‘Thank you for helping me remember a nightmare I wanted to forget’: qualitative interviews exploring experiences of death and dying during COVID-19 in the UK for nurses redeployed to ICU

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ABSTRACT

Intensive Care Units (ICUs) became key end-of-life spaces during the Covid-19 pandemic in the UK. Many nurses were redeployed to ICU from other specialities, navigating changing roles, priorities, and risks. Limited resources including time, equipment, and staffing widened nurses’ responsibilities; the virus’ infectious nature restricted family visits, even at end of life. Emerging literature explores ICU deaths during Covid-19, but little focuses on nurses’ experiences, especially those redeployed. Here, we explore how redeployed nurses negotiated these competing demands on their emotional and physical resources, and undertook meaning-making, by integrating a framework of ‘sensemaking’ with theories of coping. Drawing on interviews with six nurses from two UK-based longitudinal qualitative studies we detail profound shifts that uniquely challenged nurses’ sense of identity, duty, and purpose. This included adopting untested caring protocols, de-prioritising ‘non-essential’ care, and establishing communication rituals with patients/families. Understanding how nurses negotiated and performed their roles when paradigms of care were dramatically destabilised is vital to supporting workforce recovery from burnout, moral injury, and moral distress. This research also provides important learning for the management of future emergency responses and extends knowledge of how lived experience maps onto theoretical knowledge.

Background

Intensive care and Covid-19

Intensive Care Units (ICUs) became key end-of-life spaces during the Covid-19 pandemic in the UK, requiring ICU nurses as core caregivers to navigate changing roles, priorities, and risks. Level 3 critical care, or ICUs, manage patients ‘requiring advanced respiratory support […] together with support of at least two organ systems’ (The...
King’s Fund, 2020). This includes patients with multi-organ failure, as in acute respiratory syndrome Covid-19 which can cause ‘renal, haematological and cardiac complications’, requiring a wide range of specialist care and multidisciplinary caregivers to be available (Coughlan et al., 2020; Meyer et al., 2020, p. 3). ICUs generally have low nurse-to-patient ratios and focus on life-saving through close monitoring and the use of mechanical equipment. For dying patients, nurses shift from ‘curing to caring’ (King & Thomas, 2013; Nyman & Sprung, 2000), where dignified deaths include the physical presence and involvement of families (Wilson et al., 2019).

The UK experienced two distinct peaks of critically ill patients between March 2020 and March in the following year, according to Intensive Care and National Audit Research Centre admissions data tracking (ICNARC, 2021): predominantly in April 2020, and January–February 2021. Mortality rates in UK ICUs varied across institutions over time, between 20% and 40% (ICNARC, 2021; Marks et al., 2021). Thanks to new evidence and improved supportive care guidelines, recommendations, and treatments, outcomes for Covid-19 patients in ICUs generally improved over the course of the pandemic (e.g. Armstrong et al., 2020).

**Redeployment and end of life in ICU**

A key strategy underlying multiple policy decisions in the UK was to expand ICU capacity, for example through refashioning operating theatre spaces as makeshift ICUs and developing the Nightingale Hospitals (Phua et al., 2020; The King’s Fund, 2020). Yet the limited supply of highly skilled health workers to staff these services meant that workers without critical care expertise were redeployed to critical care areas during the pandemic (Doyle et al., 2020; Meyer et al., 2020).

In a systematic review of healthcare worker redeployment to ICUs, predominantly across the UK and USA, the authors emphasised that responding to areas of need during the pandemic was a ‘moving target’ (San Juan et al., 2021). An emerging literature explores ICU as a working environment during Covid-19 and identifies common sources of anxiety (Shanafelt et al., 2020, p. 2133), but little focuses on nurses’ experiences, especially those redeployed to ICU from other specialities.

Nurses redeployed to ICU faced extraordinary challenges. They were required to care for patients during a period when the provision of ‘tailored holistic care’ from a multidisciplinary team, key to good clinical outcomes, was not always possible, especially for end-of-life best practice (Coughlan et al., 2020, p. 188). Moreover, the infectious nature of the virus restricted family visits (Cook et al., 2020; Doyle et al., 2020). A survey of 117 UK hospitals (out of the 217 hospitals with at least one ICU) found that ‘all hospitals imposed visiting restrictions’, with 16% of hospitals (28 ICUs) allowing no visitors under any circumstances, while 63% (112 ICUs) allowed family to be present at the end of life (Rose et al., 2021, p. 1685). Due to these changes, hospitals adopted other strategies towards end of life: responsibilities for communicating with families that had usually rested with bedside nurses were shifted to other health workers; half of the surveyed hospitals (106 ICUs) established ‘dedicated ICU family-liaison teams’; and almost all instituted ‘virtual visiting’ (Rose et al., 2021, p. 1685).
**Coping and impacts for healthcare workers**

Even prior to Covid-19, scholars drew attention to alarmingly high levels of healthcare worker burnout, and the potential for moral injury (the aftermath of moral distress) in ICUs, especially when managing end-of-life situations (Neville et al., 2019; Van Mol et al., 2015). Wolcott (2016) identified the most important factor for nurses’ experience of moral distress as the ‘ethical climate’ of ICUs (p. 14), and the quality of support available for nurses facing ethically challenging situations. The desire to leave nursing can be a consequence of nurses’ suffering the loss of personal and professional identity (Jezuit, 2000; King & Thomas, 2013). These kinds of vulnerabilities in a pandemic are more pressing still. Evidence from Covid-19 studies identify that the powerlessness of health workers to provide good end-of-life and palliative care has a high potential to create psychologically and morally distressing situations (e.g. Garros et al., 2021). Clinicians have suffered both directly and indirectly from the untenability of giving ‘whole person palliation and patient- and family-centred care’ (Cook et al., 2020, p. 7). It has also been suggested that ‘visiting restrictions [caused] moral injury to intensive care staff for whom in-person emotional support of family members throughout […] is integral to professional practice’ (Rose et al., 2020, p. 102896). In some cases, psychological stress has been profound enough to lead nurses to suicide (Shen et al., 2020).

**Theoretical framework**

To illuminate how nurses negotiated unprecedented demands on their emotional and physical resources, we integrate Folkman & Greer’s (2000) model of stress and coping into Weick’s framework of ‘sensemaking’ (Weick, 1995). Weick’s ‘sensemaking’ is well established as a useful way of thinking about identity and behaviours in healthcare (Checkland et al., 2013), where it is defined as a process through which individuals and groups respond to sudden or confusing change by using their experience and tacit knowledge to create new understandings and meanings. Sensemaking is also the process through which individuals develop coping strategies – coping has been defined as a ‘special category of adaptation elicited in normal individuals by unusually taxing circumstances’ (Costa et al., 1996, p. 45). Folkman and Greer’s (2000) model for psychological well-being establishes coping as a two-part process: appraisal and coping. Appraisal constitutes the individual evaluating the event in the context of their personal history, while coping encompasses the thoughts and behaviours used to mitigate distress – coping is further refined into emotion-focused, problem-focused, and meaning-based coping (Folkman & Greer, 2000, pp. 12–13). When faced with a situation that appears uncontrollable, such as the Covid-19 pandemic, individuals are more likely to opt for emotion-focused coping (Folkman & Greer, 2000).

That sensemaking occurs when ‘the flow of action has become unintelligible in some way’ makes it particularly relevant in the context of Covid-19 (Weick et al., 2005, p. 409). Previous work on sensemaking in ICUs has identified two forms of its working within a context of shared organisational and social paradigms of care: ‘at intervals’ and ‘on-the-fly’ (Albolino et al., 2007, p. 131). In this article, we show how nurses negotiate and perform their roles when paradigms are dramatically destabilised. Placing sensemaking
into a model of appraisal and coping, we highlight nursing agency and identify practical learning about coping and resilience.

**Methods**

**Data and data analysis**

This article draws on semi-structured interviews with six ICU nurses from two UK-based longitudinal qualitative studies: ‘NHS Voices of COVID-19’, and the ‘COVID-19 Healthcare Worker and Policy Project’. Three nurses are included from each study (i.e. all those in both studies redeployed to ICU), comprising a total of 21 individual interviews, undertaken over the period March to November 2020. Nurse participants in the ‘NHS Voices’ study were each interviewed once, and those in the other study between five and seven times. This variation is a result of conducting research during a health emergency with frontline responders – as researchers, we prioritised this flexibility in data collection to accommodate participants’ needs, obligations, and constraints. While repeat interviews were planned for participants in both studies, the three nurse participants in ‘NHS Voices’ were unable to complete further interviews at the time.

We brought together the data from these two different studies because we were struck by the similarities between nurses’ experiences with dying and death in ICUs during this period. Both of us as researchers (in the social sciences and history, respectively), have prior experience of qualitative interview-based research with health workers, and both of us conducted a Covid-19 related study during this time. ‘NHS Voices of COVID-19’ is creating a national collection of Covid-19 personal testimonies from health workers, patients, and the public. Data collection for this study was led by Snow, and the three nurse participants were recruited through promotion across the project’s stakeholder networks of NHS organisations and nursing networks. The ‘COVID-19 Healthcare Worker and Policy Project’ focuses on UK Covid-19-related policy decisions and their impact on a diverse sample of health workers. Pilbeam collected data used here, and the three nurse participants were recruited through a social media (Twitter) advert for the study. The permissions given by the participants in these studies gave us unrestricted use of the data for all research purposes, which included data-sharing.

In both studies, interviews focused on exploring changes in clinical roles and practices, patient care and management with and without Covid-19, this included risk, teamwork, resource availability (of equipment, training, and time) and key challenges moving forwards. Nurses’ experiences of end-of-life care and decision-making wove throughout these areas in participants’ accounts and experiences.

The interviews were verbatim-transcribed by professional transcribers, and anonymised. Interviews were chosen based on the participant being a nurse in an ICU and interviewed during March 2020-November 2020, which encompassed the first and second pandemic waves in the UK. Bringing datasets together, we analysed transcribed interviews iteratively through zooming in and out (Nicolini, 2009), broadly informed by thematic analysis (Braun & Clarke, 2006). This involved individual holistic read-throughs, inductive NVivo coding guided by Weick’s framework, then together identifying and discussing key themes and examples before returning to data.
Participants

Five of the participants were white European, and one was from the Philippines. The gender breakdown was uneven: five participants were female and one was male. All had been redeployed into ICU settings from other areas of responsibility in the hospital. As is clear from this breakdown, the sample is limited in scope for exploring gender and ethnic dimensions due to the small number of participants. Nevertheless, participants here offer important accounts of their shared experiences of redeployment in ICU, from which we can draw lessons and build upon in future research, policy, and practice. To protect anonymity, pseudonyms have been used for all participants.

Discussion

This section begins by introducing participants’ journeys to and through the Covid-19 pandemic. We then focus on unpacking the theoretical framework introduced earlier: first, examining the participants’ appraisal and sensemaking in the context of upturned norms and paradigms of care; second, looking at how nurses employ problem-focused and emotion-focused strategies of coping; and, third, by exploring examples of meaning-making. It is important to note that we do not see appraising, coping and meaning-making as a linear, directional process but rather as an ongoing interweaving of different aspects in response to the changing dynamics of the situation. We present our findings alongside a discussion of what understanding they offer about coping processes.

A brief profile of the participants in both studies is useful to get a sense for the context of their coping:

Amanda trained as an intensive care nurse in the 1980s but left the NHS to work in pharmaceutical market research. She returned in 2015 as a theatre recovery nurse and was redeployed to ICU in a nearby hospital during the first wave.

(NHS Voices of COVID-19’ project)

Rosario trained as a theatre recovery nurse in the Philippines and moved to the UK in October 2019. She was redeployed to ICU during the first and second waves, and worked in one of the ‘make-shift’ ICU spaces.

(NHS Voices of COVID-19’ project).

Linda trained as a nurse in the 1970s and worked across chronic conditions, cancer and palliative care. She was working in the acute assessment unit which admits patients from A&E, but all the wards in her hospital became ICU units in order to create capacity.

(NHS Voices of COVID-19’ project)

Carmen is a specialist nurse usually working in an acute pain service with previous experience in high dependency nursing. She describes herself as a highly-experienced senior nurse, who is proactive and confident. She was redeployed to ICU in the first and second wave.

(COVID-19 Healthcare Worker and Policy’ Project)

Dylan has been a nurse for ten years and is a respiratory nurse. In September 2020 he began a new role as a community respiratory nurse, splitting his time between wards and home
visits. He was redeployed to ICU early on in the first wave, and on a rotational basis in the second.

("COVID-19 Healthcare Worker and Policy’ Project")

Theresa is a specialist nurse with twenty years of ICU experience, but has not worked clinically during the last four years as she had a ‘non-hands-on’ clinical advisory role. She was redeployed to ICU for 3 months in the first wave, and was redeployed again in the second on a rotational basis.

("COVID-19 Healthcare Worker and Policy’ Project")

**Making sense and appraising in ICUs**

Albolino et al. (2007) identified the intrinsic characteristics of work within ICUs as complex, critical, and uncertain, with ICU staff having to cope with stress on a daily basis. Staff undertook collective sensemaking ‘at intervals’ through formal interactions such as morning rounds, and ‘on-the-fly’ through performing work activities. The ‘knowledge and social cohesion’ built through formal interactions, which were embedded in norms and paradigms of care, created a shared understanding that then supported sensemaking during performance of daily activities (Albolino et al., 2007, pp. 136).

As a novel disease, COVID-19 overturned many of the norms and paradigms that underpinned sensemaking: there were no established protocols and pathways for treatment, and such high patient numbers meant that customary ICU staff-patient ratios for care could not be met. Instead, this intensely difficult work environment led nurses to engage in individual sensemaking by evaluating the threats that events and processes posed to their ‘beliefs, values and commitments’. (Folkman & Greer, 2000, p. 12)

Redeployed nurses performed many different roles in many different ICU spaces, depending on shifting needs. Due to insufficient staff numbers, nurses often worked long hours with few breaks and had to care for multiple patients at a time. Rosario described working 12-hour night shifts where four nurses cared for 12 patients; the allocated break-times were almost completely spent in putting on and taking off PPE. Theresa said her worries about the safety of these ways of working, for both staff and patients, were minimised by more senior colleagues. This unpredictable and chaotic nature of redeployment inhibited the ability of nurses to take ownership of the situation: as Amanda put it, ‘you just follow orders’.

Participants’ expectations of care were particularly challenged by the high numbers of deaths. This was especially poignant early in the pandemic where nurses described that it felt like working in a ‘warzone’: as many treatments were ineffective and multiple new techniques like ‘proning’ (the practice of moving patients onto their stomachs when they are in respiratory distress) were introduced. Participants commonly referred to how they had to simply make do and ‘hope for the best’:

> In terms of treatment and care […] nobody really knows what to do and what to expect and it’s just: look after them the best you can and just hope, really hope for the best. I know that sounds bad but that’s really what’s happening here at the moment.

*(Dylan)*

It was very difficult how every day the memo would change, from using this technique and to not using it, from proning the patient, to not proning the patient and all the medications […]
I would call it like trial and error every time. But we were just hoping for the best [...] Because sometimes proning would be beneficial for this patient but for the other patient it would really mess up the blood pressure, it would mess up everything, so it was very, very difficult.

(Rosario)

The lack of clear guidance and familiarity with the work contributed to feelings of helplessness, extending for redeployed nurses to feelings of incompetence. Nurses voiced feeling conflicted, simultaneously feeling helpless in many ways whilst holding more responsibility. Participants emphasised their lack of adequate retraining and support, and the attendant burden and uncertainty of being charged with monitoring and managing patients who were at high risk of dying. Carmen went ‘from being quite senior and confident in my role [...], to feeling like a student nurse again’. In the second wave, she said that ‘sometimes you might even feel like a burden to the ICU nurses because they have to teach you and that takes time’. Witnessing so many deaths, nurses spoke about the tremendous pressure they felt to keep someone alive:

I think we were just worried about the fact that we could possibly harm others. Just having to deal with the stress and pressure of essentially keeping someone alive when you don’t really [...] it’s sort of like flying a plane and not knowing what to do. You’ve got to sort of land it somehow and save people, but you’re not really given the [...] you’re just given like a bit of guidance, and that’s it really.

(Dylan)

Not only was the scale of death unprecedented but the nature of the virus meant that – even in ICU where death was anticipated – Covid-19 deaths were often an enormous shock.

We had a Rastafarian gentleman [...] a beautiful man [...] somebody brought an iPad, his family spoke to him, however he was not responsive. He had a tracheostomy; he was sedated and paralysed and he had his eyes open, but he wasn’t responding. And I thought, oh how lovely, you know, the family are trying to encourage him [...] And I went for my break and I came back and everything had been switched off and I just was so gutted. I really [...] it really affected me, that. It was really quite traumatic. I didn’t expect it because I thought it was positive having the relatives speaking to him in that way. So, I was totally unprepared for that.

(Amanda)

Other nurses related similar stories of how ‘shocking’ it was, with so much ‘uncertainty’ in a patient’s journey, to have so many patients die both under and outside of their care. Even ‘people who were very young who you thought [...] the chances of surviving was high, but the next shift you’d find them gone’ (Rosario). Carmen describes the high turnover of patients in the ICU – having conversations with patients who were then gone the next time she came in. She then had to follow-up with other nurses to find out what happened to them: ‘I only found out because I asked’. While death was not the primary focus, its continual presence could be overwhelming:

It felt like for weeks all I was seeing was death, and prolonged deaths really because they’re on a ventilator – and it’s not what I’m used to doing. And certainly, that first death where the family weren’t able to be there was probably one I’m never going to forget at all. I think I just cried the whole way home that day. Where you kind of can’t – there’s nowhere to offload, you know?

(Theresa)
What emerges from these accounts is a pattern of nurses failing to find support in sensemaking from the shared knowledge and/or social cohesion that, prior to Covid-19, would have been generated through formal interactions. Instead, they perform sensemaking ‘in crisis’, evaluating the threats and harms against their core values of nursing and caregiving. Dylan’s account of an accidental death illustrates how this impacted his expectations of responsibility and accountability:

[A senior clinician] is putting a tracheostomy at the bedside because he can’t do it in surgery because the theatres are closed and for the real emergency cases only that were still coming in – and then he nicks the artery. This lady bleeds out. They have to open her chest – and then that was it. […] And like: “It’s just COVID”. That’s kind of the thing – in any other circumstance, they would be like: “Why was it done at the bedside? Was the proper procedure done?” […] It was an accident and these things happen. […] But that was just to give you an example of some of the things that would happen, and it was just sort of left. And that was it. You just want to make sense of it all – and you were there, you were trying to assist with them opening her chest and doing cardiac massage and she’s bleeding out quite heavily and you just sort of watch them – you sort of watch their life go before your eyes, just literally within seconds. […] You can just get completely caught and tangled up in your own thoughts, I think, when these things happen.

(Dylan)

Dylan was familiar with the questions that would be asked in normal circumstances if such a tragic accident occurred, but in the absence of such questions being asked he was left struggling to reconcile what he had witnessed with his embedded assumptions about good care. His testimony exemplifies the active, social nature of sensemaking (Weick et al., 2005, p. 419). Further, it highlights how the stress process begins when ‘the person becomes aware of a change […] in the status of current goals and concerns’ (Folkman & Greer, 2000, p. 12). For Dylan, that moment was marked by the artery being nicked during a procedure that was being performed at the bedside rather than in an operating theatre, and exacerbated through his colleagues’ response: ‘It’s just COVID’.

We turn now to explore the coping processes our participant nurses employed.

**Nurses’ coping strategies: problem- and emotion-focused coping**

Folkman and Greer (2000) suggest that the appraisal process discussed above determines ‘the extent to which the situation is appraised as a harm or loss, a threat, a challenge, or some combination of these, and the intensity of the emotion response’ (p. 13). This, in turn, influences coping responses. Folkman and Greer delineate two forms of coping: problem-focused, and emotion-focused, which they assert are associated with higher and lower levels of control respectively. Problem-focused coping involves actions like ‘information search, problem solving, and direct action to solve a problem’; whilst emotion-focused coping involves ‘escape and avoidance, the seeking of social support, distancing, or cognitive reframing’ (p. 13). Redeployed nurses in ICUs working through the pandemic found problem-solving difficult because of the constraints of the situation. They understood what stood as best practice from their own specialities, but in the pandemic context that best practice was often impossible to enact. They voiced the feeling that care was often inadequate and at times unsafe:
We had quite a lot of infection rates and pressure sores where obviously we were not doing the one-to-one [nurse-to-patient care], we were doing one-to-four, one-to-six. And you know, I told you about my anxieties where we weren’t turning people as frequently, because there wasn’t anyone there. […] the infection control just wasn’t there, because we didn’t have the equipment, we didn’t have personnel – each bed space we’d share, all that kind of stuff.

(Theresa)

Theresa points here to the practical limitations and shifting priorities she faced when trying to give the level of care she felt was necessary to patients in the ICU. She described ICU care as ‘task-oriented care’, contrasting it with the ‘holistic model’ she was used to and finds so important. Her responses return to how she felt she was not able to facilitate good patient deaths, saying that in ICU during the pandemic, ‘they’re not lovely palliative care deaths’. Reframing her work environment as ‘war-like conditions’, Theresa draws distinctions between ‘holistic’ and ‘task-oriented’ care; this enables her to create space in which to reconcile these tensions. Carmen too created clear distinctions between the usual level of care she gave and the impossibility of delivering it in the Covid-19 ICU environment. She was particularly struck by procedures that she felt lacked dignity for patients, and was saddened that the priorities of Covid-19 meant that sometimes such things were inevitable. She described situations where she felt the standard of care was not what she would have given in a ‘normal situation’, highlighting competing priorities and tensions between ‘essential care’ for multiple patients, and maintaining a single patient’s ‘dignity’. She described having to hurriedly wash a soiled patient in front of a busy proning team: ‘it was a group of seven people looking at me washing his bum’. Carmen said that this incident of being ‘pressurised’ had played on her mind for a long time, and she wondered how she could have done anything differently: ‘I just felt it was wrong’.

I totally understand that the priority was to turn this patient and make sure that his breathing was okay, and I totally understand that they have to turn a lot of patients and they cannot … I totally understand what the priorities are but, yeah, still. […] When it happened, I couldn’t draw the curtain back because I was keeping an eye on another patient who was intubated.

(Carmen)

Carmen’s experience shows how the drive to save as many lives as possible potentially came at the expense of other important aspects of care. With so many practical limitations – including major staff shortages, staff sickness, and over-stretched ICU capacity (without enough space around each bed), it was not always possible to do all the appropriate procedures.

These accounts speak to the tensions produced by the impossibility of delivering good care in many instances. This continually challenged core professional values of what it means to be a nurse. Nurses engaged in cognitive reframing of the ICU working environment as distinct from anywhere they had worked previously. In the context of this break in the continuity of their experiences caring for patients, participants were able to rationalise their struggle to make sense of their new circumstances. Nurses also reported experiencing intense conflict between the detrimental impact of working on their own physical and emotional health, and the strong sense of duty they felt to
continue their role: ‘I don’t think I can do this much longer – but I don’t think I’m in a position to say, *I cannot do this anymore*’ (Carmen). Life-saving at any cost was key: during the pandemic, ‘the whole focus is on survival’ (Theresa). When deaths happened, nurses described just having to ‘move forwards’ and continue with their work. They emphasised the need, however, to spend time processing these events and to ‘debrief’—opportunities which were not readily accessible at the time. Garros et al. (2021) note how strategies like peer support, reflective discussion, and solidarity in teamwork could support healthcare professionals in coping and building resilience during challenging times.

That’s the thing that we’re not getting. […] It feels like the ICU staff of all the areas really aren’t getting that opportunity to just acknowledge that patient [who has died], where it’s all really tough and really horrible. Wasn’t it really sad that their loved ones couldn’t be there when they died?

*(Theresa)*

Nurses like Carmen grappled with the intractability of the situation they found themselves in when redeployed to ICU. This added significant pressure to nurses who felt an expanded sense of responsibility to give their all, while unable to back off to care for themselves. Dylan notes ‘my role has changed dramatically […] in terms of the level of responsibility, it feels far greater’. ICU nursing was ‘something that I did as a student […] but it wasn’t really for me – and now you haven’t got a choice, you’re in it and that’s it’. Like Dylan, many participants identified exhaustion as a particular challenge.

Compounding these complex tensions, the deaths of fellow healthcare professionals from Covid-19 heightened the reality of personal risk from the virus. Linda had Covid-19 early on and was eventually admitted to hospital. She learnt of nurses’ deaths as she was becoming seriously ill:

You were seeing [on the news] that nurses were dying and I remember saying to [my husband] “I’m in trouble here, I’m really in trouble here”, and I had been hallucinating through temps of 40 and above.

*(Linda)*

Some of the first nurses to die were Filipino, and this affected Rosario deeply.

I was very scared for myself and I was actually scared of contracting the virus but I think personally because I was wearing PPE anyway and I think I did the right hand-washing and I really made sure that I disinfected well, so even though I was scared of contracting the virus, I just thought that I’m doing my part and if it’s God’s will, that he will protect me or to contract the virus, it will be this up to luck or up to chance.

*(Rosario)*

This testimony poignantly expresses the complexity of the real-life interweaving of problem and emotion-focused coping that our nurses were engaged in. Rosario reassures herself that she has taken direct action to address the risks and mitigates her sense of vulnerability in the broader context of her faith and beliefs about Divine destiny. Rosario’s coping response leads us to consider more deeply how nurses engaged in creating meaning out of their difficult experiences.
**Meaning-making and producing positive experiences**

Meaning-based coping processes are motivated in situations where emotional distress and the ‘unresolved problem’ producing the distress are persisting (Folkman & Greer, 2000, p. 13). Nurse participants provided evidence of the important bolstering effects of doing what Theresa describes as ‘really good work’. She cared for a fellow nurse who was in ICU, tuning in to ‘the little stuff’ and finding the moments she spent with her patient, doing these things, immensely meaningful and restorative of her sense of resilience.

She [the patient/nurse] had finally been decannulated – she’d had two failed extubations on the ventilator where she hadn’t managed, and it had just been awful [...] But she finally got decannulated the day before I looked after her, so I was looking after her one day post being able to talk [...] And we just had the most amazing day. Where I was able to give her a shower – she hadn’t had a shower in three weeks, and I went in the tiniest bathroom known to man and the pair of us got completely soaked! I managed to give her this shower, which she just thought was amazing [...] and in the afternoon I actually managed to wheel her outside in the wheelchair and she was able to Facetime her family from outside the ICU, and looking at the sky. Oh, it was just the most amazing day for everyone [...] everyone was coming over and ‘oh my goodness’. You know, it just lifted us all up. And that’s what you have to remember: days like those. I suppose, where you know there was a reason why we did it, and it has helped.

(Theresa)

For this patient, Theresa engaged other ICU staff in wider meaning-making to compile a ‘little diary’ for the patient, who did not remember very much about her time in ICU: ‘I got all the staff to write something that had happened or a memory’. These meaningful bolstering moments for Theresa and other nurses helped them to reframe their experiences around their core values of nursing and caregiving: ‘I think once you start seeing that [the recoveries], then you kind of think: okay, I can do this for another day’. Rosario drew on her religious faith to shape her response to her fear of catching Covid-19, engaging in further, reflective meaning-making about her experience of caring for a patient who died from Covid-19 as being ‘fated’:

Maybe this is why this profession chose me. It was for this moment in history. It was for one person’s life. Maybe I was meant to save Peter. Or maybe I’m meant to just stay beside him and not let him die alone. Either way, after all is said and done, as countless tragedies have consistently proven, we are at our best when we care for others.

(Rosario)

One of the most distressing aspects nurses expressed in the interviews was the absence of families around the dying patient. That absence created an emotional void for patients that nurses had to mitigate as best they could. The ‘hardest thing’ for nurses, said Linda, was that patients were dying ‘scared’ and without their family with them. This was ‘draining’ because it meant that it was impossible to give ‘the best care that you can’. In the early stages of the pandemic she was told to spend a maximum of 10 min in a room with a patient before having to come out to change her PPE and then go back in. She describes caring for ‘a wee, elderly gentleman’ who was dying. Linda took a phone into the room so he could say goodbye, but as his condition deteriorated she found it impossible to follow the rules.
That’s not right. Do you know what I mean? The family should be there holding their hand and supporting them, and we’re watching the gentleman deteriorate over the next half hour, and I was like, I’m just going to go in and sit with him, ‘cause you can’t leave somebody dying on their own, and the staff were like that, but, but ... you can’t. Ah, and I was like that, ‘I am not leaving ... I went into the room, I did have full PPE on, I was totally protecting myself, protecting my family. The gentleman passed away, like, about five minutes after I went into the room, without his family round about him. [...] At the height of the pandemic, nobody was allowed near the hospital, so these wee souls were dying with a stranger holding their hand, or, in some cases, nobody holding their hand, so I think we’re all feeling a bit drained.

(Linda)

The absence of families also blurred the distinction between a professional nursing response to dying and a more human, personal responses.

What I mean is when you see the patient just as a patient, just as a case, it’s more easy to deal with the patient professionally, like you are treating the patient as a patient not as a human. But during COVID, it was really tested on me because I would see all the writing on the wall, all the facts, letters for the COVID patients [...] the family pictures, and it would break my heart every time, and I would just like to pray for them, hold them and make them feel at least that someone’s there taking care of them. I can’t explain the feeling.

(Rosario)

Rosario’s impulse to touch, talk to and pray for her patients was also influenced by her concerns about her mother in the Philippines.

I would just think about I’d like someone to care for my mother [living in the Philippines] obviously when she’s sick and I’m not there, I was just trying to be that someone for them when obviously no one was there for them except for the nurses and the doctors.

(Rosario)

She also felt a special bond with Filipino patients.

I had a Filipino patient who was there also, he was intubated as well and I would talk to him all night, even if I know he couldn’t hear me and it really broke my heart because the next day that I came to work I learned that he passed away.

(Rosario)

These bolstering experiences and moments of meaning-making helped nurses to combat what was ‘surreal’ about their day-to-day lived realities (Amanda). Amanda reflected on how difficult it was for people outside the NHS to appreciate the realities of ICUs and her fears that it will all be forgotten once the pandemic is over:

I don’t think most people realise the conditions [staff] have to work in. [...] you see pictures ... I don’t ... even my family, you know. I tell them what it’s like and you can understand up to a certain extent but I don’t think people realise what it really is like, it’s hellish [...] you know, the other day I just took a picture of my scrubs completely sodden with sweat and I just did that because it’s so surreal. I’ve never worked in such conditions. And we will forget unless ... I haven’t got much hope that things will improve.

(Amanda)
The redeployed nurses we interviewed demonstrated the need to record their experiences as a way of making them ‘real’, impactful, and meaningful as part of reflecting on and learning from them. That need to record took different forms: Amanda taking photo of herself in scrubs; Rosario taking a photo of her face after removing her mask; and Rosario writing the story of a patient who died, trying to find a broader meaning for herself. All these are strong examples of how meaning-making coping enables ‘a psychological “time out” from the distress and motivates further coping’ (Folkman & Greer, 2000, p. 13).

**Conclusions**

We have used detailed qualitative interviews to explore the work done by redeployed nurses in ICUs, integrating sensemaking and theories of coping to create a theoretical frame within which to understand our data. Our results explicate some of the mechanisms and processes through which these redeployed nurses negotiated and performed their roles, especially in relation to end-of-life situations. The combined effects of these nurses’ unfamiliarity with ICUs, and of having to care for high volumes of patients suffering and dying from a new disease without established treatment protocols and pathways, uniquely challenged their sense of identity, duty, and purpose. They experienced profound exhaustion from long, intense shifts in which they lacked time and space to perform care as they would wish, and they felt tremendous pressure to keep patients alive in the face of so much death. These factors produced intense cognitive dissonance.

Pre-Covid-19, Albolino et al. (2007) showed how the routines and working patterns in ICUs enabled collective and social processes which shaped and informed sensemaking during the performance of work. However, our participants did not describe any similar opportunities for sensemaking interactions. Further, they did not find many opportunities for problem-based coping, so many being intractable: the volume of patients, relentless disease trajectory, staff shortages. Emotion-based processes became a primary means of coping, particularly those that created distance between past and present experiences of nursing: e.g. contrasting ‘task-oriented care’ to ‘holistic care’, and Covid-19 deaths to ‘lovely palliative care deaths’. Wartime was also a common metaphor for expressing acute differences between past and present working conditions.

We have nevertheless shown how our nurse participants made positive meaning and derived strength from intimate moments with patients, such as washing them as they were recovering or holding their hand as they were dying. This deeply personal and positive meaning-making when caring for all patients, whether surviving or dying, underlines how curing and caring are equal values embedded in nursing roles which embrace the trajectory of life. The circumstances of Covid-19, which meant families were absent when patients died, led to nurses responding as fellow human beings, rather than as professional caregivers. Adding weight to their responses was the awareness that they themselves were as vulnerable to the virus as their patients – as were their loved ones.

Our findings here support earlier studies, including Maunder’s (2004) review of the psychological impact on health workers during the 2003 SARS outbreak in Toronto, which identified the benefit derived from the opportunity to reflect on experiences. Highlighting positive aspects of how nurses coped with the Covid-19 pandemic in a Chinese hospital, Sun et al. (2020, p. 597) found that nurses reported a sense of ‘growth under pressure’, and that
this had an important role in helping them maintain their mental health. Notably, nurses fed back to us that the process of participating in our research projects and having the time and space to reflect on their experiences was itself of high therapeutic value in meaning-making. The title of this paper itself comes from the feedback that Amanda gave after undertaking her interview. It expresses both the pain and value of remembering and reflecting.

Pre-pandemic literature highlights the particular challenge presented by managing deaths and dying patients in ICU settings, which focuses predominantly on life-saving. This literature details moral injury and suffering for health workers in ICU. Scholarship is now emerging on the trauma experienced by health care workers during Covid-19, and studies of redeployment highlight the need to address common fears around access to appropriate resources; virus exposure at work and becoming a vector for family; ‘support for personal and family needs as work and demands’ increase and the ability ‘to provide competent medical care if deployed to a new area’ (Shanafelt et al., 2020, p. 2133). Here, we establish how nurses experienced high stress from the absence of broad social and organisational systems of support, exacerbated by frequent changes in rota allocations to different parts of the hospital. In future crises, integrating opportunities for collective reflection and sensemaking from the outset may dilute some of the consequences of trauma for health workers.

In addition to this practical learning for future emergency responses, our findings also contribute to sensemaking and coping literature. We contribute to an understanding of what happens to sensemaking in ICUs during periods of crisis, when established macro-level frameworks and mechanisms that underpin the safety and quality of care are disrupted. Opportunities for collective sensemaking at intervals are few, and unfamiliar processes undermine sensemaking on-the-fly. By showing how sensemaking and coping is enacted at individual levels through micro-level behaviours, we identify a new form of sensemaking ‘in crisis’ that establishes the critical contribution of core professional identities and values in emergency situations. In the absence of a collective safety-net of protocols and practices, nurses were able to survive their experiences by drawing on embedded values of curing and caring.

Moments of meaning-making with patients bolstered nurses’ feelings of motivations, resilience and coping and reinforced their core values of nursing. More research is required to explore whether these responses were similar to those of other health workers working in ICUs, such as doctors and allied health professionals. As more evidence emerges of the trauma experienced by health workers during Covid-19, and support packages such as counselling and therapy are rolled out, we suggest that it will also be valuable for nurses and other health workers to participate in collective sensemaking and reflection on the most challenging health emergency of our times.

Note

1. Ethics approval for the ‘NHS Voices of COVID-19’ project was given by the University of Manchester’s Research Ethics Committee (Ref: 2020–2463–16644). All interviews were conducted remotely using telephones and digital recorders approved by the university. Ethics approval for the ‘COVID-19 Healthcare Worker and Policy Project’ was granted by the Medical Sciences Interdivisional Research Ethics Committee at the University of Oxford (R69302/RE001). All interviews were conducted online on digital platforms approved by the university.
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Data Availability Statement

Due to the nature of this research, participants of the ‘COVID-19 Healthcare Worker and Policy Project’ study did not agree for their data to be shared publicly, so supporting data is not available. The ‘NHS Voices of Covid-19’ collection of interviews will be available at the British Library during 2022.

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