017, p. 38).

Nyathera, Pandora and Kali all tell stories of being asked to provide care for COVID-positive patients with inappropriate protection in place. Nyathera shares a situation in which she got into an "absolute argument" with a patient care coordinator after refusing to help with the intubation of a COVID-positive patient until an airborne room was ready. Equally, Pandora describes how nurses were not allowed to wear masks at the beginning of the pandemic "because it was scaring the patients." It is interesting to note, that despite a widespread belief among hospital administrators that surgical masks scare patients (Nursing Times, n.d.; Scientific American Blog Network, n.d.), there is very little in the literature to support this claim (Forgie et al., 2009; Gil & Arroyo-Anlló, 2021). Pandora tells the story of how one of her immunocompromised co-workers was publicly humiliated by her manager for wearing an N95 mask while at work, noting that "it's very much like that. We have to either protect ourselves or not get fired." It appears that nurses feel judged, guilted, and shamed when they refuse to provide patient care during an infectious outbreak, a reality reflected in the literature (Maben & Bridges, 2020). Kali recalls how her hospital management told nurses to "be careful" with supplies and "recycle [their] N95[s]." Kali comments that if she had to reuse an N95 mask that she would have "rethought" what she was doing. This comment suggests that Kali had limits to moral and ethical beliefs surrounding 'duty to care.'

Indeed, despite her apparent eagerness to fulfill her professional requirement to provide care during a pandemic, the stories that Kali shares of the social stigmatization she experienced give the impression that she was challenged to live up to her ideals. For example, Kali illustrates how her best friend did not see her for a year because she "was afraid" of Kali. Additionally, Kali reflects on how being avoided for fear of contagion posed a challenge for her as she felt "terrible" and "unsupported," and comments that not being able to see her friends and family caused her to feel "stressed."

In the literature, researchers describe how the risk of infection and the possibility of taking the COVID-19 infection home to loved ones caused a predicament for ER nurses in choosing between their family's health and the provision of care to patients (Galehdar et al., 2021). Moreover, Galehdar et al. (2021) found that nurses who chose to maintain their professional commitments were forced to be separated from their families to prevent infection, leading to increased fear and anxiety. This finding resonates across all three narratives. Kali describes feeling personally responsible for keeping her family safe and powerless to do so because of her employment in the ER. She talks about how she remained distant from her family in an effort to protect them. Similarly, Nyathera illustrates how she wore a mask in her home and slept in a separate room in hopes of protecting her fiancé, who is immunocompromised. Considering the narrative dimension of time, Pandora illustrates how she initially isolated herself from her family by staying in the basement of her home but notes that when her mental health began to suffer, she "faked symptoms every two months and got swabbed to make sure [she] was negative" so that she could continue to balance her 'duty to treat' with her' duty to self.'

It is interesting to note that all three participants vocalize the feeling that working during a pandemic is "part of the job" when reflecting on the public's perception of nurses as heroes

during the first wave of the COVID-19 pandemic. In their study on the "nurse as hero" discourse during the COVID-19 pandemic, Mohammed et al. (2021) found that the hero dialogue was not a neutral expression of appreciation, but rather a tool employed to normalize the nurses' exposure to risk, enforce model citizenship, and preserve the existing power relationships that limit the ability of front-line nurses to determine the conditions of their work. Indeed, Pandora states that she found the hero rhetoric "unnerving." She remembers feeling confused as to why nurses were being called heroes when they "we're doing [their] job" and notes that they "didn't deserve it more than any other day." Kali describes the tension she felt between not being a hero because she "chose this career" and feeling like she is a hero because of the "risks" and "sacrifices" she made throughout the pandemic. Similarly, Nyathera states, "to me, it's still your job. Like, this is what you chose to do." From these three narratives, we begin to appreciate that sacrifices in nursing are not only accepted but expected. This suggests that for many ER nurses, the 'duty to care' often outweighs the 'duty to self.'

Narrative Thread Four: Nursing Shortages

Another finding that resonated across all three narratives was the nursing shortages that occurred due to the pandemic. Pandora and Nyathera both discuss how they were required to "work short" on multiple occasions due to absenteeism related to sick time and burnout. Pandora illustrates how her hospital had to close ER sections because "they just didn't have staffing." Moreover, both Pandora and Nyathera share how their hospital administrators refused vacations to support staffing. Pandora reflects on working "37 shifts in a row" during the second wave and expresses feeling as though she "couldn't leave [her] colleagues and [her patients]," suggesting that had she not worked; she would have let her colleagues down. It is interesting to note that Pandora's perception of the cause of staffing shortages is a lack of nurses picking up shifts rather

than a systemic flaw in hiring or maintaining staff. Conversely, Nyathera blames systemic issues such as unsafe workloads and an aging nursing population for the nursing shortages throughout the pandemic.

Pandora, Kali, and Nyathera discuss how the pandemic has caused many experienced ER nurses to leave the nursing profession. Additionally, they discuss how many inexperienced nurses have been hired into the ER to help alleviate the nursing shortage. As Nyathera considers how the government is trying to help the nursing shortage by hiring more new graduates, she comments that "it's a nice band-aid on the dam, but the dam is going to breakthrough." It appears that Nyathera is referring to the exhaustion of senior nurses from mentoring so many new graduates that they themselves are leaving. It also gives the impression that she has witnessed that the younger nurses do not stay in the emergency room as they come to understand the realities of emergency nursing, especially during a pandemic, resulting in their departure and more nurses being hired that need to be mentored thus the cycle continues. Reflecting on the inexperience of several nurses in the ER, Nyathera comments that "it's scary," suggesting that the inexperience of nurses can lead to poor patient outcomes. Corroborating Nyathera's narrative, Kali states that "… people looking to get out. Because it's a lot." Adding that "the new ones that are coming in… are already leaving." Giving the perspective of a more junior nurse, Pandora adds that the majority of ER staff at her hospital "hasn't even seen COVID." She laughs as she says, "when I came, I was… more junior… and now… there's probably four people in front of me to be charge, and then it's me. And I don't even triage yet." This comment suggests that Pandora believes that having a balance of junior and senior nurses is essential in providing safe and effective care. These stories demonstrate the importance of supporting and retaining experienced ER nurses and are congruent with the current nursing literature. For example, in

their study on the relationship between nursing workforce characteristics and patient outcomes, Dunton et al. (2007) found that retaining experienced nurses on patient care units is paramount in providing high-quality nursing care.

Pandora, Kali, and Nyathera admit that their experiences during the COVID-19 pandemic have caused them to consider leaving the ER and the nursing profession. However, while Pandora vocalizes her existing plan to go "up north" to take on an advanced nursing role, both Kali and Nyathera have no concrete plan in place. Kali states that "…even if [she won the] lottery, [she] would still go and nurse people." Similarly, Nyathera questions where she would go and comments that she wants to "finish out her last few years" with some of the senior staff whom she is close with. In the literature, Shiao et al. (2007) identified that ER nurses with longer tenure were less likely to leave their jobs during or after a pandemic. Indeed, the stories of both Kali and Pandora support these findings.

Narrative Thread Five: Personal Safety and PPE

In the literature, it is evident that one of the main concerns of ER nurses during pandemics is their level of personal safety and that personal safety is often equated to the availability and use of PPE (Choi & Kim, 2018; Farquharson & Baguley, 2003; Galehdar et al., 2021; Lam et al., 2020; Lam & Hung, 2013; Nie et al., 2020; O'Sullivan et al., 2008). As I reflected on all three narratives, I was interested to learn the difference in PPE supply and the level of agreement of nurses with the infection control measures taken by the hospital. Both Pandora and Nyathera discuss the shortage of available PPE. Nyathera talks about how nurses had to go down to central supply and "beg for their masks" because they were not readily available within the ER. She recalls one particular weekend when her department had run out of

isolation gowns and was told by her hospital administration to “make do.” She comments that she was asked to reuse gowns and masks “to conserve them,” noting that she “refused to do it.”

Similarly, Pandora discusses how nurses were given level one masks that had to be taped to their faces “to keep them up” because they did not fit properly. She also recalls how her department ran out of disposable PPE resulting in management asking nurses to reuse their visors. Although Pandora never explicitly states that she reused her PPE, she implies that she followed the hospital’s infection control directives to avoid potential repercussions. Conversely, Kali comments that her hospital “had N95s in abundance” and that she “didn’t ever go without anything.” Despite this, Kali recalls how her management told nurses to “be careful” with supplies and “recycle [their] N95[s],” suggesting that amount of PPE supplies for nurses may not have been as ‘abundant’ as she was led to believe. It is also interesting to note that Kali felt her hospital “provided everything [nurses] needed” to remain safe. This perception is different from both Pandora and Nyathera, who comment that the PPE provided was not sufficient to keep them safe. Reflecting on the narrative dimension of place, Nyathera remarks that the surgical masks provided to nurses in the hospital “don’t do anything for you,” pointing out that she can smell through them. Likewise, Pandora comments that the deficient PPE made her feel “more exposed at work than anywhere else.” These findings are consistent with the literature that less than half of ER nurses believe that the PPE provided by hospitals can offer them any adequate protection (Nie et al., 2020).

Regardless of the effectiveness of the PPE, both Kali and Nyathera discuss how wearing PPE was uncomfortable, recalling situations in which they performed CPR in full PPE. While Kali notes that she felt “super-hot” while performing CPR, Nyathera illustrates that she came out of the room “soaked from head to toe” in sweat. Likewise, Kali and Pandora reported their

frustrations of not being able to get any reprieve from the discomfort. Kali recounts wearing masks and PPE all day. Likewise, Pandora comments that she was not allowed to take off her mask, even in the break room, due to the potential risk of contamination.

Besides their safety experiences with PPE, I noticed a similar response to personal safety across the three narratives regarding the increasing aggression of patients towards nurses throughout the pandemic. Pandora, Kali, and Nyathera each encountered situations in which they were verbally threatened or physically assaulted. The factors influencing Pandora, Kali, and Nyathera's experiences of abuse, as they recall, reflect the social and physical dimensions. For example, Kali was threatened by patients while working in the triage area. Similarly, Nyathera had a patient scream obscenities at her because she did not address his concerns "right away." Moreover, Nyathera witnessed two workers get assaulted by disgruntled patients. Pandora was personally assaulted when an angry patient spat on her. Additionally, nurses in her department were threatened by anti-vax protestors who were planning to come into her ER with a gun to "give [nurses] something to worry about." As Pandora and Nyathera open up about their experiences of abuse, they share how each of their hospitals either does not have or does not enforce a zero-tolerance policy. The participants shared these stories to make sense of their experience of being put in danger while working during the COVID-19 pandemic. Although workplace violence is common in the ER (Sachdeva et al., 2019), violence against healthcare workers increased during the COVID-19 pandemic (Alfuqaha et al., 2022; Arafa et al., 2021). This increase was in relation to misinformation about the COVID-19 pandemic, inadequate resources in the form of shortages in the isolation facilities, ICU beds, oxygen tanks, and ventilators, long wait times, and miscommunication leading to panic, frustration, and mistrust

(Arafa et al., 2021). Through sharing their stories, Pandora, Kali, and Nyathera give us a deeper understanding of the abuse that ER nurses faced during the COVID-19 pandemic.

Narrative Thread Six: Workload and Stress

Increased workload and stress resonated across all three narrative accounts. Considering the narrative dimension of time, Pandora describes wave two as when "all chaos broke loose." Echoing her statement, Nyathera comments that "emerg has been absolutely chaotic," asserting that "it could be nothing to see over 200 [patients a day]." Similarly, Kali states that "there is absolutely no room for the amount of people that are in that emergency department on a given day." While all three participants speculate that the increase in volume resulted from the community no longer fearing the contagion, both Kali and Nyathera take this a step further, questioning if the increase in volume resulted from family physicians refusing to see their patients in person. The increase in attendance of patients in the ER during pandemics was identified as a cause of increased workload in the literature (Lam & Hung, 2013); however, the participants of this inquiry add an additional perspective by contemplating the reasons behind the increase in volume.

Both Pandora and Nyathera share how the intensity of the work increased as the number of "sick" COVID-positive patients began to rise in the hospital. Nyathera describes how her ER's eight-bed resuscitation room was always full as there was no capacity to move intubated patients from the ER to the ICU. Illustrating the tension further, Pandora illustrates how she witnessed three patients get intubated simultaneously, knowing that only one spot was available in the ICU. She describes how "once they were all intubated… the two doctors [had to determine] what patient could go to the ICU and [what] two patients could wait to be flown out to the nearest ICU."

According to Kali, another contributing factor to the heavy workload was the constantly changing protocols. She describes how hospital policies and protocols regarding the appropriate use of PPE and the care of suspected COVID-19 patients were "constantly changing… by day" and how she "didn't know what to do." Illustrating the changing policies, Kali shares that initially, suspected COVID-positive patients were isolated from others immediately after triaging while noting that they now stay in the waiting room with everyone else to "wait their turn." Describing the triage area as "not a safe or ideal environment for anybody," Kali reveals how she eventually elected to "triage everyone the same," no longer using the Plexiglas barriers provided to her by the hospital for her safety. However, the decrease in the continuous maintenance of patient care standards was not isolated to Kali. Indeed, Nyathera mentions that her ER elected to have a "dirty area" that "never got cleaned in-between" suspected COVID-positive patients. These findings are consistent with the literature in that the increased workload during pandemics results from the increased patient volume, increased intensity of work, and the need to accommodate the constantly changing protocols (Galehdar et al., 2021; Lam et al., 2016), and that nurses must cut corners to survive the workload (Andel et al., 2022; Lam & Hung, 2013).

Along with heavy workloads, all three participants described how they were expected to work more shifts and take on non-nursing-related duties to cover gaps in the healthcare system. For example, Kali and Nyathera both discuss how they were required to "wipe everything down" between patients to decrease the potential transmission of infection. Nyathera further comments that meal trays were left outside of patient rooms because the dietary aids were "not allowed to go into an isolation room" and talks about how she would have to "drop everything" to ensure her patients got their meals. Similarly, Nie et al. (2020) reported that during the COVID-19 outbreak, 75.7% of nurses had a change in their regular job duties and about half of them

reported working overtime. As previously discussed, Pandora worked "37 shifts in a row" to help fill the gaps in staffing. Additionally, Pandora recalls when she worked 15-night shifts in a row. Remembering how a patient fell during one of those shifts, Pandora recalls feeling conflicted that maybe she would have been able to catch the fall had she not been working so many nights.

Both Pandora and Nyathera reflect on their inability to rest or disconnect between shifts. Pandora comments that all she did during the pandemic was "work and sleep." She states that she had "crazy short turnarounds," sometimes only having "eight hours off" between shifts. Noticing that she did not "have time to cope or debrief" while at home or work, Pandora states that working so much caused her "mental health… [to go by] the wayside." Indeed, Pandora comments that "…in the middle of the pandemic, by all means, I was suicidal. Like, I did not believe I was going to see the end of the pandemic… I was going to work until I dropped, and that was okay with me."

In contrast, Nyathera noticed that "changing her shift pattern… made a big difference." She explains that by changing her work schedule to a pattern of four shifts on, followed by five off, she was better able to have a work/life balance. She also comments that "there's no time" in the ER to process emotions. Nyathera explains that by having more time at home, she has been able "to de-escalate the situation." The literature mirrors the same findings, particularly concerning reducing the likelihood of burnout or other adverse psychological outcomes when the length or number of shifts has been reduced (Nie et al., 2020). Both Pandora and Nyathera's stories illuminate the importance of hospital administrators providing frontline nurses with time off of work to help support physical and emotional well-being.

Narrative Thread Seven: Moral and Psychological Distress

Moral and psychological distress, particularly in regard to increased patient inflow, decreased quality of patient care, zero visitor policies, witnessing patient deaths, and the inability to emotionally process traumatic events was a common finding across all three narratives.

The increase in patient volume resulted in patient care situations that challenged the ethics and morals of each participant. For example, Nyathera describes feeling "frustrated" when discussing that her ER elected to have a "dirty area" that "never got cleaned in-between" suspected COVID-positive patients. She talks about how she elected to clean the patient care areas herself in between patients noting that she wanted to "decrease the risk for people coming in as much as possible." Similarly, Nyathera recalls how her patients were delayed getting their hot meals because the dietary aids were not allowed to go into the patient rooms to deliver them. Sharing how she had to "completely don and doff" in order to go into a patient room and occasionally had to help "set up" and feed patients, Nyathera comments that some of her patients ended up with cold meals. Vocalizing her dismay for the situation, Nyathera states, "people deserve better than that" adding that serving people warm meals is important to her. Nyathera shares that throughout this time all she felt like she could do is apologize to the patients; she states that despite wanting to "do more" for her patients she was not physically able to.

For Pandora, moral distress was caused when she had to discharge home an ambulatory patient who was "really sick" with COVID. She shares that he was discharged home because he did "not require oxygen." Pandora explains that the hospital could not admit a patient that did not need oxygen as there "was no space." Pandora recalls how the patient's wife begged for help. Pandora remembers how she was obliged to go against her personal values and beliefs, walking the patient to the door. This action caused Pandora to feel like a "shitty nurse." Like Nyathera, Pandora shares that throughout the pandemic, she felt as though "no matter what [she] did, she

[still] couldn't do enough," a sentiment shared throughout the literature (Iheduru-Anderson, 2021; Rathnayake et al., 2021).

Kali shares how the increase in patients resulted in hospital policies that decreased patient privacy, causing her to feel distressed. She describes two situations in which she felt moral anguish. The first event was when she was forced to care for patients in the hallway. She describes how placing patients in the hallway forced the patients to witness "things" and have no privacy. Sharing her frustration that the "The lights don't [even] go down," she questions how anyone can "get better in a hallway with all [the] action and no sleep." Although hallway medicine was prominent prior to the COVID-19 pandemic, the risk of nosocomial infections due to placing patients in the hallway was amplified during COVID, creating moral distress amongst healthcare practitioners (Barocas & Earnest, 2021; Innes et al., 2019; Tirupathi et al., 2020). The second event occurred when she triaged a mental health patient. She shares how the PPE that was put in place to protect her, resulted in her not being able to hear the patient's complaints. She describes how she needed to ask the patient to "speak louder" resulting in other patients being able to hear the patient's personal and private health information. Reflecting on how she would not want "open up" if the roles had been reversed, Kali calls the situation "stupid."

Kali also describes the moral and ethical distress she felt in regard to her hospital's visitor policy. She shares how her hospital went from a zero-visitor policy to a one-person policy. Sharing the challenges of both, Kali states that she zero-visitor policy was "awful" as patients died alone, and that the one-visitor policy forced her to make difficult decisions of "who can come in." In their systematic review of the effect of hospital visitor policies on patients, visitors, and healthcare providers during the COVID-19 pandemic, Iness et al. (2022) found that visitor restrictions were associated with negative emotions among most inpatients and their families.

Moreover, they found that the restriction of visitors was a source of moral distress for health care providers who did not agree with hospital policies (Iness et al., 2022). Similarly, Jaswaney et al. (2022) found that inconsistencies in the visitor policies caused stress and confusion amongst hospital staff who were trying to enforce them. To help with the moral distress, Kali comments that she would try to call the patient's family members "a lot" and that she would bend the rules and let patient's family members come in and see them if it "was really life or death." This story illuminates the emotional distress that ER nurses feel when they are unable to meet the psycho-socio-emotional needs of their patients and families, a finding consistent with the literature (González-Gil et al., 2021).

Pandora and Nyathera both describe witnessing the death of patients. Galehdar et al.'s (2021) qualitative study revealed that the increase in witnessing patients' deaths – "especially the young ones," was unbearable to ER nurses (p. 173). Pandora describes two situations in which she witnessed the death of children. The first was a twelve-year-old girl who "took an entire bottle of 500 milligram Aspirin" because she "just couldn't be stuck at home with mom's drinking anymore." Reflecting on her experience, Pandora recalls being unable to "fix it in time," leaving her to feel "really broken." The second was a three-year-old who had contracted COVID because "the mom and dad didn't believe in vaccinating [her]." Explaining how the child had a febrile seizure and stopped breathing, Pandora implicitly describes her feelings of sadness, helplessness, and anger. Despite time passing, there remains a tension between what Pandora believes the parents should have done to care for their children, and what they actually chose to do.

Nyathera recounts intubating an elderly gentleman. Nyathera recalls how the doctors wanted to intubate the patient because "his oxygen level was horrible and his x-ray was

horrible." She remembers helping the patient to call his family to say goodbye, noting that the patient did not understand the brevity of the situation. Her tensions relate to both feeling as though the doctors gave the patient and family false hope, knowing that they were intubating someone "who would have very little chance of ever coming off of a vent," and to the inability of the family to say 'goodbye' in person. Both Pandora and Nyathera comment that these experiences were the ones that "stuck out" for them, suggesting that traumatic events such as these seem to generate emotional and moral distress that exceed their temporal position by remaining closer to the present than the past (Bentz et al., 2022).

Helping family members say 'goodbye' to loved ones resonated across all narrative accounts. Nyathera recalls how she helped the aforementioned elderly man call his family on his cell phone to say 'goodbye,' stating that it was "sad" to see. Pandora recalls using iPads to help patients say 'goodbye,' commenting that "each time [she] was left in tears." Kali recalls being in the room with patients who were on the phone with their loved ones, stating that she would "push back" the tears while trying to keep her "brain busy" thinking about other things to prevent her from crying.

As I reflected across the narratives, I also noticed a common pattern that the participants struggled to care for patients who chose to ignore public health measures. For example, Pandora talks about how she struggled to provide compassionate care to a pregnant woman who contacted COVID at an anti-vaccination rally. She explains how the woman needed to be intubated, and describes how the woman denied COVID being real, even as the doctors were about to intubate her. Pandora shares the conflict she feels of providing care to patients who "don't want the prevention." Moreover, Pandora comments that there is less tolerance among nurses who believe that if patient's are not vaccinated, that they should be denied care. Kali echoes Pandora's

comment, stating that she personally feels “angry” when she hears anyone talk about not getting vaccinated. Similarly, Nyathera talks about her frustrations with family members who do not follow public health measures because they “don’t believe [COVID is] real.” These stories of the participants’ responses to those who chose to ignore public health measures illuminate the ethical and moral dilemmas that ER nurses face when providing care for those with different values and beliefs, adding a richer understanding of the challenges faced by ER nurses while providing care during the COVID-19 pandemic to the literature.

Common to all three narratives was the inability to debrief or process one’s emotions following traumatic events. Pandora and Nyathera both emphasize that there is no time in the ER to de-escalate as nurses quickly move from one patient to the next. Additionally, Pandora admits that she suppressed her emotions, so that she would “be able to come to work the next day.” Looking back on how she processed her emotions, Pandora reflects inward on a personal feeling of being numb. She states that she broke up with her partner as a result of feeling this way, suggesting that the lack of emotional processing has caused her to be emotionally distant from others, resulting in the end of her relationship. Likewise, Nyathera states that she does not “not dwell” on her emotions so that she can “go back and face it again.” In contrast, Kali shared how her hospital offered group support once a week with a psychiatrist. Despite stating that she thought it would be “beneficial” to attend, Kali only went to two sessions, citing that she found it “very emotional” and did not want her co-workers to see her weaknesses or hear her problems. She offers that she believes that individual support would have been “more productive.”

Unprocessed emotions resonated across the three narrative accounts. Nyathera’s unprocessed emotions have led to feelings of sadness, anger, and defeat. Kali’s unprocessed emotions have manifested into physical ailments, that Kali describes as having “a non-digested

stomach" and "weird" feelings in her arms and legs. Furthermore, Kali describes how her unprocessed emotions have led to an irritability that has affected her interpersonal relationships. Similarly, Pandora's unprocessed emotions caused her to be emotionally distant from others, resulting in the end of her relationship with her partner. As Pandora describes that her unprocessed emotions caused her to feel "numb," and admits that in the middle of the pandemic she was "by all means… suicidal."

These stories bring attention to the need for hospital administrators to provide frontline nurses with real-time interventions to help support emotional processing, thus preventing adverse psychological outcomes. Similar findings have been addressed by previous researchers in the literature (Aquilia et al., 2020; Bentz et al., 2022; Mueller et al., 2018).

Narrative Thread Eight: Lost Voice

Lost voice was also a dominant thread that wove over time and interaction through the individual narrative accounts. Beginning at the start of the pandemic, both Pandora and Kali comment that nurses were not given a seat at the table when discussing pandemic planning and policy at both the hospital and government levels. Sharing her frustrations about the government's unilateral decisions, Pandora states, "the government is… a bunch of… people that aren't health care, trying to make decisions… about health care… and not really knowing what they're effecting." Similarly, Kali talks about how her hospital administrators were making decisions without the input of nurses. She describes her tension between knowing what protective measures needed to be taken to protect nurses from the contagion and being told by the medical chief of the ER that "[they are] not doing that." Equally, Pandora shares her tension when her manager told her that she should not wear a mask because "it was scaring the patients." In the literature, researchers describe how not including nurses in pandemic planning leads to

guidelines made by health administrators that are often idealized and impractical, similar to the experiences of Nyathera, Kali, and Pandora. (Lam et al., 2016). When this occurs, less experienced nurses' often value the advice of senior nurses over health administrators when it comes to how to approach infectious diseases (Lam et al., 2016). Indeed, Pandora comments that when her voiced concerns were ignored regarding her hospital's initial request for nurses to avoid wearing masks, she looked towards the senior nurses for guidance on what to do. It is interesting that Nyathera, the most senior nurse in this study, had no qualms about vocalizing her concerns or taking action when required. Current nursing literature demonstrates that speaking up in health care is essential for patient safety but that nurses are often hesitant to voice their concerns (Alingh et al., 2019; Garon, 2012; Okuyama et al., 2014). Several factors influence the ability to speak up and be heard including individual dispositions, organizational attitudes and perceptions, emotions and beliefs, supervivsor and leader behaviour, and other contextual factors (Alingh et al., 2019; Garon, 2012; Morrison, 2014; Okuyama et al., 2014). However, the strongest determining factor in speaking up identified throughout the literature was the nurses' perceived risks in doing so (Alingh et al., 2019; Garon, 2012; Okuyama et al., 2014). Risks included such matters as fear of the responses of others, interpersonal conflicts, and concerns of being seen as incompetent (Alingh et al., 2019; Garon, 2012; Okuyama et al., 2014). Given Nyathera's extensive ER experience, it appears that these risks were less of a concern for her than the other participants in this study. For example, Nyathera explains how she refused to allow the physicians to intubate an infectious patient in the ER until a negative pressure room was available. Moreover, Nyathera described how she advocated for those with less seniority throughout the pandemic. For example, she offered to speak to management to request an extended orientation period on behalf of a newly hired nurse who had been rushed through her

orientation to help with the pandemic staffing demand but was not coping well with the stresses of working independently.

In addition to not having their voices heard by hospital administrators, Pandora and Kali demonstrate how patients and the community refused to listen to nurses. Pandora shares how she witnessed an elderly patient die of a COVID infection after contracting the contagion from their granddaughter. She explains how the patient's granddaughter had gone to a COVID party and then went to see her grandmother, stating to Pandora that "COVID's not real." Pandora shares that she felt "mad" at the granddaughter's "ignorance" and equates her ignorance to the lack of "health education and health information that the government was giving out." Echoing this statement, Kali says, "I… think the government… didn't know what they were going into… I wish they would have limited how much they were putting out there for the general public. One minute it was do this; one minute it wasn't. So, it was all over the place. And it becomes exhausting for everyone." Indeed, when the government's information faltered, they seemed to use nurses as a scapegoat, resulting in the community listening to nurses' concerns even less.

Considering the narrative dimension of time, Pandora shares how the community listened to nurses' concerns less and less as the pandemic went on. She describes how the community engaged in an anti-mask/anti-vaccine protest in the fourth wave, resulting in increased COVID patients within the hospital. She shares how she ended up intubating a pregnant patient who had been at the protests and described how the patient argued COVID's validity with her even as the patient was about to be intubated. Additionally, Pandora talks about an anti-mask patient who continually ignored Pandora's requests to wear a mask while receiving care in the hospital. She shares how the patient eventually spat on her and called her an "asshole" because she did not believe in the dangers of COVID. Upon attempting to advocate for nurses when speaking with

her manager, Pandora recalls being told that she "…should just be lucky that [the patient] didn't charge [her] with abandonment," demonstrating how nurses' voices are being silenced by their profession. Pandora remembers how the patient deteriorated and required intubation, stating she feels "glad [that the patient] 's intubated." This statement suggests that Pandora feels that silencing others is the only way to make hearing nurses' voices possible. Nyathera recollects a similar situation in which she witnessed a colleague being physically assaulted by a patient. Nyathera recollects how her colleague declined pressing charges, adding that she would have pressed charges had she been in the same situation. Despite acknowledging that there is little that nurses can do, she shares how she believes that nurses need to "be a voice," advocating for themselves in order to evoke change.

Like Pandora, Kali shares her frustration with the community, who continued to "challenge the vaccine" and put "conspiracy theories up on their social media." Moreover, Kali shares her frustration with being told 'what she should be doing' when out in the community. For example, Kali recalls an incident at Costco where she removed her mask to help an employee hear her better, Kali shares how her actions were met with shouts and demands of "put your mask up!" Evoking feelings of anger, Kali talks about how she felt like she wanted "to unload everything" on the employee. These stories emphasize how nurses systematically muted during the pandemic, thus eliciting feelings of helplessness, anger, and defeat.

Conceivably most upsetting for my participants were not having their voices heard when it came to their own families. Nyathera shares how she got into fights with family members who did not believe COVID was real. As Nyathera defends her position of "knowing it's real" and describes how she "had 20-something year-olds come in, be intubated," it seems as though she is genuinely hurt by the lack of understanding or appreciation that her family has for what she has

experienced. Kali also describes how her family was “not COVID feared.” She shares how her husband and children did not follow public health measures and how her husband ultimately became infected. She shares how she cared for her husband and how he thanked her, implying that he realized that his actions were wrong. As my study participants discuss the lost nursing voice within the community and their personal lives, they provide an additional perspective to the existing literature.

Contemplating whether the COVID pandemic has finally allowed nursing voices to be heard or if it is just a case of history repeating itself, Pandora states, “we thought we learned something from SARS, and yet all the stuff we had in… storage had expired. So, we couldn’t even use it for COVID. So, we will forget most of the stuff we’ve learned…” Sharing the importance of listening to nurses going forward, Pandora, Kali, and Nyathera give their advice to management and the government to prevent the ‘collapse of the healthcare system.’ Kali describes the need for hospital management to increase staffing and provide retention incentives. Equally, Pandora states that management needs to “listen to… nurses. Because even if they’re not telling you what’s the matter, you can see it. In their actions, and the way they are coping, and the way that they care for patients.” Finally, Nyathera shares how the government needs to make nurses “feel valued,” adding that Bill 124 demonstrates that nurses are “just not valued.” Although listening to the nursing voice has been mentioned, advice on what specific actions can be taken to demonstrate that nurses are being heard has not been explicitly expressed in preceding literature.

Tying the Narrative Threads Together

Threads that wove through all three narrative accounts emerged while attending to the participants’ stories. We first learn how Pandora, Kali, and Nyathera’s previous experiences with

nursing and pandemics informed how they feared contracting the disease, transferring the infection to family members, and death. The participants explain how they relied on the Government and hospital leadership to develop policies and procedures to keep nurses safe, sharing how they began to mistrust both entities as they came to understand that nurses are not being valued. They tell us that one of the main concerns they had during the COVID-19 pandemic was their level of personal safety and inform us of the challenges of both procuring and wearing PPE. Additionally, Pandora, Kali, and Nyathera explain how the public's frustration with the pandemic led to increased verbal and physical abuse towards nurses.

All three participants illustrate the dichotomy of balancing the duty to care with the rights and responsibilities of nurses to protect themselves and their loved ones. Keeping their families safe was essential to Pandora, Kali, and Nyathera. They explain the burden of feeling responsible for the safety of their loved ones, emphasizing how they are often blamed when incidents of transmission occur. They inform us of the difficulties associated with isolation, particularly the feelings of sadness and anxiety they felt as they were cut off from their support structures.

Next, we learn of the difficulties of increased workload during pandemics. Pandora, Kali, and Nyathera explain that increased workload was mainly due to increased patient volume, increased work intensity, and constantly changing protocols. They also explain how nurses were forced to cut corners to survive the workload. They shed light on the expectations of nurses to work more shifts and take on non-nursing-related duties to cover gaps in the healthcare system, explaining how this resulted in their inability to rest or disconnect between shifts. The participants describe the moral and psychological distress they endured during the COVID-19 pandemic, particularly regarding increased patient volume, decreased quality of patient care, zero

visitor policies, witnessing patient deaths, and the inability to emotionally process traumatic events.

Pandora, Kali, and Nyathera teach us about the nursing shortages resulting from the COVID-19 pandemic. They discuss how the pandemic has caused many experienced ER nurses to leave the nursing profession and how many inexperienced nurses have been hired into the ER to help alleviate the shortage. They illuminate the challenges of this restorative effort, explaining how additional senior nurses are electing to leave as they become burnt out from mentoring the continual inflow of new nurses.

Finally, we learn the importance of listening to the nursing voice. The participants describe how nurses were not included in pandemic planning, leading to guidelines made by health administrators that were impractical. Pandora, Kali, and Nyathera also share how family members, patients, and the community refused to listen to nurses, thus illustrating how nurses were systematically muted during the pandemic, resulting in feelings of helplessness, anger, and defeat.

After looking across the three narrative accounts of Pandora, Kali, and Nyathera, I gained a deeper understanding of the experience of providing care in the ER during the COVID-19 pandemic in Toronto, Canada. As the storied accounts of ER nurses providing care during the COVID-19 pandemic are mainly absent in the nursing literature, this inquiry addresses several gaps by offering a unique portrayal of the stories ER nurses tell. The purpose of the inquiry was to share each participant's story, provide meaning to their individual experiences, and allow for healing through storytelling. Despite the differences in their stories, all of the participants call attention to similar concerns. As such, the individual stories presented in Chapters 4 to 6 of this thesis and their resonating narrative threads serve to illuminate our understanding of the

complexities of providing care in the ER during the COVID-19 pandemic and can be used to inform and develop solutions to problems for future pandemics as well as inform and advance nursing education, practice, and research. This is discussed in further detail in the following chapter.

Chapter 8: The Final Story – Learnings About Providing Care in the ER During the COVID-19 Pandemic in Toronto, Ontario, Canada

The following is the final chapter of my master's thesis. I begin by reflecting on my experience as a novice researcher embracing narrative inquiry and summarize what I learned from engaging in this research process. Next, I address the significance of this study by discussing how the interpreted findings will serve to inform and advance future nursing education, practice, and research. Finally, I address the strengths and limitations of this study and conclude with my final thoughts.

Embracing Narrative Inquiry

When I began my studies, my specific research interest was reducing the incidence of PTSD in front-line emergency room nurses. This was based on my own experience of working in the ER, including my unique journey of developing PTSD and healing from trauma. However, with the advent of the COVID-19 pandemic and my thesis supervisor's help, I felt compelled to take a narrower approach to my research. Through conducting a literature search, I learned that the literature regarding the lived experience of ER nurses during the COVID-19 pandemic in Toronto is lacking. Additionally, I discovered that the nursing voice during pandemics is also missing. As such, I refined my research to explore the effects of providing care during the COVID-19 pandemic on ER nurses in Toronto, Canada. Adopting the narrative methodology allowed me to give the nurses who shared their stories the power to direct the inquiry based on their unique experiences of providing care during the COVID-19 pandemic.

As a novice researcher, I had little experience collecting, analyzing, and interpreting data. To address my limited research knowledge, I completed the Research Methods in Nursing course at the University of Ottawa. To familiarize myself with narrative inquiry, I immersed myself

with the work of others, particularly other nursing research studies that used narrative inquiry as a methodology. I adopted the narrative inquiry approach to research as outlined by Clandinin and Connelly (2000). I was especially attentive to the narrative dimensions of time, social interaction, and place as a means of interpreting the data. Close collaboration with my thesis supervisor and committee was instrumental throughout all aspects of the inquiry, and my process journal served as a means of documenting decisions that were made.

Narrative inquiry as a methodology has been embraced throughout this thesis, beginning with the inclusion of the autobiographical narrative found in the first chapter. Through writing my own narrative, I came to understand the vulnerability associated with openly sharing my experiences. At first, I felt anxious about publicly telling my story, fearing that I would be judged. However, I reminded myself that this inquiry was inspired by my own experiences of working in the ER, developing PTSD, and healing from trauma. By telling my story openly, I recognized that I was allowing another layer of myself to heal. More importantly, I realized that any external judgment or harsh words in reaction to my story are not about me. Instead, they are about the person offering them because of the insecurities or wounds that they hold on to. I also came to understand that my story could also serve as a healing point for others, knowing that they are not alone in their journey. Therefore, I had to honour my experiences by being honest in my reflection.

While reflecting on my past experiences, I was attentive to the feelings and beliefs that accompanied the stories I shared. Publicly exposing memories that, until now, have only been revealed to those within my circle of trust was a therapeutic experience. I believe that the initial step of reflecting on one's own experiences and writing an autobiographical narrative was the most crucial step throughout the entire research process. It allowed me to recognize the

vulnerability and lack of control that one can feel from sharing their story, especially when the person who is hearing the story is going to amplify their voice on a public platform. This allowed me to understand what I was asking the participants to do to help me achieve my research goals.

At the beginning of the research process, I felt insecure about my abilities as a novice researcher. Given the immense amount of burnout among nurses that had been reported throughout the pandemic, I wondered whether ER nurses in Toronto would be interested in participating in my study. Before meeting with Pandora, Kali, and Nyathera, I contemplated what stories the participants would tell of their experience of providing care during the COVID-19 pandemic. I was worried that my participants would be reluctant to share their experiences with a stranger. Fortunately for me, the participants were eager to share their stories of providing care during the COVID-19 pandemic.

Emerging Learnings from this Study

I learned four lessons while engaging in this narrative inquiry. First, I learned the importance of allowing myself to be vulnerable and authentic. During my practice interview I struggled to get the participant to reveal any intimate details of their experience in providing care during the COVID-19 pandemic. Reflecting on this, I realized the potential fear of vulnerability and judgement that the participant felt in telling their story, as I was nothing more than a stranger to them. My thesis supervisor was instrumental in guiding my learning in respect to the interview process. She encouraged me to begin each interview by first sharing my story. By sharing my story at the beginning of each subsequent interview, I was able to demonstrate my own vulnerability, thus encouraging them to do the same. Ultimately, it was this openness that permitted the development of empathetic relationships with my study's participants, resulting in their ability to share their stories more easily.

Second, I learned that the narrative dimensions are useful not only as a research process, but also as a reflective practice. Using the narrative dimensions to draw meaning from the participant's stories helped me to develop an understanding in the way the temporal, social and physical positions influence each person's experience. By recognizing the multitude of factors influencing each person's experience, I gained a new sense of understanding and empathy for others that goes beyond this inquiry. Moreover, reflecting on the narrative dimensions in my own life helped me to embrace my life's story with a sense of compassion.

Third, I learned to value and appreciate the pragmatic paradigm, its intersection with narrative inquiry, and its practical application in the research process. Pragmatism allowed me as a researcher to critically reflect on existing practices, explore factors affecting practice, generate research problems from experiences, and develop actions and approaches to addressing them effectively. More importantly, embracing the pragmatic stance allowed me to honour the lived experience of ER nurses as a source of knowledge and understanding and promote the healing of ER nurses through storytelling.

Finally, I came to understand the fulfilment of engaging in scholarly research to advance nursing education, practice, and knowledge. As I engaged in discovering the stories that ER nurses tell about providing care during the COVID-19 pandemic in Toronto, I learned that the nursing voice had been lost. Realizing this, I felt it imperative that my research act as a voice for the participants. While I continued to work on my study, I was invited to present my preliminary findings at a nursing conference in Washington, D.C. Through publicly presenting the preliminary findings, I was able to amplify the participants' voices, honouring their stories in a way that had not yet been done. Allowing the nursing voice to be heard while adding to the

advancement of nursing knowledge gave me a new appreciation for the research process and filled me with a tremendous sense of pride.

Significance to Practice

In this research study I used a narrative approach to gain a deeper understanding of the lived experience of ER nurses providing care during the COVID-19 pandemic in Toronto, Canada. Specifically, I collaborated with Pandora, Kali and Nyathera, to bring a voice and meaning to their experiences of providing care. The stories Pandora, Kali, and Nyathera tell about providing care during the COVID-19 pandemic in Toronto, provide insight into the lived experience of each participant. The depth and breadth of their experiences, their individual personalities and characteristics, and their various relationships in and outside of nursing create a richness within and across their narratives. Throughout this inquiry, attention was given to listening, learning, and honouring the unique lived experiences of each participant. The interpreted findings from this study provide insight into nursing education, practice, and research.

Education

Findings from this study suggest that ER nurses do not debrief or process their emotions following traumatic events and indicate that improved education in regard to emotional processing would help to prepare nurses for the emotionally charged situations they will encounter in the ER. Nursing education should focus on developing a nursing curriculum in which emotions and emotional processing are made more explicit to support nurses and prevent adverse psychological outcomes. Implementation of undergraduate nursing courses focused on emotions and strategies for processing emotions could prove beneficial. Additionally, the development and implementation of simulations, including virtual simulations with supportive

debriefing, can provide a realistic learning experience for nursing students. The simulations could introduce traumatic events, such as caring for the critically ill, patient and family aggression and violence, and the death or resuscitation of patients, particularly in children. For example, Overstreet's (2008) study revealed that simulation exercises can provide learners with a safe place to practice their reactions to emotionally charged experiences. In this way, nurses can learn how to work through the feelings of patients, family members, peers, and themselves when a traumatic event occurs (Overstreet, 2008). The simulations could also be offered as part of a formal orientation to the ER.

Until then, nurse educators need to create and implement educational tools and resources to help develop emotional processing in nursing staff with little or no previous experience. In addition to this, hospital administrators must work towards creating supportive work environments in which emotional processing is widely accepted and encouraged. Finally, nurse educators need to work with hospital administrators to develop standardized debriefing practices, policies, and protocols to help coach and support ER nurses with processing traumatic events and to establish positive attitudes towards emotional processing throughout the organization (Copeland & Liska, 2016; Kessler et al., 2015; Mullan et al., 2013; Theophilos et al., 2009; Zigmont et al., 2011).

Practice

Nursing Shortage. In 2009, the Candian Nurses Association predicted a critical shortage of 60,000 nurses by 2022 (CTV News, n.d.). The findings from this study indicate that the COVID-19 pandemic not only amplified the predicted nursing shortage, but made it happen quicker. Pandora, Kali, and Nyathera discuss how the pandemic has caused many experienced ER nurses to leave the nursing profession due to unsafe workloads and burnout. Focusing on the

retention of experienced ER nurses is vital to preventing the collapse of healthcare in Ontario. Repealing Bill 124 and providing nurses fair compensation for the work they deliver could provide a resolution to the worsening nurse shortage. There are several ways to address this issue. First, the Registered Nurses Association of Ontario (RNAO) and the Ontario Nurses Association (ONA) must ferociously advocate for nurses, demanding that the Ontario Government immediately repeal Bill 124. Second, ONA must negotiate a deal with the province and the Ontario Hospital Association (OHA) in which Ontario nurses see a 6.7% wage increase through a contract that retroactively stretches from April 1, 2020, to March 31, 2024. This wage increase is set to match the current inflation rate in Canada and puts nurses at parity with other first responders (Canada Inflation Rate, n.d.; CityNews Ottawa, n.d.).

Additionally, hospital administrators need to provide nurses with resources (paid sick days and mental health support) to show nurses the respect they deserve. Finally, hospital administrators should create and implement ‘wellness’ areas within the hospital where nurses can go on their breaks to relax and recharge. The wellness area could offer services for the body, such as Reiki or massage treatments, and services for the mind, such as guided mediation rooms or psychological services. Indeed some Toronto area hospitals have already implemented hostic wellness programs to nuture the mind and body. For example, Michael Garron Hospital offers fitness, meditation and art classes, along with discounted on-site massage, acupuncture and shiatsu therapies (Hospital News, n.d.). Moreover, preliminary findings from the initiation of ephemeral spaces for the rest and relaxation of hospital staff during the COVID-19 pandemic at Confluence Hospitals in Créteil, France, demonstrate the strength of maintaining hospital wellness areas to reduce the psychological and physiological tension (Bayon, 2021).

In addition to the recommendations mentioned above, the RNAO has also published several recommendations to improve the retention and recruitment of nurses. For example, published recommendations suggest that the provincial government: 1) increase the supply of RNs through increasing nursing school enrolments and corresponding funding, compressing RPN-to-BScN bridging programs, expediting processes for internationally educated nurses, and supporting nursing faculty retention and recruitment, 2) develop and fund a Return to Nursing Now Program (RNNP) to attract RNs back to the nursing workforce, 2) expand the Nursing Graduate Guarantee program and reinstate the Late Career Nurse Initiative, and 3) establish a nursing task force to make recommendations on matters related to recruitment and retention of RNs (RNAO, 2021).

Personal Safety and PPE. There was a widespread shortage of PPE during the first, second, and third waves of the COVID-19 pandemic. For two of the three ER nurses in this study, the availability of PPE was of particular concern. For example, Nyathera talked about how nurses had to go down to central supply and "beg for their masks" because they were not readily available within the ER. She recalls one particular weekend when her department had run out of isolation gowns and was told by her hospital administration to "make do." Although the recommendation after SARS was that institutions maintain adequate PPE supplies in case of another emerging infectious disease, this guideline was not followed (Possamai, 2020). As Nyathera points out, one of the issues of PPE supply at the beginning of the pandemic was Canada's 'reliance on external countries' to "get [us] through" the pandemic. To address the shortage of PPE available in Canada, the government of Canada could ramp up the domestic manufacturing capacity of PPE. Moreover, mandatory audits of hospital PPE supplies could be

implemented as part of a regulatory accreditation process, with fines for those who do not comply.

In addition to this, Pandora, Kali, and Nyathera discuss how wearing PPE was uncomfortable and report their frustrations of not being able to get any reprieve from the discomfort. Therefore, regular PPE breaks could prove beneficial to nurses during pandemics. As such, hospital administrators need to develop policies to ensure the application of regular and frequent breaks for nurses.

The findings of this study also indicate an increase in patients' aggression towards nurses throughout the pandemic. All three participants expressed encountering situations in which they were verbally threatened or physically assaulted. The development, implementation, and enforcement of hospital zero abuse policies can provide a safer environment for ER nurses. Although two of the participants acknowledged that zero abuse policies exist in their organization, neither participant believed that these policies were being supported or enforced. Therefore, hospital administrators could develop collaborative agreements with local police services for immediate response to actual or potentially violent situations. Moreover, hospital administrators must support and encourage nurses to report workplace violence incidents and prosecute individuals who commit violent acts.

Workload and Stress. This study suggests that the increased workload during pandemics results from the increased patient volume, increased intensity of work, and the need to accommodate the constantly changing protocols. Additionally, this study demonstrates that during the COVID-19 pandemic, ER nurses were expected to work more shifts and take on non-nursing-related duties to cover gaps in the healthcare system. Furthermore, Nyathera discusses how nurses were required to 'mentor' several staff members while carrying out their roles within

the department. Optimal hospital staffing levels could have improved this situation. Therefore, hospital administrators should endeavor to increase hospital staffing levels with appropriate and qualified health care professionals in dedicated roles during pandemics to address issues related to increased workload. Hospital administrators also need to assign dedicated professionals to monitor and mentor new staff.

This study also illuminates the importance of hospital administrators providing frontline nurses with time off of work to help support emotional processing. For example, Pandora comments that she worked "37 shifts in a row" to help fill the gaps in staffing. She comments that all she did during the pandemic was "work and sleep," adding that she had "crazy short turnarounds," sometimes only having "eight hours off" between shifts. Furthermore, Pandora states that working so much caused her "mental health… [to go by] the wayside," as she did not "have time to cope or debrief" while at home or work. In contrast, Nyathera noticed that "changing her shift pattern… made a big difference." She explains that by changing her work schedule to a pattern of four shifts on, followed by five off, she was better able to have a work/life balance. In addition, she explains that by having more time at home, she has been able "to de-escalate the situation." Therefore, Hospital administrators should introduce adjusted or flexible work schedules during pandemics to reduce the work intensity for ER nurses, thus reducing the likelihood of burnout or other adverse psychological reactions.

Moral and Psychological Distress. The findings from this study suggests that moral and psychological distress, particularly regarding increased patient inflow, decreased quality of patient care, zero visitor policies, witnessing patient deaths, and the inability to emotionally process traumatic events, were common among ER nurses. For example, Kali described the moral and ethical distress she felt regarding her hospital's zero visitor policy. Equally, Nyathera

recounted the moral and ethical distress she felt in helping an elderly gentleman call his family to say goodbye, noting that the patient did not understand the brevity of the situation. Indeed, the moral and ethical distress of witnessing patient deaths and helping family members say goodbye to loved ones via technological means resonated across all narrative accounts. Therefore, the development and implementation of consistent, safe, and compassionate hospital policies to lessen the impact of infectious outbreaks on the vital priority for patients to receive visitors, unless medically dangerous, could prove beneficial.

This study also illuminates ER nurses' inability to debrief or process their emotions following traumatic events. Pandora and Nyathera both emphasized that there is no time in the ER to de-escalate as nurses quickly move from one patient to the next. Additionally, Pandora and Nyathera remark that they suppressed their emotions to "be able to come to work the next day." Moreover, Pandora admits that her unprocessed emotions led her to feel "suicidal," highlighting the importance of processing one's emotions. These stories stress the need for hospital administrators to provide frontline nurses with real-time interventions to help support emotional processing, thus preventing adverse psychological outcomes.

The development and implementation of a standardized debriefing process that addresses the nurses' emotional and psychological needs may be a valuable tool to give the support needed to mitigate the negative impact of high-stress situations (Adriaenssens et al., 2012; Hammerle, 2017). Therefore, nurse educators and hospital administrators could develop and implement a standardized debriefing process to address the nurses' emotional and psychological needs following a traumatic event. Additionally, hospital administrators could provide dedicated social workers to help ER nurses talk through their feelings. For example, Browning and Cruz (2018) found that a social worker-facilitated reflective debriefing process helped alleviate the moral

distress of ICU nursing staff through regular debriefings. Finally, practicing 'self-compassion' and 'tapping' may prove beneficial for decreasing anxiety (Practicing Self-Compassion, n.d.; ETF Tapping, n.d.). As such, hospital administrators could offer training programs to teach frontline ER nurses the techniques of self-compassion and tapping.

Lost Voice. During the COVID-19 pandemic, ER nurses were at the forefront of assessing, treating, and caring for COVID-positive patients. Nonetheless, there was no process in place to ensure that their voices or experience were heard. For example, Pandora was denied the ability to wear an N95 mask while caring for suspected COVID-positive patients. Furthermore, during the first wave of the pandemic, her hospital administrators denied her ability to wear a mask based on the mask, "scaring the patients." What angered Pandora was that her safety concerns, which turned out to be well-founded, were dismissed by her hospital administrators. In addition to not having their voices heard by hospital administrators, the participants demonstrated how patients and the community refused to listen to nurses. Equating the publics' "ignorance" to the lack of "health education and health information that the government was giving out," Pandora states, "the government is… a bunch of… people that aren't health care, trying to make decisions… about health care… and not really knowing what they're affecting."

Similarly, previous research reveals that during the SARS pandemic in Toronto and the Ebola pandemic in Dallas, further outbreaks could have been mitigated had hospital administrators listened to ER nurses' concerns (Rankin, 2006; Wolf et al., 2016). As such, the concerns of ER nurses should be taken seriously. Therefore, Government officials and hospital administrators need to give frontline nurses a seat at the table when discussing pandemic planning and policy. Moreover, hospital boards and administrators should endeavour to promote

frontline nurses into advanced leadership roles to ensure that the nurses' voice is heard and acted upon.

Research

The purpose of this narrative inquiry was to provide meaning to the lived experience of ER nurses providing care during the COVID-19 pandemic in Toronto, Canada. However, the findings from Pandora, Kali, and Nyathera's narratives also highlight areas for new inquiry. Several different qualitative studies could be conducted to support the literature on this topic. For example, further narrative inquiries could be conducted to gain additional perspectives on the experience of providing care during the COVID-19 pandemic. These studies could include participants from different hospital areas or other parts of the country, including those practicing in more rural or urban areas. Similarly, a phenomenological research design could further investigate the lived experience of frontline nurses working during the COVID-19 pandemic. A longitudinal qualitative study could also be used investigate the long-term effects of the pandemic on the physical and emotional well-being of frontline nurses. For example, researchers could study the psychological impact of the COVID-19 pandemic among ER nurses in 3-, 5- or 10-years time. Finally, a participatory action research study could be used to produce knowledge about the COVID-19 pandemic and raise consciousness and assert action on the issues that matter the most to frontline nurses.

Alternatively, a quantitative randomized control trial evaluating the efficacy of interventions to promote the well-being of frontline nurses is warranted. For example, the education and practice interventions suggested above could be studied for their effect on ER nurses and pandemic nursing.

Strengths and Limitations of the Study

This study aimed to gain a nuanced understanding of the experience of ER nurses providing care during the COVID-19 pandemic in Toronto, Canada. The narrative approach served as an ideal methodology to guide the study. By inviting the participants to 'tell their story,' the participants themselves could decide which events and experiences were of most importance to them. This study provided a meaningful way to explore and honour the experience of providing care during the COVID-19 pandemic for the Pandora, Kali, and Nyathera. Additionally, it allowed the participants to begin healing from the traumas they endured throughout the pandemic. Pandora, Kali, and Nyathera vocalized that telling their stories to an empathetic audience helped them feel seen, heard, and understood.

However, it is imperative to acknowledge the limitations inherent in this inquiry. First, the sample for this study only includes ER nurses from Toronto, Ontario, Canada. One consideration is the unique social and geographical context of the ER in Toronto and how this setting contributed to and shaped the stories and experiences of the nurses in this study. Although the results of this study may not represent nurses who work in other areas of the hospital or other parts of the country, including those practicing in more rural or smaller urban areas, the research process can be used to replicate this inquiry with other samples of nurses.

Second, the inquiry explores the experience of ER nurses providing care during the COVID-19 pandemic from a female perspective. To my knowledge, there is no public demographic data specific to the ER nursing. However, the nursing profession is female-dominated, with females accounting for 91% of Canada's total nurses (Canadian Nurses Association, n.d.). Similarly, 62.3% of women aged 25 to 54 in Canada serve as caregivers to family members or friends (Statistics Canada, n.d.). Therefore, it is necessary to acknowledge

that male nurses may have had an innately different experience providing care throughout the pandemic.

Third, due to the COVID-19 pandemic restrictions, interviews were conducted over the secured video conferencing platform Zoom ©. Looking on the bright side, the participants could choose a location suitable to their needs to partake in the virtual conversations. Furthermore, the video conferencing platform enabled me to connect with the participants through eye contact and smiling while allowing me to observe the participants' body language. Additionally, Zoom's © recording capability helped me to obtain accurate conversational data (verbal and non-verbal) with complete wordings from participants.

Fourth, the primary method of data collection was through participant interviews. It is possible that the participants were reserved in sharing their stories despite the assurance of confidentiality. Participant journals were also provided to the participants. The purpose of the journals was to serve as a tool to help participants communicate any pertinent information they wished to convey that was missed during the interviews. Although one participant made a few notes to discuss during their subsequent interview, all three refrained from documenting in the provided journals. Other field texts, such as observing the participants in the clinical setting or having the participants take photographs or construct memory boxes, could have helped achieve a more enriched narrative. However, these data collection methods were impractical due to issues with ethics and confidentiality.

Lastly, I am a potential limitation to the study due to being a novice researcher and my personal experience of working in the ER. Acknowledging my inexperience with conducting a research study, I continually consulted with my thesis supervisor and committee for guidance. Additionally, I immersed myself in the work of others who had used narrative inquiry as a

research methodology. At the outset of the study, I engaged in a personal narrative. Throughout the study, every effort was made to position myself as an inquirer. I continually documented in my process and reflexive journals and engaged in peer reviews and member checking throughout the research process to ensure this study's credibility, dependability, confirmability, and transferability. On a positive note, my experience of working in the ER allowed me to understand some of the nuances of the participant's experiences. It also allowed me to connect to my participants on a deeper level, having understood the challenges of ER nursing.

Final Thoughts

At the beginning of this narrative inquiry, I questioned what stories the participants would tell about their experience of providing care during the COVID-19 pandemic in Toronto, Canada. The freedom and autonomy afforded by using a narrative approach allowed Pandora, Kali, and Nyathera to speak freely and candidly about anything they felt was relevant to their experience of providing care. The three narratives presented in this thesis illustrate the uniqueness of each participant's story and offer a rich understanding of the experience of providing care during the COVID-19 pandemic in Toronto, Canada. Through our conversations, Pandora, Kali, and Nyathera each brought forward their experience and reflections about nursing during the COVID-19 pandemic and about their lives and their identities as ER nurses. By situating the events and experiences of each nurse within the narrative dimensions of time, social interaction, and place, I was able to interpret the stories to generate meaning. The interpretations of each individual's story are organized around plotlines ('before they were heroes,' 'hero,' 'fall from grace,' 'villain,' and 'to be continued') and narrative threads (mistrust in leadership, fear and isolation, expectations and duty to care, nursing shortages, personal safety and PPE, workload and stress, moral and psychological distress and lost voice) that resonate across the

stories. This inquiry offers a new perspective for understanding the lived experience of ER nurses providing care during the COVID-19 pandemic in Toronto and honours the voices and stories of Pandora, Kali, and Nyathera. More importantly, this inquiry turns anger into action (Kali), embodies the spirit of survival among nurses (Nyathera), and provides hope for the future of nursing (Pandora).

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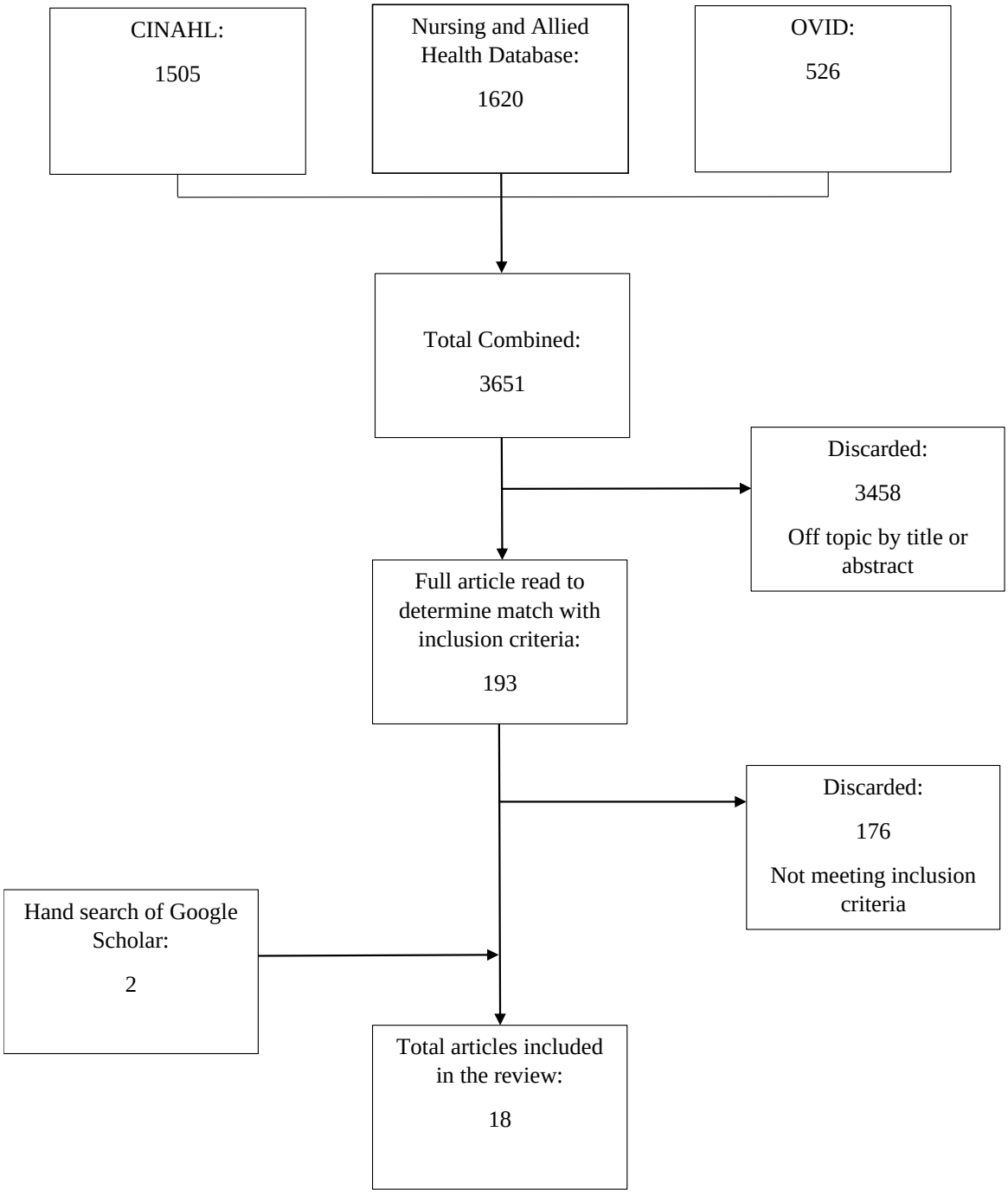
Appendix A: Literature Review – Inclusion and Exclusion Criteria

Inclusion:	**Exclusion:**	**Reason for Exclusion:**
ER Nurses (who worked during an outbreak, epidemic or pandemic) were the subjects.	Articles that focused on the patient experience only.	Not reflective of the nursing experience.
An outbreak, epidemic, or pandemic occurrence.	Articles based solely on ER patient flow or redesign of ER space.	Not reflective of the nursing experience.
A part of the lived experience (thoughts/feelings/perceptions/physical ailments or recommendations for future pandemics) is reported or discussed in general.	Articles that used the phrase 'frontline workers' or 'frontline nurses' without defining the clinical setting.	It is presumed that the lived experiences of nurses may be different depending on the area of clinical practice.
Articles from 2001-present.	Non-English articles.	Language comprehension.

Appendix B: Literature Review – Screening Process



Appendix C: Literature Review – Synthesis and Critique of Articles

Author and Date	Study Population	Outbreak/ Epidemic/ Pandemic	Method	Threads	Notes
Cui et al. (2021)	Emergency Nurses (*n* = 453)	COVID 19	Cross-sectional survey Self Rating Anxiety Scale (SAS): 20 item scale, uses a 4 point scoring system to measure the frequency of symptoms Perceived Stress Scale (PSS): 14 items and two dimensions. Tool for monitoring stress. Simplified Coping Style Questionnaire (SCSQ) Measures two dimensions of positive coping and negative coping.	• Fear of infecting family • Regret for being a nurse • Anxiety • Stress • Negative coping styles	• Training = lower levels of stress • Fewer breaks and night shift workers have higher stress • Respondents with children have higher anxiety • Burden of caring for children at home when schools closed make them more anxious **Lessons Learned:** • Psychological intervention necessary • Hospitals need to ensure proper training and staffing, reduce # of night shifts, ensure rest, and support nurses with children
Galehdar et al. (2021)	Emergency and ICU and CCU nurses (*n* = 13)	COVID-19	Mixed methods Online Questionnaire and Telephone interviews Practice Environment Scale of the Nursing Work Index (PES-NWI)	• Mental and emotional distress • Death of patients -especially young ones • Stress and anxiety • Duty to care vs. Health of their family • Forced to be separate from kids • Physical pain • Restrictions on breaks, eating and drinking	• Medical errors r/t stress, PPE, exhaustion • Painful to wear PPE • Restrict movement and increase body temp and sweating • View of nurses improved • Proud as a nurse • Nurses cont. to care for patients like family

			Medical Office Survey on Patient Safety Culture Granada Burnout Questionnaire	• Workload • Exhaustion • Professional growth • Sense of altruism • Depression, insomnia, anxiety, stress • Increased work hours	• Expect to be compensated for their sacrifice • Opportunities were also created where nurses can flourish **Lessons Learned:** • Shorten work hours • Provide rest periods • Provide PPE • Use this situation to improve nursing position in healthcare • Compensate frontline workers • Provide psychological counselling
González-Gil et al. (2021)	ER and ICU nurses (*n* = 557)	COVID-19	Cross-sectional study	• ER nurses under high stress • Anxiety, depression, lack of sleep • Imbalance of workload and human resources • Lack of rest • Emotional and physical exhaustion • Managers not listening to frontline staff proposals • Moral suffering	**Lessons Learned:** • Staffing with good nurse to patients ratios • Crucial to provide PPE • Psychological counselling needed for frontline nurses • Communication between frontline and management is key to ensuring efficient care
Lam et al. (2020)	Emergency Nurses (*n* = 24)	Nurses who worked any outbreak/ epidemic/ pandemic of 21st century	Semi-structured interviews	• Risk perception related to: • Novelty of EID • Severity of EID • Proximity to EID • Complexity of EID • Response levels to EID	• Gatekeepers to healthcare system • Ebola was regarded as a novel challenge due to lack of understanding and clarity of disease and nature of the threat • Understanding of severity r/t their impressions of impact on the public e.g. deadliness • SARS devastating because it was highly lethal and transmissible • Proximity influenced understanding of disease

Nie et al. (2020)	Frontline Nurses (*n* = 263 Including ER, fever clinic, isolation ward and ICU Nurses – majority worked in ER (74.5%)	COVID-19	Cross-sectional study Psychological distress measured using 12-item General Health Questionnaire (GHQ-12) Coping Style Assessed using SCSQ. 20 coping and behavioural patterns relating to two dimensions: positive coping and negative coping. Impact of Event Scale: revised version (IES-R) Used to evaluate intrusive thoughts related to COVID-19 and avoidant behaviour PSSS: 12 items related to support from family and friends - used to evaluate social support	• 66% of nurses have psychological distress • 75.7% report COVID-19 changed regular job duties (p. 4221) • 51.3% worked OT (p.4221). • Fewer than half believed PPE could offer effective protection • 40.3% treated differently because they work in a hospital • Most showed concern about themselves or families risk of being infected with COVID-19	• Nurses need more social support • More psychological distress if they believe PPE does not protect them **Lessons Learned:** • Need more social support and effective precautionary measures to prevent negative psychological outcomes
Ruiz-Fernández et al. (2020)	Nurses and Physicians working in COVID-19 units and ERs (*n* = 506)	COVID-19	Cross-sectional online questionnaire ProOoL Scale 30 item scale to identify Compassion fatigue, burnout and compassion satisfaction Perceived Stress Scale (PSS-14) 14 item scale – used to measure the level of perceived stress	• Compassion fatigue and burnout higher in those working in the ER • Compassion satisfaction higher in nurses than in MDs – may be r/t moral decisions on treatment provided	• Nurses may feel good when working hard and seeing how others benefit from their efforts (p. 4327) **Lessons Learned:** • To reduce CF and BO, programmes aimed at CS and quality of life among nurses should be implemented.

			experienced in the last month		
Lam et al. (2019)	Emergency Nurses (*n* = 26)	Nurses who worked any outbreak/ epidemic/ pandemic of 21st century	Semi-structured interviews	• Workload increase • Short staffing • Health risk of contagion to staff -higher than other departments • Health of family • Abrupt changes to guidelines • Uncertainty of situation	• Nurses face barriers with EID • Limitations on PPE • Noncompliance with guidelines • Insufficient isolation rooms – use of rescus rooms when isolation rooms not available **Lessons Learned:** • Hospitals need to address technical problems of ER layout and availability of PPE
Choi & Kim (2018)	Emergency Nurses (*n* = 169)	MERS	Cross-sectional study looking at ethical problems during MERS. Researcher developed 4-point scale for ethical problems was used. Visual Analogue Scale (VAS) was used to measure perceived risk of infection. Researchers composed 4-point scale to measure social stigmatization. Researchers developed a six item, 4-point scale to measure agreement with infection control procedures.	• Duty to care vs personal risk • Mindset of patient avoidance is most common ethical problem. • Social stigmatization -avoided in the community. • Psychological impact of fear of contagion	• HCW at high risk of infection • Nurses' experience ethical problems between professional and personal risk when providing care to patients. **Lessons Learned:** • Hospitals need to establish protocols for precaution against infectious diseases and educate nurses on these to help decrease ethical problems in caring for patients. • Nurses must have safe work environments with proper PPE. • Need to compensate nurses for their sacrifice. • 79% of HCW would work through a pandemic if they were able to do so voluntarily p. 343

Kim & Choi (2016)	Emergency Nurses (n = 215)	MERS	Cross-sectional study looking at burnout from MERS. Burnout was measured using the Oldenburg Burnout Inventory (OLBI), a 16 item, 5-point scale with two subdomains of emotional exhaustion and disengagement from work. Job stress was measured using the pressure from time and anxiety 9 item, 5-point scale. Fear was measured on a one item, 10-point scale. Hospital resources for the treatment of MERS was used by a 3 item, 4-point scale developed by the researcher. Social support was measured by a 4 item, 4-point scale developed by the researcher.	• Burnout corelated to stress, fear of infection, availability of tx, and support from family and friends • Stress biggest predictor of burnout • Shift work also a major factor • Emotional exhaustion higher in nurses with exposure to traumatic events • MERS was considered a traumatic event	• ED nurses are the first HCW to be infected with contagious diseases • ED nurses faced with constant hectic unpredictable everchanging situations • They do not have time for significant recovery from stress • 26% suffer from burnout (prior to MERS) p. 295 **Lessons Learned:** • Efforts should be made to decrease nurse work stress • Hospitals should be prepared for potential outbreaks • Nurses social support should be enhanced through the organization
Lam et al. (2016)	Emergency Nurses who have worked through emerging infectious	SARS, H1N1, Ebola	Semi-structured interviews to explore the experience of frontline emergency nurses regarding guideline	• Getting work done • Guideline idealized and impractical in actual situations • Senior colleagues give valued advice	**Lessons Learned:** • Frontline nurses must be involved in developing practical guidelines • Workload hinders adherence

	diseases (SARS, H1N1, Ebola)		implementation and adherence	• Adapting to accelerated infection control measures • Workload as obstacle for following infection control guidelines • Compromising care standards • Impossible to maintain same standard of care during epidemics • Resolving competing clinical judgements • Concerns over cross-departmental collaborations • Wards queried and disputed ER nurse judgements over admission with isolation	• Limited staffing and facility resources hinder adherence
Wolf et al. (2016)	Emergency Nurses working during Ebola	Ebola	Position paper	• Nurses need to help develop policy • Ethical issues • Duty to treat vs. duty to self • "There is no obligation for an emergency nurse or physician… to provide care to a highly infectious patient in the absence of appropriate training and protective equipment" p. S36 • Ethical obligation of employer to provide training and PPE • Advocate for self	**Lessons Learned:** • Nurses need to be "invited to participate in debate, discussion and planning when policy affecting practice or the care of patients is being made" p. S38
Bell et al. (2014)	Emergency Nurses (*n* = 332)	Avian Influenza	Cross-sectional Survey Survey instrument was developed using Protection Motivation Theory (PMT).	• Fear of infecting family and friends • Fear of illness • Fear of being isolated • Stigma when nurses don't report to work for personal reasons	• Fatality rates 50-80% p. 212 • 1/6 nurses report they would not report to work during an Avian influenza threat p. 212 • 33% report no disaster preparedness training in past year p. 214

			Social Responsibility Scale, 7 item, 5-point scale.		• "Current study revealed that 16% of emergency nurses… are unlikely to report to work in the event of an Avian Influenza outbreak" p.215 • 20% of ER nurses have primary care responsibility outside of home p. 216 **Lessons Learned:** • Organizations need to find ways to help nurses with home care responsibilities
Lam & Hung (2013)	Emergency Nurses	H1N1	Semi-structured interviews 10 participants	• Personal Health Concerns • Vulnerable to infection • But saw threat as mild compared to SARS • Health of household members • Health of public – felt public was overreacting • Administration Issues • Communication excessive guidelines, rapidly changing • Manpower • Adequate staffing needed • Adequate PPE- saw PPE as not user friendly • Professionalism • Eager to fulfill professional requirements • Psychological effect on nurses • Fear anxiety frustration and powerlessness • Stress and increased workload	**Lessons Learned:** • Pandemic experience strengthens perceived preparedness • Ambiguity of guidelines can adversely affect adherence to infection control measures • Need staff to alleviate stress • Training increases ability to combat outbreaks • During pandemics elective investigations and surgeries can be halted to reserve manpower in critical care areas
O'Sullivan et al. (2008)	Nurses from ER and ICU (*n* = 1543	SARS	30-minute online survey The survey tool included items from the Canadian	• Full-time nurses more prepared • Previous experience with infectious diseases more prepared	"During the 2003 SARS outbreak, emergency and critical care nurses in the Greater Toronto Area worked under extreme duress with dwindling supplies, constantly

			Community Health Survey (CCHS) and the APEX study	• Believe employers have adequate PPE • No education on emergency planning • Low confidence towards preparedness of Canadian healthcare institutions • No family care supports by institutions	changing and conflicting infection control guidelines, widespread stigma both within and outside of the hospital, and emotionally distraught patients, visitors, and fellow co-workers" p. s11 **Lessons Learned:** • Need emergency preparedness training
Shiao et al. (2007)	Nurses who worked during SARS: Nurses (*n* = 753)	SARS	Self-administered anonymous questionnaire to determine factors predicting nurses' consideration of leaving job during SARS	• 25.9% looking for another job or considering resigning because of risk of SARS • Longer work tenure less likely to leave • In-service education increases positive attitudes • Age is not a factor • Increased workload and stress, perceived fatality and affected social relationships were the top three reasons to leave • 'People avoid because of job' Yes – 2.7x more likely to consider leaving nursing • Culture: Care not refused even with personal risk • "During the epidemic in Canada, some nurses refused to care for patients with suspected SARS" p. 15	**Lessons Learned:** • Higher salary important for retention
Rankin (2006)	Ontario ER nurses employed as frontline workers during SARS	SARS	Account of public responses of Ontario nurses in response to SARS	• Nurses captured public attention • At risk of illness • Minimal voice in drafting policies and procedures • Second wave r/t not listening to nurses • Fear	• Fear and isolation • Nursing shortages • Exhaustion • Mental health issues • Ineffective coping strategies • Nurses silenced

				• Isolation – not allowed in Toronto businesses • Alone- social distancing at work • Treated as "modern day lepers" p.134 • Depleted healthcare system/nursing shortage • Worked long hours with few breaks • Exhaustion • Confusing and contradictory messaging about means of transmission, infection control, PPE required • Distrust in management • Deficiencies in the System – Government not prepared, nursing shortage and lack of PPE, no isolation rooms	**Lessons Learned:** • Fit testing q2years • Neg pressure rooms and rooms with private bathrooms • Need for more full-time positions • Hospitals need to maintain a PPE supply for possible pandemics No more hallway medicine
Tham et al. (2004)	Emergency nurses and doctors	SARS	Self-administered questionnaire examining the psychological effect of ED nurses and MDs during SARS Impact of Events Scale (IES) General Health Questionnaire 28 (GHQ-28)	• Psychological distress rates between 22- 38.9% among ER nurses • Changes frequent sometimes daily or hourly • HCW feel "pressure and embarrassment of being lauded as heroes" p. 220 • Psychological impact decreases over time – r/t PPE availability and reassurance that it worked	**N/A**
Farquharson & Baguley. (2003)	ER staff	SARS	Not specified	• Doing procedures is difficult in full PPE • Stress of home isolation and fear or transmitting illness to family members • Emotional support is needed	• 51% of SARS cases in GTA are nurses and physicians p. 742 • 77% are result of hospital exposure • Stay 3 ft apart • Stopped social gatherings outside of work

					• Only work in one hospital or facility • Nurses were seen as a community threat **Lessons Learned:** • Restriction on visitors • No more hallway medicine • Need N95 mask supply store in hospital for possible future outbreaks • Chane to single use equipment • Air filters • Isolation rooms • Emotional support is needed • Positive words and encouragement keep up morale

Appendix D: Story Theory Framework

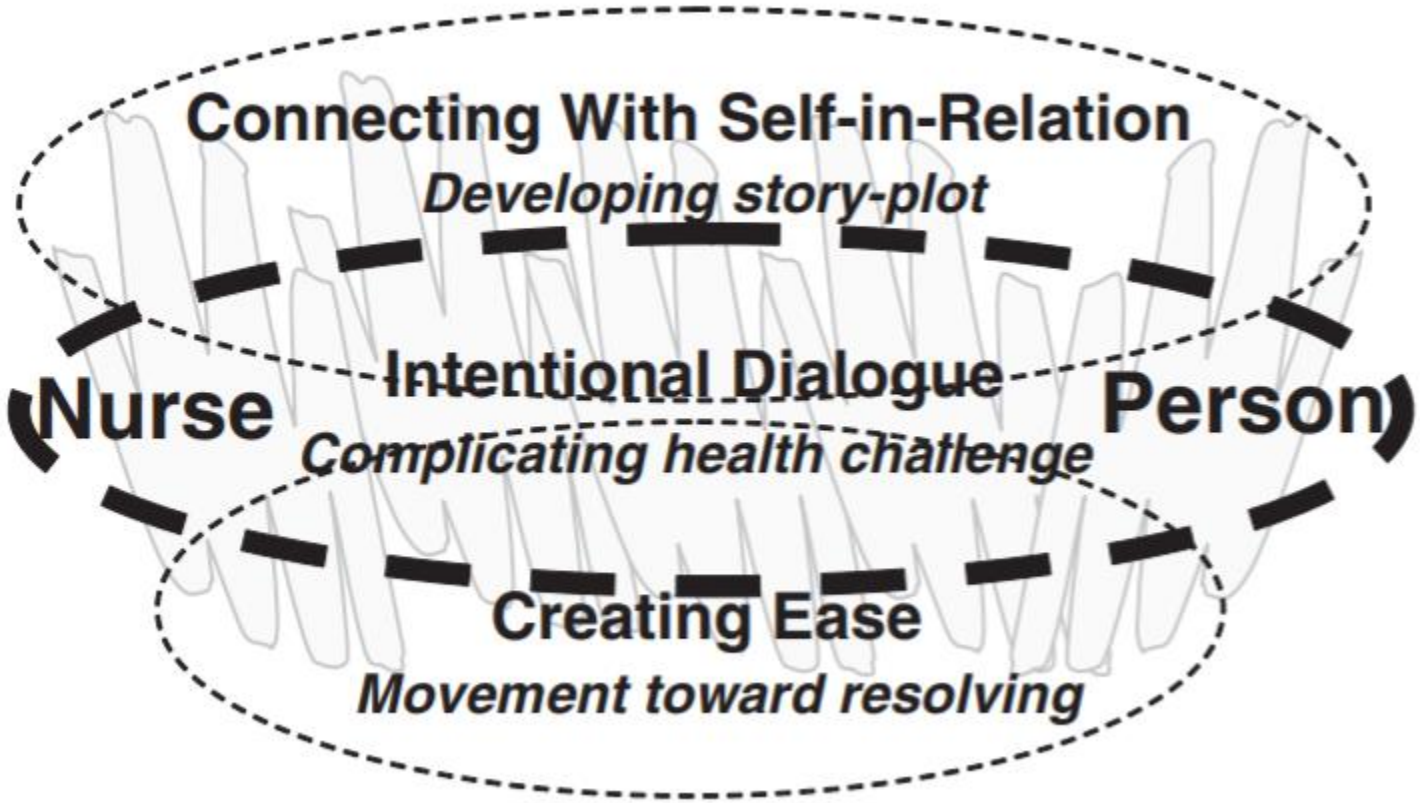


Figure 1. Conceptual Diagram of Story Theory (Smith & Liehr, 2014, p. 234)

Appendix E: Certificate of Ethics Approval

09/08/2021

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-07-21-7129
Titre du projet / Project Title	Untold Stories of the ER: Providing Care During the COVID-19 Pandemic as Narrated by Emergency Room Nurses in Toronto, Ontario, Canada
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	09/08/2021
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	08/08/2022

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Andrea MARSH	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Jane TYERMAN	École des sciences infirmières / School of Nursing	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street, Room 154
Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics

09/08/2021

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Riana MARCOTTE
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board**

550, rue Cumberland, pièce 154 Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street, Room 154 Ottawa, Ontario K1N 6N5 Canada

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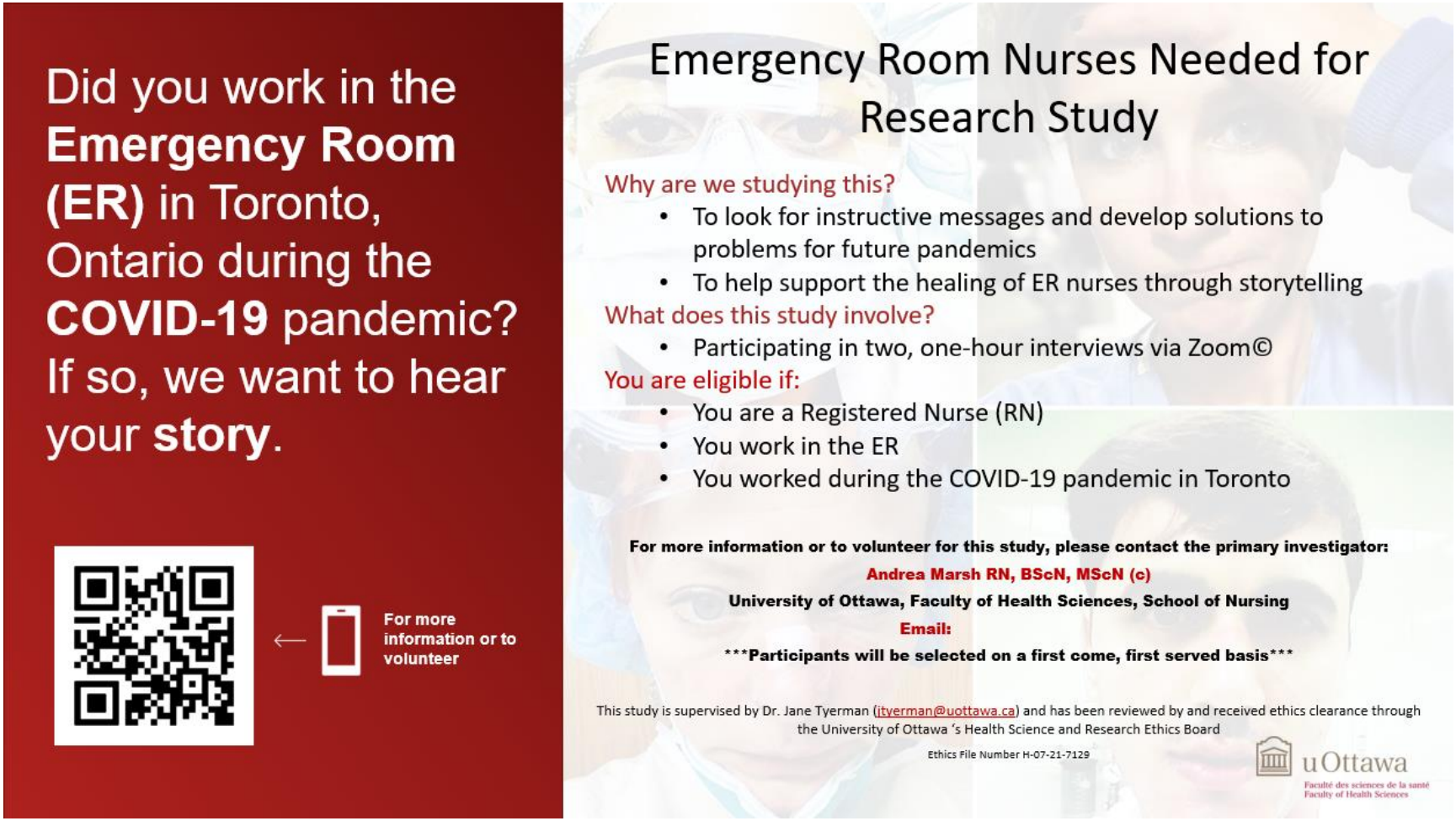
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics

Appendix F: Recruitment Poster



Appendix G: Letter of Information

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Faculté des sciences de la santé
Faculty of Health Sciences

Information Letter

Study Title: Untold Stories of the ER: Providing Care During the COVID-19 Pandemic as Narrated by Emergency Room Nurses in Toronto, Ontario, Canada

Investigator: Andrea Marsh RN, BScN, MScN (c)
School of Nursing
Faculty of Health Sciences
The University of Ottawa

Supervisor: Dr. Jane Tyerman RN, PhD
School of Nursing
Faculty of Health Sciences
The University of Ottawa

Dear Participant,

You are invited to participate in a research study to explore the experiences of nurses working in the Emergency Room (ER) in Toronto Ontario, Canada during the COVID-19 pandemic. This study aims to describe, interpret, and understand the thoughts, feelings and problems facing ER nurses who worked the frontlines in the fight against COVID-19. To participate in this study, you must be employed as a Registered Nurse (RN) in Toronto. You also must have worked for at least one year in the ER during the COVID-19 pandemic and had contact with suspected or positive COVID-19 patients. Previous studies about nurses' experiences during past and present epidemics/pandemics have been conducted; however, we have yet to clearly understand the meaning of the experience from the perspective of ER nurses working in Toronto, Ontario, Canada. Your participation will help us improve our understanding and help prepare for and support ER nurses in Toronto in future outbreaks/epidemics/pandemics.

Before you decide whether to participate in the study, it is essential that you understand what the research is for and what you will be asked to do. Please take time to read the following and discuss with others if you wish. You will receive a copy of this information letter for your records.

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Faculty of Health Sciences

Purpose:
The purpose of this study is:

1) To describe, interpret, and understand the thoughts, feelings, and problems facing Emergency Room Nurses in Toronto during the COVID-19 pandemic.
2) To look for instructional messages and develop solutions to problems for future pandemics.
3) To allow for the healing of nurses through storytelling.

This study is part of the investigator's thesis work being completed for the Master of Science in Nursing (MScN) program in the School of Nursing, Faculty of Health Sciences, at the University of Ottawa. Dr. Jane Tyerman is supervising this project.

What will happen if you take part in this study:

1) As a participant, you will have two interviews with Andrea Marsh. During the initial interview, Andrea will invite you to talk about your experience of working in the ER during the COVID-19 pandemic and to share your stories. You may wish to talk about experiences you have had. During the conversations, Andrea Marsh will ask you the following question, which may lead to subsequent questions based on your stories:

   Can you tell me your story, the events, and experiences of working as an ER nurse during COVID-19 that are important to you?

   The second interview will follow a semi-structured interview style to allow for follow-up discussion. Interview questions will be tailored to each participant to further explore previous discussions and to clarify any misconceptions.

2) Interviews will be scheduled at your convenience. The researcher will arrange a date and time of your interview(s) with you. Due to the COVID-19 pandemic, interviews will be conducted over the secured video conferencing platform Zoom ©. The interviews will be recorded and typed for further analysis. However, recording can be paused as necessary to allow for breaks. Additionally, you may turn off your video feed if it is your preference. Furthermore, you can refrain from answering questions that you do not wish to discuss.

3) Each interview will last approximately one (1) hour.

4) Later, Andrea Marsh will invite you to review your personal narrative and provide clarification or feedback. Subsequent interviews to clarify or elaborate are available to participants anytime during the study and may be requested by the participant or Andrea Marsh.

5) Upon completing the initial interview, Andrea Marsh will provide you with a blank journal to allow for personal reflection. Your journal will be mailed to your preferred mailing address to maintain social distancing. You may use your journal to record any emerging thoughts, feelings, memories, or stories about your work experiences during the

COVID-19 pandemic. This will serve as a tool to help you communicate any pertinent information that you wish to convey to Andrea Marsh during the interviews. The journal is not mandatory but rather an optional source for you to share your reflections. Journals will not be collected or used by Andrea Marsh at any time.

What are the benefits to you:

There may be no benefit to you personally. However, through this research you may gain new insights and find personal meaning into your experience of working as an ER nurse during the COVID-19 pandemic. The results of this study may help inform future pandemic preparation and nursing support.

What are the possible risks to you:

There are no significant risks involved in this study; however, answering some questions may make you feel fearful, sad, angry, or upset. The researcher will make every effort to minimize these risks, and the participant may take breaks as required during the interview or stop the interview process entirely if needed.

Should you require psychological support following an interview, free psychological counseling is available in Ontario at ConnexOntario:

Toll-free by phone: 1-866-531-2600

Live web chat: https://1576prairiefyre.cloudcollaboration.ca/ccmwa/chat/a91000d1-9584-466b-bb4f-6b039b802173?client=99_238_242_204.

We do not know of any other risk of taking part in this study.

How we will maintain your privacy:

We will not write or disclose your name in any of the information collected. Unless you wish to have your first name affiliated with your stories, pseudonyms will be used in all documents. Anyone who takes part in the research will be given the option to be identified only by code numbers or false names.

Participant interviews will be transcribed verbatim by the primary researcher into a Microsoft Word electronic document. Electronic documents will be stored on the researcher's password-protected computer and onto an encrypted USB for backup. Hardcopies of research documents, researcher notes, and the encrypted USB will be stored in a locked filing cabinet in the researcher's personal locked office. Consent forms will be stored in a separate locked filing cabinet in the thesis supervisor's secured office in a locked filing cabinet at the University of Ottawa. Only the researcher, thesis supervisor, and committee members will have access to the information collected. Additionally, one encrypted USB with all study-related materials will be

kept in a locked filing cabinet in the thesis supervisor's office at the University of Ottawa School of Nursing building for five years.

You can request a copy of the interview transcripts if you wish. At the end of the research, we will write a report, and the results may be published in peer-reviewed journals and conference presentations.

Upon completing the research project, all data stored on the researcher's computer will be deleted, and print copies of materials will be destroyed using a professional confidential shredding service.

Voluntary Participation:

Your participation in this study is entirely voluntary. You are under no obligation to participate. In the interviews, you do not have to answer all the questions if you do not want to. If you wish to withdraw from the study at any time, you are entirely free to do so. If you choose to withdraw, all data gathered until the time of withdrawal will be securely disposed of.

If you have any concerns about the study:

Please feel free to contact the Protocol Officer for Ethics in Research, University of Ottawa:

Tabaret Hall
550 Cumberland St
Room 154
Ottawa, ON, Canada
K1N 6N5

Tel.: 613-562-5387
Fax.: 613-562-5338

ethics@uottawa.ca

Ethics File Number: H-07-21-7129

If you are interested in participating in this research study, or have any questions or concerns, please feel free to contact the researcher or their supervisor.

Researcher:	Supervisor:
Andrea Marsh	Dr. Jane Tyerman
Phone:	Phone: 613-562-5800 ext. 8609
Email:	Email: jtyerman@uottawa.ca

Appendix H: Participant Consent Form

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Faculté des sciences de la santé
Faculty of Health Sciences

Consent Form

Title of the study: Untold Stories of the ER: Providing Care during the COVID-19 Pandemic as Narrated by Emergency Room Nurses in Toronto, Ontario, Canada

Name of researcher:
Andrea Marsh, RN, BScN, MScN (c)
School of Nursing
Faculty of Health Sciences
The University of Ottawa
Phone:
Email:

Name of Supervisor:
Dr. Jane Tyerman, RN, PhD
School of Nursing
Faculty of Health Sciences
The University of Ottawa
Phone: 613-562-5800 ext. 8609
Email: jtyerman@uottawa.ca

Invitation to Participate: I am invited to participate in the above-mentioned research study conducted by Andrea Marsh under the supervision of Dr. Jane Tyerman.

Purpose of the Study: The purpose of the study is to:

1) To describe, interpret, and understand the thoughts, feelings, and problems facing Emergency Room Nurses in Toronto during the COVID-19 pandemic.
2) To look for instructional messages and develop solutions to problems for future pandemics.
3) To allow for the healing of nurses through storytelling.

This study is part of the investigator's thesis work being completed for the Master of Science in Nursing (MScN) program in the School of Nursing, Faculty of Health Sciences, at the University of Ottawa. Dr. Jane Tyerman is supervising this project.

Participation: As a participant, I will have two interviews with Andrea Marsh. She will invite me to talk about my experience of working in the ER during the COVID-19 pandemic and to share my stories. During the conversations, Andrea Marsh will ask me the following question, which may lead to subsequent questions based on my stories:

"Can you tell me your story, the events, and experiences of working as an ER nurse during COVID-19 that are important to you?"

Interviews will be scheduled at my convenience. The researcher will make arrangements to organize the date and time of my interviews. Due to the COVID-19 pandemic, interviews will be conducted over the secured video conferencing platform Zoom ©. The interviews will be recorded and typed for further analysis. However, recording can be paused as necessary to allow for breaks.

Additionally, I may turn off my video feed if it is my preference. I am free to refrain from answering questions that I do not wish to discuss.

Each interview will last approximately one (1) hour.

Upon completing my initial interview, the researcher will provide me with a blank journal to allow for personal reflection. My journal will be mailed to my preferred mailing address to maintain social distancing. I may use my journal to record any emerging thoughts, feelings, memories, or stories about my work experiences during the COVID-19 pandemic. I recognize that the journal will serve as a tool to help me communicate any pertinent information that I wish to convey to Andrea Marsh during the interviews. I understand that the journal is not mandatory but rather an optional source for me to share your reflections and that the researcher will not be collecting my journal at any time.

Later, Andrea Marsh will invite me to review my personal narrative to provide any clarification or feedback. Subsequent interviews to clarify or elaborate are available at anytime during the study and may be requested by myself or by Andrea Marsh.

Risks: There are no significant risks involved in this study, however, answering some questions may make me feel fearful, sad, angry, or upset. Should I require psychological support following an interview, I am aware that free psychological counseling is available in Ontario at ConnexOntario.

Toll-free by phone: 1-866-531-2600
Online web chat: https://1576prairiefyre.cloudcollaboration.ca/ccmwa/chat/a91000d1-9584-466b-bb4f-6b039b802173?client=99_238_242_204.

I have received assurance from the researcher that every effort will be made to minimize these risks and that I may take breaks during the interview or stop the interview process if needed.

Benefits: There may be no benefits to me personally by participating in this study. However, through this research I may gain new insights or personal meaning into my experience of working as an ER nurse during the COVID-19 pandemic. The results of this study may help inform future pandemic preparation and nursing support.

Confidentiality and Anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for the purposes outlined above and that my confidentiality will be protected.

Anonymity will be protected in the following manner:

1) The researcher will store consent forms and study information separately to protect my identity.
2) Only the researcher, thesis supervisor and thesis committee members will have access to my information. The researchers will not write or disclose my name in the information

collected unless I wish to have my first name affiliated with my stories and not select a pseudonym.

3) Anyone who takes part in the research will be given the option to be identified only by code numbers or false names.
4) I can request a copy of the interview transcript if I wish.
5) At the end of the research, the researcher will write a report, and the results may be published in peer-reviewed journals and conference presentations.

To maintain my anonymity, I request that the researcher uses *(check one)*:

- ○ a pseudonym
- ○ my first name only

when writing my stories.

Conservation of data: One encrypted USB with all study-related materials will be kept by the primary researcher in a locked filing cabinet in the researcher's personal locked office for five years. Additionally, one encrypted USB with all study-related materials will be stored in a locked cabinet in Dr. Jane Tyerman's office at the University of Ottawa. The researcher will keep all information from this study for five years.

Voluntary Participation: My participation in this study is entirely voluntary. I am under no obligation to participate. In the interviews, I do not have to answer all the questions if I do not want to. If I wish to withdraw from the study at any time, I am entirely free to do so. If I choose to withdraw, all data gathered until the time of withdrawal will be securely disposed of.

Acceptance: I, _____, agree to participate in the above research study conducted by Andrea Marsh of the School of Nursing, Faculty of Health Sciences, University of Ottawa, under the supervision of Dr. Jane Tyerman.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa:

Tabaret Hall
550 Cumberland Street, Room 154
Ottawa, ON
K1N 6N5

Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

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Faculty of Health Sciences

Signature of Participant	Date
Signature of Researcher	Date

Statement of Primary Researcher:

I, or one of my colleagues, have carefully explained to the participant the nature of the above research study. I certify that, to the best of my knowledge, the participant clearly understands the nature of the study and demands, benefits and risks involved to participants in this study.

Signature of Primary Researcher	Date

Appendix I: Participant Journal Instructions

Participant Journal

Participant Journal Instructions:

Please feel free to use the following journal to record any thoughts, feelings, or reflections on the interview or the research topic (your experience working in the ER during the COVID-19 pandemic in Toronto, Ontario).

This journal is **not** mandatory and will **not** be collected by the researcher or research team. The journal serves as a tool to help you write down your thoughts and feelings and reflect on any pertinent information that you wish to communicate to the researcher during your interviews.

Thank you,

Andrea Marsh