

# The lived experience of nurses transitioning to professional practice during the COVID-19 pandemic

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## Abstract

As a result of the COVID-19 pandemic, newly graduating nurses have entered into rapidly changing clinical environments, experiencing healthcare in a manner for which they were not fully prepared. The purpose of this study is to describe the lived experience of these newly graduated registered nurses (RNs) who transitioned to practice during the COVID-19 pandemic, and to gain understanding of how to better prepare future graduates for similar situations. A multisite qualitative phenomenological design was used in this study of 12 frontline nurses that graduated in the spring of 2020 and transitioned into their new role as RNs. A trained research team conducted semistructured interviews and completed a thematic analysis of the data. The results were six themes that emerged from the study participants' interviews: (1) fear, (2) emotional conflict, (3) self-doubt, (4) alone, (5) communication barriers, and (6) finding the positive.

## KEYWORDS

COVID-19, nursing, pandemic, qualitative research, transition to practice

## 1 | INTRODUCTION

The cohort of newly graduated nurses of 2020 entered the nursing profession during the time in which the world was learning together at a rapid pace about a disease that was previously unknown and causing illness and death at a pace the healthcare industry was not prepared to encounter. There were significant limitations to these new nurses' preparation for practice. Some nursing students were unable to complete their final clinical experiences in person and in many cases, new nurses had a limited orientation in their place of employment. It became evident that these challenges, upon entering practice, were taxing to both personal and professional wellbeing with the potential of long-term effects.<sup>1-4</sup> It is vitally important to seek an understanding of the lived experience of this cohort of young professionals and to plan for optimal preparation for those who will follow in the nursing profession.

## 2 | VULNERABLE NEW GRADUATE NURSES

Multiple studies before the global COVID-19 pandemic have highlighted the significant stress associated with the first year of nursing practice in the hospital environment, regardless of preparation, hospital size, or clinical experience acquired before graduation.<sup>5-7</sup> How or if these data have changed since the beginning of the pandemic has yet to be determined.

Limited studies have been published looking at the new nurse onboarding and experiences during the COVID-19 pandemic. A study by Garcia-Martin et al.<sup>8</sup> found that recent nursing graduates transitioning to practice in an emergency room in Spain during the pandemic experienced fear and anxiety associated with the unknown, lack of experience, as well as the vulnerability associated with the fear of infecting loved ones. A recent study by Naylor et al.,<sup>9</sup> looking at novice nurses' experiences while providing care for COVID-19

patients, reported themes including dealing with death, personal protective equipment (PPE), high-acuity care with limited training, difficulties being short staffed, everything is not okay, support for the healthcare team, nursing school preparation, and lastly, affirmation of choosing the nursing profession. This study found anxiety, depression, and posttraumatic stress disorder in some of the interviewees and suggests nursing educators may benefit from incorporating psychological interventions into nursing education curriculum. Another qualitative study by Sessions et al.<sup>4</sup> investigated new nurses' experience in a similar timeframe caring for COVID-19 patients in a hospital setting. Similar themes emerged including uncertainty, vulnerability, and resilience. As valuable research regarding the experiences of this cohort of novice nurses is reported, it is important to note the similar and dissimilar geographic locations, demographics of the participants including educational background, and the healthcare environments in which they practice.

### 3 | PURPOSE

The purpose of this study was to understand the lived experience of new graduate nurses that entered nursing practice in the spring of 2020. It is important to investigate whether new nurses lacking a firm professional foundation will have requisite coping and resilience skills to persevere and build productive healthy careers, while maintaining mental and physical wellbeing. This is an important consideration for the future of the nursing profession.

### 4 | METHODS

This multisite qualitative study used an interpretative phenomenological approach to explore the lived experience of new graduate registered nurses (RNs) in two tertiary hospitals in the rural Upper Midwest region of the United States. The phenomenological approach seeks to uncover the common meaning from several individuals related to a lived human experience.<sup>10</sup> The research questions for this study were:

1. What is the lived experience of newly graduated RNs who transitioned to practice during the COVID-19 pandemic?
2. How does the meaning of the lived experiences of newly graduated RNs impact nursing knowledge and preparation of future graduates for similar situations?

Approval was obtained from the Institutional Review Boards of the health organizations where the study was conducted. Core ethics of the research process were followed throughout the process, ensuring safety and confidentiality and anonymity of the participants. Numbers were assigned to interviews and corresponding transcripts; names of participants were not used. The researchers used purposeful sampling to recruit eligible, consenting participants. The study participants were recruited from both hospitals' nurse

residency programs, as both cohorts met the inclusion criteria. The participants were aware of the institutional affiliation of the study team members through the recruitment information they had received. Unique identification numbers were assigned to audio recordings of the interviews and corresponding transcripts to protect confidentiality, including keeping the participants deidentified from the other research team members.

Eligibility requirements for inclusion in the study were (1) nurses working on an adult unit with patients diagnosed with COVID-19; (2) graduated from a baccalaureate registered nursing program in the spring of 2020. Exclusion criteria included nurses that only worked in the float pool, those from a travel agency, or had taken a leave of absence.

#### 4.1 | Data collection

The phenomenological approach was used to elicit the meaning of the phenomenon being studied.<sup>11</sup> Interviewers underwent training on the phenomenological perspective and interview techniques. Interviews were conducted by four of the five research team members. Demographic data were collected at the time of the interviews, which were conducted in a private area in the hospitals or academic facility. A brief introduction occurred at the beginning of the interview, and any questions that the participants had were addressed at that time.

Unstructured interviews were conducted with the primary question presented to the study participants of: What has it been like for you to transition from a student role into your first registered nurse role during the COVID-19 pandemic? The interviewer asked the participants to discuss using this open-ended question to allow the interviewee, rather than the interviewer, to determine the content discussed.<sup>10</sup> Follow-up questions and probes were used to delve deeply into the phenomenon and to allow the participant to discuss their experiences fully.<sup>12</sup> The interviews were audiotaped and transcribed by a secure online transcription service. The interviews varied in time from 20 to 67 min with an average interview time of 46 min. Single interviews provided adequate data. No attrition of participants occurred.

#### 4.2 | Data analysis

Verbatim transcripts were analyzed for accuracy, patterns, and themes using an iterative format according to phenomenological methods to enhance the reliability of the data.<sup>11</sup> The authors immersed themselves individually in the data, identifying essential characteristics from each interview during self-reflection to ensure validity of the data.<sup>10</sup> This was followed by data reduction and line-by-line coding. All authors then met together, themes were identified and validated as a group over several data analysis sessions, allowing for reflection and discussion, to ensure scientific rigor and triangulation of the data.<sup>10</sup> Additionally, the research team kept an audit trail

of evolving perceptions, procedures, and methodologic decisions made during data analysis. After initial data analysis began, three more interviews were conducted to ensure data saturation. At this point, there was cessation of emerging themes. Consensus among the research team was reached on themes and subthemes.

## 5 | RESULTS

Descriptive statistics using percentages, means, and SDs were used to describe the demographic characteristics of the participants. A total of 12 female nurses with baccalaureate degrees completed the interview process. The average age of the participants was 23.25 years (SD = 0.54). There were 5 (41.7%) participants who reported they were able to complete their senior-level internship/preceptor experience completely in person before graduation, while the remaining nurses ( $n = 7$ , 58.3%) completed some of their hours in person, due to the shift of nursing education programs to online learning. The majority ( $n = 8$ , 66.7%) were hired onto medical surgical units, with a smaller number ( $n = 4$ , 33.3%) that designated the Intensive Care Unit (ICU) as their home unit. The majority of the nurses ( $n = 11$ , 91.7%) completed more than 20 shifts caring for patients hospitalized with COVID-19. Of the sample, no participants had previous experience with epidemics or public health-related crisis situations.

The participants transitioned into their new role as RNs during a significant surge of the COVID-19 pandemic in this rural geographic area. The nurses were consistently 10–12 months into their practice during the time of the interviews in July and early August 2021, at which time COVID-19 cases in the region were waning. When asked about their lived experience of transitioning to professional nursing during the pandemic, participants responded in ways that reflected their personal experiences and response to the events of this time period. The main themes of fear, emotional conflict, self-doubt, alone, communication barriers, and finding the positive were evident as they described their lived experience of transitioning into their new nursing practice.

### 5.1 | Theme 1: Fear

**Definition:** “An unpleasant, often strong emotion caused by anticipation or awareness of danger.”<sup>13</sup>

The study participants had a common theme of fear in the descriptions they provided of transitioning into practice during the COVID-19 pandemic. Their perceptions were coupled with strong emotional experiences where they were overwhelmed and encountered many unknowns during their professional transition. As one participant remembers, “...I just want to emphasize the fear of the whole thing... the fear of taking patient loads that you're not comfortable with, seeing things that you're not comfortable with day

after day, and knowing that even though I'm not comfortable with this, I have to do this. But if I mess up, I might lose my license... I was afraid every single day for months...”

Within the theme of fear, participants voiced a subtheme of overwhelmed. Participants were overwhelmed with the complexity of care and the changing dynamics of the clinical environment and their patient's conditions. Additionally, some units implemented a patient care delivery model of “buddy nursing” that these nurses had not experienced in nursing school. “Buddy nursing” was an intervention utilized by the hospital systems to support the work of the understaffed nurses, by moving nurses from noncritical, or less busy work environments to support the nurses caring for critical patients with COVID-19. Transitioning to this type of practice in a pandemic was overwhelming. “I had six or seven patients during the day shift on a very busy floor with a buddy nurse, but my buddy nurse couldn't really hang medications and... it was overwhelming because [the patients] were more sick than I've ever seen in my entire life.”

Additionally, a subtheme of unknown was voiced by the participants. As new graduate nurses, they did not have a depth of experience in basic patient care to provide a foundation of knowledge, which contributed to the feeling of unknown. Some participants found themselves newly out of orientation in an ICU environment taking assignments typically given to experienced nurses. “I was just scared...when we're intubating we paralyze and then our plan is to prone immediately... Except in that moment, I didn't know how to do that.” For some participants, it was basic management of high flow oxygen that was essential knowledge for management of patients with COVID-19. “I hadn't reviewed oxygen levels for a long time and I didn't understand the meds we were giving necessarily... I tried to understand, and I felt like every single shift I'm trying to Google to understand heated high-flow... [I was] turning up a level on something that I don't even really understand how it's functioning for them or their lungs. I just know this is the only knob I can touch, and I'm just turning it up because they're dipping.” The majority of participants reported that their orientations included basic nursing care typically required prepandemic for their home units. They reported not having experience with patients diagnosed with COVID-19 until they were off of orientation and practicing independently. Refer to Text Box 1 for further study participant quotes.

### 5.2 | Theme 2: Emotional conflict

**Definition:** “...mental struggle resulting from incompatible or opposing needs, drives, wishes, or external or internal demands.”<sup>13</sup>

An overarching theme of emotional conflict was present in the interviews. While this conflict was present in a variety of situations, a predominant experience verbalized by these new nurses was feelings of conflict associated with accepting patient assignments they did not feel prepared for and perhaps did not feel safe with. One of the new nurses stated, “How do they even trust me with this... what am I doing risking my license right now? Because this is on me, this is an

**BOX 1 Quotes related to the theme: Fear****Overwhelmed**

- “As a new nurse, people are just handing me meds from outside their room and the doctor just said over the screen what I was supposed to give and I'm like, I've never done this before. I feel I don't know what I'm doing...I think I just felt like overwhelmed and unprepared and scared and didn't know what to do.”
- “And then in November is when the COVID cases really started to kick in, and it became extremely exhausting and fatiguing.”
- “I remember the first time I took a BiPAP patient that was really on a significant amount of oxygen...a respiratory therapist was in the room and I said...”I don't even know how to turn up a BiPAP machine. Can you show me?” Like, “What do I look for?” And I remember feeling overwhelmed in the moment...”

**Unknown**

- “I had no idea what to do, no idea what supplies to grab, nothing, and so I was just scared.”
- “I think that there's still times now that I'm not the most prepared nurse to care for a patient, but it doesn't mean I'm not going to do a good job... [the patients are] scared, and secretly I'm scared too. I don't really know what's happening.”
- “[The mental stress] got really, really bad when I would show up, not really knowing what to do...I would have four intubated patients with a buddy nurse. Whether that may have been a NICU nurse, or a med-surg nurse, or someone out there who is willing to help me, when frankly I don't even know what I'm doing...it was like the blind leading the blind... These ratios are so unsafe. What am I supposed to do when two of my patients desat at the exact same time? Or deteriorate, something happens, they get hypotensive at the exact same time. What do I do and I have four people on ventilators?”

assignment I accepted. I always thought if you don't feel safe you don't have to take the assignment... and I couldn't say no.”

When discussing emotional conflict or decisioning, feelings of guilt arose. The participants voiced guilt, the second subtheme in this category, as the experience of perceived shortcomings, such as not being able to spend enough time with patients who had no other human contact, expressing feelings that the care given was inadequate. One participant expressed: “...in the moment, I was terrified. I thought, I screwed up. I'm done. This is it. I did four years of nursing school, now my first week off [orientation] and I killed someone... I wasn't able to do enough.” Although the patient died, it was clarified in further discussion that it was due to complications of the disease, not inadequate care.

The second subtheme that emerged is public/community perception. The dichotomy of information and disinformation infused in public perception has created challenges to healthcare professionals, and the level of distress to these new professionals was apparent. “...when we tell people that COVID is serious...we get laughed at...I don't want to speak to my extended family anymore

because they... say that COVID doesn't matter and refuse to wear masks...refuse to get the vaccine. It sucks, it's really hard.”

Secondary trauma is the third identified subtheme. It is defined by Figley<sup>14</sup> as “the stress deriving from helping others who are suffering or who have been traumatized” (p. 2). Although not quantifiable by this study methodology, the participants described experiences consistent with those noted in secondary trauma, including but not limited to mood and sleep disturbances, intrusive thoughts, feelings of decreased connection with their patients. “...I feel we, as new grads have... become a little bit hardened...zipping up body bags, seeing people die left and right... I feel disconnected when my patient passes. If I was more connected would it cause more emotional upset, am I heartless and just have no feelings? That's kind of traumatic stuff.” Refer to Text Box 2 for further study participant quotes.

**5.3 | Theme 3: Self-doubt**

**Definition:** “A lack of faith in oneself: A feeling of doubt or uncertainty about one's abilities, actions, etc.”<sup>13</sup>

Feelings of self-doubt were expressed frequently throughout the interviews. “... I remember being hit [by it], I'd had that patient the day before and he had passed [overnight]... it was very emotional; it makes you start to question... did I do all that I was able? Did I do everything that I was trained for or if he would have had a different nurse, a more experienced nurse, would he have had a different outcome?” It was apparent throughout the interviews that as they were growing into their careers, there were times that the questioning and growth could not be adequately supported by the healthcare team. As this nurse states, “...I think I was riding a very very careful line every day that I showed up to work, between feeling confident in my abilities to take care of these people and this [situation being] beyond what I am comfortable pushing... mental health and career wise...” Refer to Text Box 3 for further study participant quotes.

**5.4 | Theme 4: Alone**

**Definition:** “Separated from others; exclusive of anyone or anything else.”<sup>13</sup>

Study participants often felt alone and shared their perceptions that patients also were alone due to family and visitor restrictions. A contributing factor to feeling alone was related to the restricted number of staff in the rooms of patients that were COVID-positive. These restrictions were initially in place to conserve personal protective equipment (PPE) and later for infection control purposes. A participant described, “...it was such a lonely time for the patients and for the staff, because it's so draining to be there physically and mentally.” Another participant remembered, “...one of the most challenging things that we faced was just how much the patients felt isolated and how much we as nurses felt isolated.”

## BOX 2 Quotes related to the theme: Emotional conflict

### Guilt

- “[I had] misplaced guilt that I wasn't saying the right words, or feeling like I wasn't able to listen or really be present with patients when I was the only contact that they had. But, I also had 500 other things that I need to do.”
- “I felt guilty even describing the situation to people because I didn't want them to know that there were people in the hospital that weren't safe being cared for by me... I want them to feel safe when they come to the hospital. “
- “I felt like I wasn't doing enough for them,... leaving work I was unsettled, because I didn't feel like I made a big enough impact on them, because I know they're lonely.”

### Public perception

- “... we were talking about how many nurses left the floor during COVID... because they couldn't take it. He said basically something along the lines of, Soldiers don't ask for it either, but they keep their head down and do their job'.”
- “[I was] going home for Christmas... was so hard for me because I would have people that were so blunt that would be like, “Do you not want to have kids someday? You got vaccinated?” Like, “Why? Do you not care about your future? Do you not care about how this is going to affect you?” There was such a gap of what I saw and what they saw. And I had people say that to my face. And that was really hard.”
- “So living [where I lived] most of them thought that masks were dumb, vaccines were dumb and that COVID was non-existent. And so I was so frustrated and angry and so worn out that I just was more frustrated with my community, even that so many people were denying this thing that I was constantly struggling with.”

### Secondary traumatic stress

- “I think [this] has fundamentally changed me as a person, as it made me a good nurse. I think I'm a good nurse, but there are definitely times where I just feel less empathy towards people than I used to. And that scares me, that scares me a lot.”
- “...I feel we, as new grads have kind of become a little bit hardened, just with having this first year experience... zipping up body bags, seeing people die left and right...I feel disconnected when my patient passes, just kind of like, Okay, this is just another... It's more like a task to do all the post-mortem things...if I was more connected would it cause more emotional upset.... Am I heartless and just have no feelings? That's kind of traumatic stuff.”
- “I knew that If I would've felt every death I've ever had, like deeply, I don't know if I would go back to work because it's sad... I feel cold almost, like, “Should I still... I don't feel super affected by this. Should I? Am I heartless and just have no feelings?”

Participants voiced their concern for the patient's mental well-being as a result of being alone in their rooms while being so ill. One nurse recalled taking care of a patient whose husband wasn't able to be with his dying wife, “...that was the worst situation, it was people not being able to see their loved ones...these patients are isolated and

## BOX 3 Quotes related to the theme: Self-doubt

- “... I wasn't familiar, I wasn't confident, I was scared. I remember going into the bathroom that night, I hadn't sat down till 3:00 am, it was a night shift. I hadn't sat down once, and I finally got to go to the bathroom and I just bawled my eyes out. I was questioning everything that I was doing...”
- “... I remember I'd had that patient the day before and he had passed [overnight]... it makes you start to question... did I do all that I was able? Did I do everything that I was trained for or if he would have had a different nurse, a more experienced nurse, would he have had a different outcome?”

by themselves, and we're isolating them more by them not seeing their friends. FaceTime can only do so much. Having someone there to actually hug you and holding you is a huge difference.” Another nurse stated: “...It's very anxiety causing. They can't see their family...And you're just there. And you can't touch them because you have to have your PPE on. And so it was just so lonely.”

The participants also described how the requirements of patient isolation contributed to the experience of feeling alone when providing care. One participant, when recounting a rapid response, described how the response team left the patient's room after the patient was more stable. “I felt scared... I was stuck in there because of the whole precaution, closed-door thing...I wanted someone to stay with me and stay for longer... I just felt abandoned... I was just afraid and felt alone and felt like no one could hear me or listen to me...the video call was super short and once it shut off my communication with the doctor was over, and I was still in the room, and he was gone. All the nurses were gone.”

Participants also described how the experience affected their mental wellbeing and left them feeling alone. When talking about the decision of whether to seek counseling, a participant recalled, “I would just come home and sit in my apartment and I would just stare at a wall ...it felt like I was calling out into the void. I know there's help out there, I know that I could talk to somebody about this. But I can't get to that. I can't reach them.” Refer to Text Box 4 for further study participant quotes.

## 5.5 | Theme 5: Communication barriers

*Operational definition derived from the voice of the participants: situations or items that cause difficulties in verbal and nonverbal communication.*

The participants expressed challenges that were encountered due to communication barriers. Infection control precautions and wearing PPE created communication difficulties between providers, patients,

**BOX 4 Quotes related to the theme: Alone**

- “without having visitors, it was such a lonely time for the patients and for the staff, because it's so draining to be there physically and mentally and take care of them”
- “I tried to stay in there, as long as I could to give these patients some hope. Because they were just so alone.”
- “And I would love to sit in my patient's room and talk to them and help them not feel so lonely and isolated in their room, but you can't do that. That's not reality. You have other COVID patients that you need to go see, and all these other meds, and it's not always your priority, which is hard.”
- “I just felt so alone. I don't know how to describe it. Just being the only one in the room, because I feel like the PPE was a barrier to other people coming in with us as well as just covid, why the doctors didn't come in and so I just felt a little bit helpless and alone standing next to my patient.”

**BOX 5 Quotes related to the theme: Communication barriers**

- “... you wanted to call families and update families, but a lot of times you didn't have the answers. And a lot of times you just frankly did not have time in your day, other than once a day to call families, because they're not there and they're not seeing.”
- “I've seen patients die in ICU (looking through a] glass window and their family is on the other side. Nothing prepares you for that.”
- “Sometimes it was really nice just to have an N-95 because you don't have to try and finagle to get to your ears with the stethoscope, but the PAPRs are really nice because they can see your face. They can see you smile. They can see you in the depths of the emotion that they're feeling, which I think was huge. Just knowing that someone was there and someone cared.”

and family members. A study participant described these feelings when providing care for an unstable patient, “no one else can pop into my room...[it] felt like this [computer] screen is all I have to communicate to the outside world of what's going on with my patient.”

The participants were concerned for the mental wellbeing of their patients due to the lack of family presence and the need to keep the family apprised of the patient's condition,

... you would have tons of phone calls all the time, or several phone calls from the same family member. And you want to be able to communicate with them as best you can, and it's understandable that they're worried about their family that they love, but you can't be sitting on a phone call with a family all day.

The required PPE, including the hooded powered air purifying respirator (PAPR), acted as a physical barrier to communication with patients and other staff. It also impacted nurses due to weight, noise, and length of time wearing the garb. A nurse described the impact of PPE, “Let alone what it did for my relationships with my patients and not being able to communicate with them... Even being able to hear them, I'd be holding the sides of my masks together to try and hear them and yelling through. Just the barrier that created for our communication and my desire to just converse with my patients... definitely made it so challenging.” Refer to Text Box 5 for further participant quotes.

**5.6 | Theme 6: Finding the positive**

*Operational definition derived from the voice of the participants: reflecting on an event or events in time and noticing positive feelings or outcomes.*

Among the stories of fear, fatigue, and self-doubt the participants shared learnings of their experience. In reflection, this cohort of nurses was able to identify areas of professional growth and team support that carried them through some of the most unimaginable times. A collective theme shared among the group was the ever-growing support for one another and the team response they felt amongst their units. A participant shared, “Using all the resources you can get, and being open with your team, and having a lot of teamwork, because I think that's what got me through COVID, and all my coworkers through COVID, is we had a really good team.”

The nurses shared that the primary reason for agreeing to working extra shifts was to support their coworkers and team. The semantics of team, teamwork, and support arose repeatedly in the interviews. The participants wanted to give credit and praise to the nurses they worked alongside stating “...it was very affirming just knowing that I made it through all those really tough days and that as a team, we all came together and made it through. I'm very, very, just impressed and as I look back just shocked at how much we all managed to learn and go through as a team.” The newly graduated nurses discussed all they had overcome in a short time to care for complex patients. One participant shared the personal growth stating, “...I think just making it through something like that makes me feel stronger as my identity as a caregiver, and I feel more well-rounded as a caregiver because I've had to go through something where I did feel super uncomfortable. I've gone through something that was super hard to adapt to.” Working through a pandemic presented new challenges but also opportunity for growth. “It gives me more personal confidence in my ability as a nurse. It's a little bit of a title too, it's a badge of honor, like I was the COVID nurse. I survived COVID nursing.”

Along with expressing pride in their teams and profession they also shared the feeling of pride in their endurance. Many of the participants also stated that they were unlikely to remain in their



current roles, although not necessarily leaving the profession; citing job stress as the primary cause. Refer to Text Box 6 for further participant quotes.

## 6 | DISCUSSION

There is minimal data regarding the experiences of this cohort of new nurses in the midst of the global COVID-19 pandemic. The study participants voiced gratitude for the opportunity to talk about their experience, some stating that it was the first time they had the opportunity to “tell their story.” Hearing the voices of this cohort is essential to creating meaningful support for professional retention and continuation of a safe healthcare environment.<sup>3,9,15</sup>

The theme of fear was related to feelings of professional inadequacy as participants were placed in situations they did not feel adequately prepared to handle. Naylor et al.,<sup>9</sup> in a similar study of novice nurses in urban southern region of the United States, had a similar finding. A study by Frawley et al.<sup>1</sup> studied the experience of nurses across the spectrum of age and experience noting fear in this group of participants to be primarily related to becoming infected or potentially infecting others. Although fear is likely to be a feeling of most, if not all bedside nurses during the pandemic, the focus of the fear may vary for the novice cohort who have not had the opportunity to develop a firm professional foundation before their pandemic experience.

Fear has been identified as a driver of secondary traumatic stress (STS).<sup>16</sup> Although quantifiable data are not available in this study, there was evidence within the interview data that fit criteria of STS. The participants verbalized experiencing intrusion, recurrent and intrusive distressing recollections, and avoidance which is described as avoiding stimuli associated with the patient situations, and numbing of responsiveness, all consistent with STS.<sup>14</sup> According to Orrú et al.,<sup>14</sup> nurses who are more involved in direct care of these patients were at higher risk of STS and associated psychological

consequences. There are concerns that the identified experiences of this cohort of nurses will lead to professional burnout; however, burnout is understood to be a multifactorial entity that occurs over time and therefore was outside of the scope of this study.

The theme of emotional conflict was pervasive in the participant interviews. Several of the participants reported feeling a lack of voice in patient assignments. Their perception that they were not prepared to manage either the acuity or patient volume resulted in emotional conflict. This emotional conflict can lead to moral distress, characterized in Hamric<sup>17</sup> as being unable to take morally justifiable action towards an ethical endpoint. Lake et al.<sup>2</sup> investigated moral distress in a group of RNs who were frontline caregivers during the pandemic and concluded the unique features of patient care in this pandemic generated moral distress.

Although self-doubt can be considered relatively common for nurses and other professionals in the novice states, the circumstances this cohort experienced referenced the gravity of the pandemic environment they faced as new graduates.<sup>4,9</sup> Self-reflection of most novice healthcare professionals will lead to feelings of self-doubt; however, the extremes experienced by this cohort due to the severity of the illness and quantity of patient deaths were emotionally illustrated in the interview responses. Whether it was experienced more intensely than previous years seems likely due to limited preparation for what they were introduced to upon entrance to practice.<sup>4,9</sup> Further elucidations on this question can be expected as new research on the experiences of nurses with and without experience during the pandemic continues to be evaluated.

The theme of alone has not been previously identified in the literature. This theme was heavily supported by the participants' descriptions of their experience. Participants included feelings of being alone in patient rooms with inference of a sense of isolation from colleagues and support. They also verbalized experiences of not being supported in communities where COVID-19 was not believed to be a problem, leaving them with feelings of being alone. They also identified how painfully alone their patients were without family allowed to be present, and the associated distress of these nurses not being able to be as present as they wished to be due to heavy workloads. This cohort had not had time to develop the collegial and professional support that comes with time and experience in healthcare, likely intensifying the feelings of being alone.

Communication barriers may have contributed to the participants feeling alone. Participants described the inability of team members to enter patient's rooms necessitating virtual conversations with physicians, even during crisis. The isolation practices and intensity of the PPE impacted the nurse's ability to fully interact, in some cases to hear or be heard during patient communication was perceived as stressful and isolating. Due to infectious concerns, patients in isolation had only virtual communication available to communicate with their families, if the patient was critically ill the nurse was the facilitator of difficult conversations. The impact of this barrier caused additional stress to these new nurses with limited experience for these complex situations.

### BOX 6 Quotes related to the theme: Finding the positive

- “... I think just making it through something like that makes me feel stronger as my identity as a caregiver, and I feel like more well-rounded as a caregiver because I've had to go through something where I did feel super uncomfortable. I've gone through something that was super hard to adapt to.”
- “and having a lot of teamwork, because I think that's what got me through COVID, and all my coworkers through COVID, is we had a really good team.”
- “You can do hard things. We can do hard things. Things that are more difficult than any of us have ever imagined possibly happening in our lifetime.”

Finding the positive was noted in the participants verbalizing being proud of the nursing profession and their own personal accomplishments in the midst of the pandemic. They also voiced being exhausted and being unsure if they would be able or willing to endure going through this type of overwhelming experience, such as another COVID-19 surge again. In spite of the challenges discussed, the overwhelming sentiment regarding the participant's commitment to their career was positive, the predominant overall regard for the profession was pride and feeling as though they had chosen the right profession. Study participants verbalized the importance of supportive co-workers and their ability to find strength from one another; this concept correlates to mental wellbeing, and as such their ability and desire to continue in their current profession and roles.<sup>3,9</sup>

The majority of participants stated that they did not intend to stay in their current positions. One participant had already transferred to a nursing position on a different unit due to the level of stress caring for patients with COVID-19. The majority stated they intend to go back to school seeking advanced practice nursing positions in the near future. This finding correlates to the study from Frawly et al.,<sup>1</sup> pertaining to novice nurses in Ireland, finding that both work stress during the pandemic and perception of clinical competence negatively correlated to intent to stay in bedside nursing positions.

It is apparent that there are similarities in the transitional experiences of new graduate nurses from previous years. When looking more deeply at the quotes from this cohort, their experience has an intense and deep emotional component that comes from witnessing traumatic illness and death that resulted from this pandemic. Further clarification of transition to practice differences between this cohort and previous cohorts may occur as more data are gathered. This new knowledge may assist in determining best practice to adequately support new nurses as they enter practice. As one participant stated, "We're going to be great nurses at the end of this, but God, at what cost? At what cost?"

## 7 | RECOMMENDATIONS

The following recommendations come directly from the participants who lived through their transition to professional nursing practice during the pandemic. The participants unanimously recommended that mental health support be more visible and accessible in the practice setting. Additionally, the nurses recommended that academic educators revise curriculum to enhance the mental preparation and resilience that students will need to transition to practice in the aftermath of the pandemic. Participants also wished that the orientation they received on their unit of hire had better prepared them to meet the changing needs of patients. The participants desired taking higher acuity patients during their orientations to experience the care process alongside their mentors during orientation.

At the time this manuscript was written, there were no published studies conducted in the rural Upper Midwest on this topic. Strengths of this study include data saturation from rich

interviews from participants eager to describe their experiences. This study also uncovered new knowledge of the theme of alone. The results of this study add to the growing body of data being published to achieve a deeper understanding of the experiences of this cohort. A limitation is differentiating the emotions felt by the study group compared to new graduate nurses who transitioned before the pandemic. Another limitation is the gender and ethnic homogeneity of the study, having only white female participants. Though there was research team consensus of the study findings, it is difficult to achieve complete bracketing of bias by the research team who experienced transition to practice in a stable healthcare environment void of a pandemic.

In conclusion, the experience of newly graduated nurses transitioning to practice during the pandemic in rural America is not well understood. It is becoming increasingly evident as research is reported that healthcare providers involved with care of the patient with COVID-19 are at risk for levels of mental stress and trauma, rarely, if ever, experienced in healthcare. The mental wellbeing of nurses who are living through this unprecedented global healthcare crisis must not be ignored or forgotten. Strategies to prepare for high-stress clinical settings must be developed within academic institutions and in healthcare settings. These strategies will support nurses, for the wellbeing of the nurses as well as the communities they serve. Future studies are recommended to elucidate the mental, emotional, and moral impact of the pandemic on this cohort of nurses.

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## DATA AVAILABILITY STATEMENT

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

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