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Adaptation of the ICU Nursing Team Working During COVID-19 Pandemic: Qualitative Focus Group Analysis

Sigal Shafran-Tikva[1], Julie Benbenishty[2,*], Naela Hayek[3]

[1]Director Nursing Research and Innovation, Hadassah Hebrew University Medical Center, Kiryat Hadassah, 12000, Jerusalem, Israel
[2]Hadassah Hebrew University Medical Center, PO Box 12000, Ein Kerem, Jerusalem 91120, Israel
[3]ICU Division Supervisor, Hadassah Hebrew University Medical Center, Jerusalem, Israel

***Correspondence:** Julie Benbenishty, RN PhD, Academic Consultant, Hadassah Hebrew University Medical Center, PO Box 12000, Ein Kerem, Jerusalem 91120, Israel, Tel: 972507874009; E-mail: julie@hadassah.org.il

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Abstract

Background: Throughout the COVID 19 pandemic ICU nurses globally, have suffered from anxiety, stress, and depression due to high workload, insufficient personal protective equipment, lack of knowledge of the pathogen, and direct contact with patients. Leadership action is needed to assess and care for nurses' mental health and wellbeing. Nurse leaders need to use innovative strategies to sustain and support nurses.

Objectives: To analyze interventional action of structured social support provided by nurse division leader to critical care nurses between first and second COVID 19 wave.

Design and Methods: Focus groups of intensive care COVID 19 nurses "free speech open conversation" platform exploring Logistical, Clinical, Emotional challenges of working in intensive care COVID 19.

The data collected through focus groups from participating ICU nurses were analyzed using a categorization technique that made it possible to broadly reflect participants' perceptions and experiences.

Results: Group participants included 15 nurses, 4 males. Before COVID 19 working in Respiratory, Medical, Cardiac, and Neurosurgical intensive care units. All found that working in a non-organic team, unfamiliar environment, treatment plan uncertainty, non-standardize treatment, difficulty in clinical decision making, family pressures from home and families of COVID 19 critically ill patients' stress, compounded the difficulties of daily work. Positive outcomes included post COVID 19 return to original unit viewed as heroes and much knowledge and respect acquired. The relationships developed in original unit were not as close as those working together in COVID 19.

Conclusion: As a result of these sessions, conditions were changed and improved. This reflected that the nursing administration seriously listened to the nurses and took their recommendations earnestly.

Keywords: Intensive Care; Intensive Care Nursing; Leadership; Management and Organization of ICU; Professional Issues; Support Workers in ICU

INTRODUCTION

The COVID 19 pandemic is creating stress in the general population, but healthcare workers who were already at high risk of stress, burnout and suicide before the pandemic began are experiencing even more stress [1].

Throughout the COVID 19 pandemic ICU nurses globally, have suffered from anxiety, stress, and depression due to high workload, insufficient personal protective equipment, lack of knowledge of the pathogen, and direct contact with patients [1-4].

It is necessary to implement interventions that help detect, assess mental stress among ICU nurses in the long term. Nurses' stress is a complex problem that must be addressed by combining interventions based on communication, teamwork, meditation, and/or mindfulness that have been proven to be effective [5]. Protecting the mental health of ICU nurses is a priority for policymakers. The impact of the current crisis on the mental health of nursing staff is likely to be unprecedented [6].

Organizations need to assess and care for their staff's mental health and wellbeing during this pandemic [5]. Prevention and mitigation is far more important than cure. Nurse leaders need to be innovative in activating system and individual level strategies to sustain and support nurses [7]. These leaders can mitigate pandemic-related stress issues including anxiety due to the risk of infection, moral injury; providing safe and quality nursing care for patients with COVID-19 and end-of-life care as needed; dealing with relatives who cannot be present, and care for grieving relatives and colleagues [7]. Nurse managers who want to lead and support their staff through the pandemic must ensure nurses security, safety, and mental balance to ease anxiety and strengthen well-being. Leaders must be proactive in initiating support interventions with empathy and confront the sources of nurses' anxiety and provide concrete organizational solutions supporting the bedside ICU nurses [7]. A Canadian study seeking to support health care workers during the first weeks of the COVID 19 outbreak initiated eight listening sessions (involving a total of 69 individuals) Found that the participants expressed a desire to be supported by their organization through open communication, transparency, comprehensive organizational risk assessments, sufficient and appropriate staffing and ongoing psychological support [8].

BACKGROUND

In our urban Israeli university-affiliated level 1 institution during the initial wave of COVID19, ICU nurses were overwhelmed with anxiety. There were a few clues that the ICU division nurse leader recognized as extreme anxiety, for example-an an overload of telephone calls all hours of day and night to the ICU division supervisor. These telephone calls consisted of communication of difficulty with coping, inability to complete nursing tasks, the dissonance between efficiency of work in general ICU and COVID 19 ICU to name a few. Nurses expressed disillusionment with their own capabilities, despite being charge nurses with decades of work experience. Bedside nurses, clinical instructors, deputy head nurses as well as ICU physician administrators all communicated different aspects of distress, stress, and the overwhelming sense of loss of control and deterioration of professional morals.

Leadership action was needed in order to allow a legitimate arena for expression, to share experiences with each other, promoting social support to achieve positive outcomes, preventing burnout, and leaving the profession. Another important mission was to weed out problems that can be solved, improve conditions wherever possible and prepare for the next wave of COVID 19.

Social Support received by nurses in the workplace from supervisors and coworkers is found to play a fundamental role in preventing burnout [9]. However, to date the bibliography on this issue is scant, and there is little consensus as to the degree of social support received. Burnout prevention plans, with attention to social support, should be developed to improve nurses' quality of life and to enhance the care they provide.

The relationship between burnout and a deterioration in the quality of nursing care provided has been highlighted in previous research [10,11]. Among factors that enhance resistance to burnout are certainly personal and occupational resources, which tend to strengthen personal commitment, foster positive results and raise the efficiency of nursing staff [12]. One such resource is the presence of appropriate leadership providing emotional social support.

Conceptually, Social Support is defined as assistance and protection given by others. It may be formal (immediate supervisors) or informal (family, coworkers). Four defining characteristics of Social Support have been described: emotional support, which is related to affection and includes attitudes such as attention, trust, empathy, civility, and affection. Instrumental support, that is, the provision of tangible goods or services or specific assistance; informational support, or the provision of information in times of stress. Evaluative support, by which information is provided to enable self-assessment [13].

Very few studies have been conducted on the Social Support received by nurses, although various papers have focused on the support that patients need from those who attend them. Among various aspects of interest in the study of burnout is the relationship between the development of the syndrome and the lack of social support perceived by professionals who experience this condition [14].

Aim

The current study aim is to explore the adaptation of the ICU nursing team working during the pandemic using focus team forum groups provided by nurse division leaders to ICU nurses between the first and second COVID 19 wave in an urban level one medical center.

DESIGN AND METHODS

Setting- ICU division nurse administrator decided to initiate a "free speech open conversation" team forum. An invitation was sent via email and WhatsApp media to all ICU nurses in an urban level one medical center. All nurses expressing intent to attend received notification of dates, times, and place of meeting. In this medical center, the ICU COVID 19 nursing teams were comprised of nurses from all the critical care units in the hospital (pre- COVID 19, there existed 5 different ICUs. Once COVID 19 ICUs opened, the staff were pulled from "home" units to create new teams in an old abandoned section of the hospital, where 5 COVID 19 departments and ICUs were created). Nurses expressing interest in participating in the free speech open conversation focus group session replied to the ICU division leader. The division leader responded to each nurse individually explaining the process, rules of focus groups, and that the session would be recorded and used for research. Each nurse could opt-out or consented to participate at this point. Nurses were excused from clinical duties in order to participate. The groups included all nurses, regardless of seniority from all the ICUs at the medical center- Open heart ICU, Cardiac Intensive Care, General ICU, Medical ICU, and Neurosurgical ICU.

In preparation for the team forum, the division administrator requested the assistance of a neutral (non-ICU nurse) research nurse to join the managing of the meetings.

In order to avoid the open conversation team, focus group from becoming a chaotic complaining session, the administrator and researcher team decided to focus on professional work experiences. The research question posed to the group was "Please share your experiences with the working conditions and patient care in the COVID 19 ICU?" The nurses participating in the free speech team focus group met twice. This study is an analysis of conversation content and climate during these meetings.

Method

All team focus group sessions were tape-recorded in the native language spoken in this country- Hebrew. Two researchers listened to the recordings repeatedly to analyze the content. An independent researcher transcribed all the recordings into English for using quotations as citations in this text. Pseudonyms for participant narratives citations are used in the text

The data collected from all team forums were phenomenologically analyzed. In this study, we have chosen phenomenological methodology since this method seeks to describe the essence and deep meaning of working in ICU COVID 19 known through nurses' senses rather than by thought or intuition. We seek to explore this situation by using narratives of nurses experiencing this phenomenon. In our study, we wanted to examine how nurses expressed their sense of being while working in COVID 19 units.

Institutional Ethical Approval was Granted

The content analysis of the phenomenological methodology process began with a rereading of the texts received from the transcript performed (transferring the recording to a WORD file) from all the interviews as well as a re-listening of the recordings [15,16].

Re-listening to the recordings allowed the researchers to recreate the energy and atmosphere that prevailed in the room during the team forum session. The repeated readings provided a broad and comprehensive orientation of the information, even though this is not an initial encounter with the data. In addition, during the reading and listening of the recordings, the investigators underwent a thought process of organizing the data and all the material collected to create a possible narrative.

At the initial reading stage, no categories were built, however, a deep conceptual understanding was made using the descriptive information of the participants, a careful examination of words and concepts as well as an inquiry of questions. The continuation of the analysis process was performed using references to each group as a single analysis unit without binding to the sentence or paragraph structure. Later in the analysis, the expressions used by the participants were re-referenced accurately. The analysis of the text was performed by writing categories in the margins of the text, where sometimes the category name relied on the answers of the participants and sometimes on the questions asked, depending on the content uploaded and the researchers' understanding. Subsequently, a secondary content analysis was performed that included associating content to parent categories, a secondary categorization. Categories written in the margins of the text formed the basis for constructing the category table that will be presented later in the findings section.

In the second stage of the analysis, the categories were mapped. An examination of the initial categories and creating connections and relationships between the categories were reduced and sub-categories were built from them. This resulted in the development, consolidation, reduction, and redefinition of the initial

categories. Towards the end of the categorization process, associating all the statements into categories, re-examining the sub-categories in the table, and finding the connections between them, main categories (parent domains) were identified that will be presented in the findings section.

We emphasize that the analysis principles described above were performed in the same way for each team focus group and only after the initial and secondary analysis of each group and the mapping of the categories was the consolidation of all the categories from all the groups into one category table. The findings section will present the entirety of the content analyses that were performed.

The way the content analysis findings from the team focus groups were presented was complex, mainly due to the difficulty in selecting the "non-quoted" citations. It is possible that this difficulty was mainly due to a load of significant and relevant information received. The findings will be presented continuously, textually, bringing in substantial citations, from the different groups and representing different perspectives of each group. The purpose of reporting the quotes is based on the desire to maintain authenticity and to convey the spirit of what was said in the group, as much as possible. In order to maintain the anonymity of the participants, as promised to them, each group member was given a number. General findings, atmosphere, and group management will be presented as well.

Findings

The participants voiced many views, perceptions, and experiences. The themes identified are Logistical challenges, Clinical challenges, and Emotional experiences. Each of the themes contains a few sub-categories.

The average age of study participants is 38.6, average time working as an ICU nurse, 11 years. The study included 4 male and 11 female nurses. Regarding the distribution of place of work prior to COVID 19: 5 nurses from Respiratory ICU, 4 from Medical ICU, 3 From Neurosurgery- open heart ICU, and 2 from Cardiac critical care (Table 1).

Logistical Challenges: Themes and Categories.

Human resources: Because of the highly contagious conditions that COVID 19 pandemic dictated work environment, unfamiliar logistical circumstances arose. Physicians and nurses who normally do not work as a team were scheduled together and met for the first time bedside the patients. This forced the nurses to deal with critically ill patients- and unfamiliar "leaders" simultaneously. This non-organic team also included nurses from other ICUs as well as nurses never experiencing ICU conditions or patients before the current shift.

P1 "resource allocation of nurses was terrible no one came to relieve me for a break. If I go out for a break someone must watch my patients- break time not defined how much time can I take – not comfortable to take too much time. - I

Table 1: Demographic distribution of study participants.

Nurse	Age	Gender	Years nursing	ICU before COVID19	Post graduate ICU training
P1	37	F	3	*RICU	YES
P2	26	M	2	+ICCU	NO
P3	38	F	10	^MICU	YES
P4	49	F	25	#NICU+@CSICU	YES
P5	26	M	3	MICU	YES
P6	46	F	12	RICU	YES
P7	58	F	20	NICU+CSICU	YES
P8	33	F	5	MICU	YES
P9	32	F	5	RICU	YES
P10	38	F	15	MICU	YES
P11	59	F	30	RICU	YES
P12	25	M	2	NICU+CSICU	YES
P13	55	F	24	RICU	YES
P14	25	M	2	ICCU	NO
P15	31	M	6	NICU+CSICU	YES

*Respiratory Intensive care
+Intensive cardiac Care
^Medical Intensive care
Neurosurgical intensive care
@Cardiac Surgery intensive care

had to take care of 4 ventilated patients with a nurse from the surgical department. Staff- not enough numbers but also not proper experience"-

P2- "All the time I worked with nurses who did not know how to work with ICU patients. People called in sick and no one wanted to replace them".

These narratives emphasize the nurses' feelings of abandonment and lack of direct leadership. At the end of this team forum session the division leader present, directed a change in work schedule, training, and supervision of all staff working in the COIVD 19 unit.

Equipment and Environment

The COVID 19 ICU was created in an old abandoned part of the hospital. Up to date monitors, computer documentation, patient space was extremely limited compared to normal ICU standards, ICU computer systems could not be applied in this provisional environment.

P3-" I didn't know where to undress or dress? When I had to start resuscitation, I didn't know where the cart is- where are the drugs? I am a lousy nurse".

"Why didn't I have proper pillows for prone? So many patients got bedsores because the equipment was lacking".

P4- - "no proper equipment—or organization of equipment, could not find oxygen regulator, there simply were none! - Not enough drugs- not enough fentanyl. I cannot nurse! -at least 3 hours I did not change my gloves. No justification for us to work this way".

P4-" in the beginning I had to ask for Personal Protective Equipment (PPE) suits all the time- it took a lot of time for the organization to realize how much PPE we needed"

Equipment and environmental adjustments and explicit protective dress instructions were made immediately after the team forum sessions.

Clinical Challenges

Treatment plan: The trained ICU nurses are familiar with treatment plans and protocols and they could independently carry out ventilation weaning, sedation vacation, and many other familiar routine standard tasks. In this new reality, nurses are thrown together to work in the pandemic crisis forced to deal with treatment plan uncertainty, non-standardized treatment, difficulty in clinical decision making, and unknown treatment approaches.

P5- "Narcotics- should be double-checking this was not upheld in COVID 19 ICU. I tried keeping all the standards- but I felt that I was the only one-I asked many other nurses during the shift. I didn't know who the charge nurse was during my shifts"

P6 " no monitors outside of rooms so when I had to prepare syringes, I had to quickly grab the drug and equipment and prepare everything inside the room where there was not enough space. I found a patient at the beginning of my shift without fluids- I could not investigate why this patient is not receiving fluids; who decided this? Why did this happen?"

P4- "I was working with physicians who could not decide how to care for patients. They let SAO2 get to 79% for hours. In the end this physician was removed from working in the ICU".

As a result of these narratives, the nurse leader revised drug preparation areas, performed daily narcotic surveillance checks and documentation, and worked closely with the senior physicians.

Teamwork

Teamwork is essential when working in ICU. The need for belonging, that is, to feel a part of a cohesive team with shared working objectives. It is known throughout the literature that ICUs are becoming increasingly complex, and to function effectively within these environments, nurses need to work in a collaborative and supportive manner [16]. In circumstances that the contribution of each health care professional is acknowledged and understood at an association level, this provides a more robust infrastructure to support a commitment to these concepts at a unit and practitioner-patient level [17].

P2-"I always thought that teamwork is so important- after working in COVID 19 unit everything is different- in the beginning of the shift and I was in charge I saw the other nurses didn't want to work here. - I have to work with nurses who I don't know who they are and what they know- after I finished a shift- I was thankful that I am a survivor".

P5- "teamwork was great! – All of a sudden I found syringes were prepared without asking anyone".

After these team forum sessions, interventions were implemented promoting team cohesiveness.

Emotional

The emotional stress of working with patients suffering from COVID 19 was overwhelming. In this investigation, the emotional burden is categorized by stress associated with family life and originating from work-related variables. The lack of knowledge and experience about

the disease is one of the principal sources of anxiety expressed by study participants. Critical care nurses may be particularly affected by severe emotional distress, which has been associated with the development of compassion fatigue, and/or burnout [17,18], caution against ignoring vicarious traumatization caused by the COVID-19 pandemic.

Personal and Family

P5–" my parents didn't want me to work in the ICU COVID 19. They warned me, they were frightened for me- eventually, they understood my need to go. After many weeks of working, I finally only went to visit them after I did a COVID 19 test – I had to fast during Ramadan – I understood that this work was meaningful, and I was proud of myself that I donated" –

P3- "I also left my first shifts crying- my kids comforted me"-

P2- "At home, my husband says I've never seen you cry so much".

These narratives symbolize needing family support conflicting hesitancy in potentially infecting those providing support.

Work-related

P4- "I've been a nurse for 40 years – I lost all my morals and values. I felt a severe lack of knowledge about COVID 19 and how it affects patients. I didn't know what to do to help. If I am broken, think of all the young nurses- this should not have happened".

P2 –"I can't sleep at night. I told my husband- give me chamomile- I felt afraid that I wasn't the best nurse I could be. During my 2nd shift, I began to try to de-stress myself by deep breathing exercises- I need the patience to recruit myself; to admit even more patients. Everyone understood that this place is only GIVING- no complaints no drinking because you can't go when you need to the bathroom- all my needs are put away. The first 2 weeks I worked all the time- my heart is broken. In my Neurosurgical ICU, I am a fish in water- in COVID 19 I am in the desert- no friends, no telephone no contact to the outside world".

P2- -" I see all the COVID 19 ICU nurses broken. They are the strongest nurses and they are all broken. What kind of nurse am I if my patients die without saying goodbye to their family- my dying patient had a phone ringing in his clothes and he died and I did not answer the phone? During my break, I went out of the ICU to talk with the families".

P7- "excuse me that I am crying- I have the feeling that I am caring for patients alone- this is a feeling that never leaves me- I cared for a 50-year-old patient in a prone position not ventilated she was hungry for air, for human touch for her family".

These emotional accounts highlight the significant need of these nurses to share their stories and support each other as well as asking for support.

In the summary of the social support sessions, the session organizers asked for the participants to share positive experiences.

P5 –"After I worked in COVID 19 and returned to ICCU, I returned as a hero and have much more knowledge- and I am respected much more. The relationships I developed in the Intensive Cardiac Care Unit were not as close as those working together in ICU COVID 19".

P4- "I met new people felt that we were generous to each other- even when in normal times the ICUs are a little in competition- brothers and sisters in crisis".

As a result of these sessions, conditions were changed and improved. This reflected that the administration seriously listened to the nurses and took their recommendations earnestly. In addition, the organization offered free psychological and psychiatric consultation for any hospital worker requesting such assistance. Many nurses received months of mental health relief from the psychologists employed at the hospital free of charge and anonymously.

RESULTS and DISCUSSION

The aim of this study is to analyze focus group narratives of ICU nurses between the first and second COVID 19 wave in an urban level 1 medical center. The aim of the ICU nurse division supervisor leading these groups gained a deeper understanding of the lived experiences and challenges of the bedside nurses.

ICU nurses will continue caring for COVID 19 patients throughout the coming years. Understanding the complexities of providing care for this multifaceted population during pandemic times is essential to sustain our working force and ensure quality care delivery. Previous studies have examined the incidence of psychological outcomes and their associated risk factors among healthcare workers during outbreaks of infectious diseases. A Chinese study surveyed 85 Chinese ICU nurses looking at psychological stress found a wide range of stress manifestations, including decreased appetite, fatigue, difficulty sleeping, nervousness, frequent crying, and even suicidal thoughts [19]. The authors recommended addressing the psychological

problems of ICU nurses who care for patients with COVID-19 and take action as soon as possible to relieve the psychological pressure on these nurses. Early data quantifying the Italian ICU nurse workload when caring for COVID 19 patients by using the Nursing Activity score show that the nursing workload in COVID-19 patients is dramatically increased [20]. Applicable, suitable, and focused interventions are needed to sustain our ICU nurses' emotional and mental health status and reduce persistent psychological which is common and found in previous epidemics such as Severe Acute Respiratory Syndrome Coronavirus 2002 and the Middle East Respiratory Syndrome Coronavirus 2012 [21,22]. The investigators in the current study aimed to examine ICU nurses experiences with the working conditions in the COVID 19 ICU, providing nursing care to COVID 19 patients and feelings about working with COVID 19 patients. In addition to this examination, interventions were implemented to improve the working conditions, solve difficulties with the provision of nursing care and establish a team forum to ventilate their feelings. There have been many papers published exploring ICU nurses' stress and anxiety during COVID 19 [1-4,6]. Some papers provide evidence-based recommendations for relieving these symptoms [7,12,13,16]. However, few studies have been published regarding focus group studies investigating nurses' experiences. One Canadian study using 8 focus group "debriefings" including nurses, senior physicians, and residents during the first week of the COVID 19 outbreak. The investigators found that health care leaders were able to create solutions to challenges raised in the participants' narratives addressing their concerns, therefore, providing support to their health care team [8]. The authors concluded that although health care professionals don't expect leaders to find solutions for all the clinical problems but having them ask, listen, and acknowledge requests is appreciated [8].

The nurse critical care division supervisor leading this team focus group supported the anxious bedside staff by actively listening, reflecting, and performing improvement changes. It is in her authoritative power to make changes and demand improved conditions. In order to alleviate stress by reducing the challenges found in this study, many changes were implemented. Between the first and second COVID19 wave non ICU staff was provided with extensive, comprehensive training, facilities were changed (instead of 4 ICU patients occupying 1 room, reduced to 2 patients per room, break time was defined and nurses were relieved from their bedside duties and daily updates between staff and administration were initiated).

The study participants related their breakdown in morals, emotional state, and professional de-evaluation with each other as a sounding board as well as with a leader with the power to make a change. Our findings support previous publications which report concerns of ICU nurses that uncertainty that their organization will support/take care of their personal and family needs if they develop infection [23-25]. In addition to supporting other personal and family needs. As work hours and demands increase, non-ICU nurses have to function as ICU nurses, and lack access to up-to-date information and communication [23,24]. Regarding professional de-evaluation, a Chinese qualitative study exploring experiences of involvement in the COVID-19 on the professional identity of nurses also found that working during the current pandemic had overall a negative influence on the professional identity among nurses. They suggest that perhaps the negative impact of work-related experiences on professional identity will change over time, and still needs to be explored in future longitudinal studies. Teamwork is intrinsic in establishing positive ICU working conditions. In the study hospital setting, during COVID 19 teams were undefined and changed every day. In the current pandemic, ICU nurses work on new units and experience heightened role ambiguity. It is especially important that team members feel they can ask questions or provide critical feedback, as psychological safety helps prevent medical errors and improves the team's ability to develop creative workarounds for problems [8,25]. Lack of familiarity with team members and role ambiguity is likely to impede trust initially, leading to increased difficulty developing cognitive and affective trust down the road [26]. For health care teams, role stressors can differentially impact affective and cognitive trust. Though unfamiliarity may impede affect-based trust, members' lack of expertise is more likely to impede cognitive-based trust [27].

LIMITATIONS

This was a qualitative single-center study. Some of the issues raised were specific to the environment of this organization. The nurses in this institution share the same organizational culture, which might not be generalizable to other hospitals and other COVID 19 ICUs. Not all nurse managers share the same philosophy as the manager in the current study. There might be some biased in those nurses attending the team forum sessions. As these nurses who are willing to share their experiences. We do not know the feelings and perceptions of those nurses not participating in the sessions and therefore data might be missing. However, the method of nursing administration

leading team forum groups of bedside nurses has had many positive implications. In addition, the original intent of this study was simply to create a safe environment for nurses to share their COVID 19 lived experience and to explore the phenomenon through their narratives. As the narratives developed, the nurse leader was compelled to make many workplace changes. This was not the original motivation for performing this study.

Finally, there are limitations to content analysis using phenomenological methodology regarding credibility and reliability; as it is the researcher's responsibility of convincing oneself and one's audience that the findings are based on the critical investigation. There are no substantial tests for reliability and validity. The researcher in this study might have been biased, or her presence potentially influenced the participants' narratives.

IMPLICATIONS and RECOMMENDATIONS for PRACTICE

During this devastating health crisis ICU nurses have been particularly affected by stress, social and familial isolation, workload challenged, and impacted negatively. Nurse leaders need to be proactive in relieving these burdens and demonstrating compassion. Active listening and, promoting free speech are paramount in supporting our nurses. Nurse leaders can gain insight into the experiences, sources of stress, and challenges facing bedside nurses through focus groups.

CONCLUSION

This pandemic has had an overwhelming impact on ICU nurses. COVID-19 has generated a mental health emergency. The lack of knowledge and experience about the disease is one of the sources of anxiety. Logistical Challenges of equipment and environment, the Clinical difficulties including treatment plan ambiguity, unstable teamwork, and the emotional burden of personal and professional morals and values, all play a heavy burden on the ICU nurses working with COVID 19 patients. As a result of the interpretation of these data findings from this study, the nurse division leader initiated several changes in the COVID 19 environment. The two focus group sessions provided support for the frontline nurses; a secondary benefit occurred when nurses realized that changes and improvements were made in the COVID 19 ICU between the first and second waves as a result of their speaking out in the focus groups and sharing their experiences.

DECLARATIONS

Conflicts of Interest: Authors declare no conflict of interest.

Funding: None.

Complete Ethical Information

This study did not include patients; therefore, a patient informed consent is not relevant.

The institution review board of the medical organization granted approval to conduct this study.

We did not use any material from other sources.

Availability of data and material: The raw data transcript into a word document and is available.

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