Nurses' Extraordinary Experiences During the COVID-19 Pandemic

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There was Something in the Air

By

Kirsten B. Smith, Paula M. Gabriel,
Margaret Mullen-Fortino,
James R. Ballinghoff and
Pamela Z. Cacchione

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This work is a composition of nurses' stories during COVID-19. It is dedicated to all the courageous nurses at Penn Medicine and all the nurses around the world who endured a pandemic and provided care for patients and their families with dignity, respect, and compassion.

The world is forever indebted to you.

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COVID-19 AND THE YEAR OF THE NURSE AND NURSE MIDWIFE

PAMELA Z. CACCHIONE,
PHD, CRNP, BC, FGSA, FAAN

The year of the Nurse and Nurse Midwife was a year of loss, grief, and pain
It was also a year of unconditional love, faith, and hope
A year like no other in our lifetime
Preparation, personal protective equipment, and teamwork was not enough
Changing Guidelines, N95 mask use and reuse, no humidification- yes humidification
Left nurses on edge.
Nurses showed up and sweat through their PPE
Nurses gowned up and prayed
Prayed for and with their patients
Nurses provided hope and a healing touch
Nurses wore emotional armor to walk through the doors for one more shift
Nurses cared
Nurses cried for and with their patients
Nurses were lifelines for families in the face of death
Nurses celebrated the birth of a baby
Mourned the loss of a mother
Nurses sacrificed time at home with loved ones and answered the call
Witnessing death after death
Being present for each patient so they were not alone
Postmortem care took on a new reverence
COVID showed no mercy
Nurses were not immune they too contracted COVID
We lost many
Surviving nurses met challenges with ingenuity and courage
Nurses embraced solutions – vaccines, masks, social distancing, and herd immunity

Nurses fear a maskless society - they are not ready
Nurses selflessly provided care, emotional support, patience, and understanding
Now is the time to help them grieve, heal, and grow
The Year of the Nurse and Midwife was a year like no other
Nursing and Nurses will never be the same

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INTRODUCTION

KIRSTEN SMITH,
MSN, RN, ACNS-BC, ATCN

"Over the years, nurses have contributed to some of the world's most important public health achievements. They have enlisted and pitched in during all major crises, including natural disasters such as hurricanes and floods – and epidemics and pandemics" (Nissen, 2020).

Globally, nurses are widely credited with the sustained mass immunization campaign which led to the eradication of smallpox, the only human disease ever to achieve that distinction. However, throughout history, there have been many other wars against disease in which nurses have supported similar immunization campaigns: against cholera, diphtheria, measles, mumps and rubella, hepatitis A and B, and H1N1, among many others (Nissen, 2020).

That sense of selflessness is embodied in Florence Nightingale, now known as the founder of modern nursing, who was born on 12 May 1820 - making 2020 the 200th anniversary of her birth. She came from a wealthy family and defied all traditions of the time to become a nurse and take care of strangers. During the Crimean War, she went to the frontlines to determine why most soldiers were dying. Through her pioneering use of medical statistics, she was able to uncover that the primary cause of death of soldiers was due to infection resulting from unsanitary conditions. From this, she gained a platform that led to national attention on public health (Nissen, 2020).

Today, nurses are waging war worldwide against COVID-19, a foe as formidable as any in recorded human history. Under levels of duress more likely to be felt in a battle setting, nurses are staffing hospitals and clinics, pulling long shifts, wrestling with trauma and exhaustion, and putting themselves at risk of infection to care for people in need (Nissen, 2020).

Nurses remain the most trusted profession, with 78% of U.S. adults currently believing nurses have high honesty and ethical standards (Brenan & Jones, 2024).

However, what is often less recognized, and what COVID has brought into sharp view, is the ever-evolving, ever-expanding role of the nurse in

the healthcare system—a trend that is accelerating with this pandemic. It is fitting that in a year in which the vital role nurses play has come into focus, the World Health Organization (WHO) designated 2020 the *Year of the Nurse and the Midwife* (Nissen, 2020).

At Penn Presbyterian Medical Center (PPMC) in Philadelphia, Pennsylvania nurses were paying close attention to what was happening in Europe and then in New York City. It was very scary, we knew the virus was coming, just not when and how severe the effects would be.

Penn Medicine was ferociously preparing for the worst: rapidly spreading education, stockpiling personal protective equipment (PPE), and creating plans to keep staff and patients safe.

Once COVID "hit," the first patients we received, landed right in critical care. There was the first patient, then five, then units began to fill up. Over roughly two and a half years, nurses fought a war against this pandemic. This was something none of us had ever experienced. Nurses provided care to the sickest patients they had ever seen. Treatment was unknown, and we did the best we could.

My husband Chris is a nurse in the Surgical Intensive Care Unit (SICU) within the Penn Medicine system. His unit became a COVID unit for 2 years. We watched COVID rapidly spread through Europe and then New York City. We knew its appearance in Philadelphia was imminent. We decided to send our beloved son Braeden to New Mexico to be with Chris's parents for a while, since it was not as severe out West, yet. He spent 3 months there. It was a very difficult decision, but we were both nurses who needed to be in the hospital caring for our patients and our staff. Most of all, we wanted to keep our son healthy and safe.

My husband Chris worked in a COVID ICU. Early in the pandemic he shared with me his experience with one of his patients who died. She was a young Jewish woman, a mom in her 40's. Her family was not with her. She succumbed to COVID due to what we call in medicine "end organ failure." The team did everything they could to resuscitate her, but the physician called the code, meaning they stopped resuscitation efforts after the ICU team had done all they could.

In the moments after, one by one the team left the room, except for Chris. He was raised Roman Catholic and knew little about the Jewish faith. Still, he felt she should die with dignity. Chris went to the computer in the room and searched "Jewish death prayers." A few came up, he chose one, he sat at her bedside, held her hand and recited a Jewish death prayer for her. As he was talking, tears streamed down my face. I told him how proud I was of him and that he is truly a wonderful nurse.

Next, I thought: if my Chris has stories of his experiences with patients with COVID, there must be so many other stories out there that need to be told. It was important for me to share nurses' experiences and stories and pay tribute to them for their amazing work during COVID. I spoke with Chris about my idea and suggested debriefing sessions, something my friend and colleague, Paula, and I, are skilled in. But Chris suggested that we should just provide a safe space and let them tell their stories in their own words. Thus, we embarked on a qualitative study and interviewed 25 nurses from Penn Presbyterian, while COVID was still considered a pandemic. These are their stories. Some of their names have been changed on their request. But the stories are real and often raw. We hope after you read this book you will share our admiration for these nurses and for nursing as a profession.

FOREWORD

THE CHIEF NURSE EXECUTIVE PERSPECTIVE

JAMES BALLINGHOFF,
DNP, MBA, RN, NEA-BC

"Hardships often prepare ordinary people for an extraordinary destiny."
— C.S. Lewis

It was scary, extremely daunting, and yet also inspirational, for me to experience the COVID-19 pandemic as a nursing leader in the medical profession. At the time, I had been in the Chief Nursing Officer role for eight years and had been in the nursing profession for 25 years. Although there seems to be a never-ending series of challenges facing nursing leaders, I would never have anticipated what we would come to experience.

When I first started hearing about patients showing up in New York City (NYC) hospitals with unique respiratory symptoms which were progressing to full-on respiratory arrest, it was reminiscent of the feelings I felt in the early 80's, when there was talk of a new "gay cancer" having an eerily similar impact on society. It was a frightening time, marked with an overwhelming feeling of confusion and helplessness. It was also reminiscent of the Ebola scare just a few years prior to the pandemic. However, the Ebola crisis provided us a foundation for responding to an existential threat that was difficult to prepare for. During that time, we put emergency response processes in place, evaluated supply needs, and created protocols to guide us in managing this specific patient population. We also developed training programs and educated core staff who would potentially be faced with this patient population.

As the news of COVID was spreading in early 2020, and outcomes seemed to be getting worse in NYC, we started focusing on preparing for cases to hit our organization. We started reviewing processes we had put in place for a potential influx of highly contagious patients. We did an analysis of our existing supplies with a specific focus on personal protective equipment (PPE) needed to prevent the spread of infection. We looked at

this from an entity and system perspective. Fortunately for us we had been stockpiling masks and gloves and it appeared that we would be in pretty good shape for any initial impact. We also analyzed our drug supplies, monitoring capabilities, and surge plans for any expanded services that may be needed beyond our normal capacity limits.

While everyone was stepping up and fully engaged, generating ideas, responding where needed, I began to detect a shift in the environment, and I was starting to observe a feeling of dread and panic among the staff. Everyone was coming to the realization that this wasn't just a drill and that it was inevitable that we would start to receive patients in the very near future. At this point, how the virus was transmitted was unknown. The consensus at that time said that airborne infection was unlikely. So, we focused on surfaces – bleaching and wiping down everything. We mandated that everyone stay six feet apart in hopes of preventing spread from droplets. The staff I spoke with shared the processes they put in place at home to protect their loved ones from potentially acquiring the virus from them directly. Children were sent off to grandparents and other relatives if at all feasible. This alone added an additional level of stress for staff with children. Older adults were isolated from their families as a mode of protection. Staff were getting changed in their garages and cars before entering their homes in fear they would spread the virus to their loved ones. Masking was recommended, but we didn't have a mandate at that time.

The safety of all staff was our top priority. We were evaluating and assessing their vulnerability as individuals. We needed to protect everyone, but we knew that some staff were more vulnerable than others. We had many baby-boomers on staff and because there was a concern that age played a role in severity of the illness, we suspected that this group of older colleagues could be especially vulnerable. For those staff who were older, and closer to retirement age, we made working on the front lines optional. Anyone with a medical condition was able to opt out as well. We also knew that we had immuno-compromised staff who were dealing with their own illnesses, as well as an unknown number that hadn't revealed their own medical vulnerability. Our pregnant staff were given an option to work in areas where the risk was lower. It was a universally agreed upon fundamental principle among staff and leadership that we make protecting our most vulnerable a top priority, and to step in where needed. In that time, I never heard anyone complain because we gave a higher level of protection to some staff over others.

Based on what we were hearing and seeing happening in NYC hospitals, we started to evaluate our care models: where would we put patients who needed intensive care once all current available beds were filled? We were

still providing full service and treating all patients, including procedures and a full operating room schedule. However, we were starting to get cancellations as patients and families became concerned. Eventually, a mandate came down from the state Department of Health to stop all elective procedures. With these services now dormant, we had an opportunity to consider using preoperative and post-operative spaces to place an influx of new patients. We were also evaluating a plan to use operating rooms if we hit a full-blown crisis of an unprecedented increase in patient volumes. There was no way to be sure just how bad it would get, so we needed to be as prepared as possible.

We were confident in our logistical planning and the ability of our clinical staff. However, the biggest concern would be the problems associated with staffing challenges. How would we staff not only the existing clinical units, but also staff in these additional areas if, or when, we started receiving an influx of patients requiring higher levels of care with a limitation of space to provide it? We started putting plans in place to provide a team-based care model. Our Nurses have always worked well as a team, with strong relationships among our colleagues, each other, and supporting departments. However, what we were considering was a different, more defined process for providing team-based care so that we could capitalize on the knowledge and skill sets of individual clinicians and disciplines. How could we utilize operating room nurses who haven't worked in clinical settings outside the perioperative area? How could we utilize, and benefit from, nurses and other staff who work in now closed service departments, such as clinical practices and procedural areas?

We met with many of these nurses to assess comfort levels, skill sets, and willingness to practice outside of their designated areas. The response was overwhelmingly positive. However, there was still trepidation related to skill sets and comfort. So much was still unknown and unknowable. Since we weren't yet sure of the route of viral transmission, the donning and doffing of protective equipment was critical to everyone's safety. Because our perioperative nurses and surgical technicians are experts in that area, we immediately assigned one to each of the inpatient areas to help train, provide observation and oversight, and ensure and maintain adequate levels of personal protective equipment and supplies. This immediately gave nurses a sense of relief knowing that they would have expert support to help keep them safe from potentially exposing themselves, or their colleagues, when removing their protective equipment.

Because the decision had been made to put a hold on all elective surgeries and procedures, additional staff from surgical units and recovery areas were subsequently freed up. On paper we started creating teams of

care providers that would work together to provide the intensive care these patients required. Our critical care nurses would lead the teams and provide oversight of critical care equipment, such as ventilators and infusions. The surgical nurses would utilize their skill sets, such as placement of IVs, documentation, and lab draws. Nursing assistants would span several patients and be used for positioning, running for supplies, and transporting as needed. This plan had to be tested and perfected. The first staff members we identified to provide preparation and education were our critical care nurses, who would lead these teams. Although nurses are experienced at delegating tasks to other support staff, this would be a different approach since resources would be limited and resources would be stretched beyond any current capacity and experience.

I started with the nurses from one of our intensive care units. They were all on board. I asked them to help test the model. Traditionally, each nurse is assigned two patients and responsible for overseeing total care of those patients, with some support from ancillary staff. I asked that they start working in a team-based model in which specific team members would each be assigned specific duties. I asked that three nurses be responsible for six rooms and take responsibility for three patients each. Specific tasks were assigned to a third nurse. The number of resources remained exactly the same for the trial run, with three registered nurses for six patients in total. Despite having the same number of resources, nursing staff found it very challenging to function in this type of model. It's not that they didn't embrace the concept; rather, it was more about changing how they did things and thinking differently, which can be uncomfortable for well-trained and seasoned medical professionals. Rather than continuing to challenge the norms, we decided to move forward with our typical staffing models, at least until we no longer had the resources to do so. I was confident that if we needed to pivot the team would do what needed to be done. We did start to supplement the teams with additional staff resources while they were available, which had the unintended (but beneficial) effect of helping the nurses begin to understand and appreciate the team-based model concept.

Simultaneously, while we were evaluating our inpatient resources and processes to effectively handle what was heading towards us, we refined our Emergency Department (ED) intake processes for patients experiencing respiratory type illnesses. We knew that if we had good processes on the front end and could safely treat and get people home to isolate in the comfort of their own homes, the impact on the inpatient setting would be greatly reduced and would keep beds available for more acute patients who would need higher levels of care.

The ED set up an outside structure in which they could rapidly assess and evaluate incoming patient needs. With this process, the ED could quickly determine the level of care needed, while simultaneously isolating any individuals at risk of spreading respiratory illness.

Once we received our first COVID-positive patient, it quickly became a progressive stream of COVID patients from that point forward. At the same time, we also started experiencing staff developing symptoms and testing positive for the illness. In addition to these challenges, we were also receiving a steady influx of patients from skilled nursing and long-term care facilities. Even patients who tested positive, but were only experiencing minimal symptoms, got transferred to us. There was a sense of panic in these facilities, a fear that the virus would easily spread and could wipe out an entire population of residents. These facilities were so afraid of the spread to other vulnerable patients that they began sending everyone to the hospital. We recognized this as an opportunity to partner with these facilities and share our knowledge, experience, and our resources (if we were able to spare them). We helped these facilities with testing, creating isolation processes and protocols, and with clinical management for those patients who could safely stay within their facilities. Our hospital is surrounded by several skilled and long-term care facilities, and although the influx of patients continued on a steady basis it would have been significantly worse had we not collaborated and partnered with their leaders and staff.

At this point, the hospital started getting hit hard with an increasing number of patients. Many were able to be discharged directly from the emergency department, while those who were admitted were very sick or critically ill. We were presented with very young people struggling to breath and placed on ventilators and extracorporeal membrane oxygenation (ECMO) for circulatory support. We were starting to feel the moral distress that comes along with a sense of helplessness even though we were doing everything possible. We were so much more prepared because of what we learned from our colleagues in NYC. I can't imagine the fear they experienced. We were so much more prepared and better off but still not sure how bad it would get.

Although we were better prepared, the tension and anxiety of the unknown was suffocating in many ways. As the CNO, I continually questioned myself. Was I doing enough? What more could I do? I came in every single day and rounded on every unit for 100 days straight. I wasn't trying to be a hero or a martyr. I just didn't know what else to do. I lived close to the hospital, so it wasn't a burden. Going to the hospital, rounding each day, and checking on staff, supplies, and patients gave me a small sense of being useful in challenging and uncertain times. I just wanted the staff

to know that I was there with them, doing what I could do, as they were doing what they could do. I know that they appreciated me being there every day. They told me so.

Each and every day that I was in the hospital rounding, I was amazed at how nurses were stepping up to the challenge. The demonstration of empathy and compassion for our patients, families, each other, and beyond. They were coming up with creative and innovative ways to care for our patients, keep families informed, and care for each other during these unprecedented and challenging times. The following chapters will highlight many of the extraordinary scenarios and actions that I witnessed firsthand throughout those challenging times. I am honored to have had the opportunity to work with these amazing nurses and nurse leaders. It is with great pride that I will cherish these memories.

PART I

CHAPTER 1

EVERYTHING CHANGED

MARGARET MULLEN-FORTINO, PHD, RN

There are moments which mark your life. Moments when you realize nothing will ever be the same and time is divided into two parts - before this, and after this.
—John Hobbes, played by Denzel Washington in the 1998 movie, *Fallen.*

In 2001, the Institute of Medicine published Crossing the Quality - Chasm, a seminal report that outlined problems with the US Healthcare system and offered clear strategies for improving the quality and safety of care (Institute of Medicine, 2001). Included in the strategies was a need to reduce unnecessary variations in care. Healthcare stakeholders were charged with providing care based on scientific evidence and implementing "best practice" models for performing tasks and procedures. Through the development and dissemination of best practice guidelines, clinicians were providing care in a standard manner. As an example, there is a procedure that lists each step of proper handwashing to prevent infection. Healthcare systems and clinicians periodically revise policies and procedures to reflect current best evidence.

To support safety of care efforts, health systems often employ improvement advisors – staff with special training in quality improvement methods and tools. Quality improvement advisors also have process management skills and serve as change agents for the entity. I was employed in the improvement advisor role when COVID-19 arrived in Philadelphia, and it is through that lens that this chapter is written.

PPMC was aware of two confirmed cases of COVID in Philadelphia and we began to create a COVID response plan. PPMC leaders hosted a one-hour virtual town hall meeting to outline the strategy. A recording of the town hall was posted on a COVID specific website created as an additional source of communicating and up to date information in real-time. As an improvement advisor, I was assigned as part of a team to review current processes and create new processes that would minimize risk to staff and control the spread of infection while simultaneously keeping patients safe.

Key features of the initial plan included educating staff on the proper donning and doffing of personal protective equipment (PPE) which included ensuring that everyone had a proper fitting N-95 mask (a mask that filters at least 95% of airborne particles). An Infection Control nurse provided in- person education to dedicated PPE champions, who in turn educated staff members in their respective units. Nurses from the Department of Education conducted testing twelve hours a day to determine the proper N-95 mask size for staff. Within one week, over nine hundred staff members were prepared to care for patients with COVID.

A fundamental principle of the COVID plan included cohorting patients to a single medical-surgical unit and a single critical care unit. Staff working on these dedicated units emerged as specialists in providing care to patients with COVID; these specialists were then available to coach and educate staff as new units opened during COVID surge admissions. The team developed a surge plan that outlined the number of patients that each unit could accommodate before opening a new dedicated unit.

All elective surgical procedures were cancelled, resulting in a low inpatient census. Some staff nurses were given the opportunity to take paid time off to limit their exposure to infection. Others were redeployed where needed. The goal was to ensure there were always enough healthy nurses to care for patients. Operating room (OR) nurses, with expertise in sterile and clean technique were redeployed to units caring for COVID patients. The OR nurses observed and provided coaching in real time to nurses as they put on and took off PPE. The OR nurses also assisted in retrieving and cleaning equipment after it was used in a COVID room. Surgical resident physicians were available to perform procedures such as central intravenous line placement (an intravenous line placed in a large vessel, usually in the chest; helps with specific medications and fluids for critically ill patients), or surgical feeding tubes.

COVID was a new virus; there was little information about the course of illness or guidance on interventions to treat the illness. Information changed daily and we needed a way to communicate with staff. PPMC set up several fifteen-minute virtual huddles facilitated by physician and nurse leaders with the goal of addressing concerns raised by staff and sharing the most up to date information. Included in the huddles were the current census, surge location and staffing plan, and current stock of PPE.

It was during a huddle that a critical care nurse practitioner noted that secretions during extubation (removal of the mechanical ventilation "breathing" tube) were very thick, and patients often had to get reintubated (replace the "breathing" tube). The group decided to add humidity to the mechanical ventilation circuit. After adding humidity, patients no longer

required replacement of the tube once removed, and overall outcomes improved. These interventions were adopted across the health system and the experience along with clinical outcomes were published in the Annals of Internal Medicine (Anesi et al., 2021).

As part of the initial COVID plan, changes were made to the inpatient clinical emergency response. The clinical course of COVID is exceedingly difficult to predict. Healthy patients typically have an oxygen level of between 95 and 100 when measured with a special instrument called a pulse oximeter. Often, patients with COVID would have a pulse oximeter reading of 95 and within 15 minutes, the level would drop to a dangerous level of less than 90. Prior to COVID, a nurse could call for help and many people would arrive, eager to help. With COVID, we needed to ensure staff would not get infected with the virus. The process for responding to a clinical emergency changed to identify a limited number of people who would work in the room, and people outside of the room who would provide necessary items and arrange for transfer. Clinical emergency simulations were conducted several times a day for staff to practice the new process. Prior to COVID getting staff to attend simulations was sometimes challenging. Simulations related to the care of patients with COVID were well attended.

Many patients, because of the lack of oxygen, were confused and restless and at higher risk of falling and sustaining an injury. Typically, a hospital staff member is assigned to sit in the room with the confused patient to help redirect them, assist them to the bathroom, or help them get back into bed. Nursing leadership at PPMC knew it was not safe for staff to spend 8 to 12 hours so close to a COVID patient in a closed room. A few nurses suggested an innovative solution: video baby monitors. Members of nursing leadership created a guideline outlining the procedure for use of electronic baby monitors for continuous observation. One family, whose father was recently discharged from a UPHS hospital, contacted George Iyoob, MSN, RN, Clinical Director, Surgery and Trauma to donate 10 additional baby monitors and the following message

> *"Good luck G. I've included my mom and all my siblings on this email. I've also included Paul. We got your back. Wash those hands brother."*

Figure 1.1. Baby monitors donated by family.
Photo courtesy of George Iyoob, MSN, RN, Clinical Director

Several new processes were created to help care for patients with COVID. The Emergency Department (ED) set up tents to assist with triage of patients seeking care for suspected COVID. The ED also created a COVID Watch program. Patients diagnosed with COVID during their ED visit and discharged home were enrolled in the program. The program sent text messages to patients assessing for shortness of breath symptoms. Within one hour a physician or nurse called patients reporting worsening symptoms for further evaluation. Patients also had access 24 hours a day to physicians through telemedicine visits.

Everything changed. All the standard processes we worked on building over two decades were necessarily dismantled. Most every process

including meal delivery, room cleaning, transport of patients from the emergency room to their inpatient room and post-mortem care required some revision to limit viral exposure.

Christine, RN described the struggles:

I remember one scary moment when there was a meeting of some of the smartest people in the hospital, and they just didn't know what to do; these patients were so sick. They were hearing mixed reviews on whether or not to use steroids, whether or not to anticoagulated, they were figuring it out as they went along because there were no guidelines.

Dr Ballinghoff, the CNO, was confident,

I think the health system did a good job of trying to keep everybody informed and stay up with the guidelines, but it was overwhelming. First, we had to do one thing, and the next day new information would come out and the first thing was no longer relevant. Like wiping down beds before they leave the room, and then wiping them immediately after they leave a room. We then found out that wiping the bed at any time wasn't necessary. It's a lot to keep up with and almost makes you mistrust the person that's telling you because it was different information last week.

Dr. Ballinghoff continued,

We (healthcare staff) have experience, and we have education that provides us with tools to be able to respond. And we did respond. I felt confident that what we were doing and how we would pivot was helpful. But it wasn't a playbook.

Examples of new and revised processes are seemingly endless. We planned as much as possible but remained flexible and adjusted as needed. We learned as we went along, thanks largely to multiple daily communication channels. We were a powerful force fighting against a formidable opponent.

Like so many others, I worked over 90 days straight. Some days, such as the weekend, I worked only four hours. But most days I averaged 10 hours a day. It was the hardest I ever worked in my 44-year career. And it was the best, most meaningful work I have ever done. I was witness to the power of teamwork. I learned that even the smallest change can have a profound impact on outcomes. I am proud of the work that we accomplished.

CHAPTER 2

HOME LIFE

MARGARET MULLEN-FORTINO, PHD, RN

One day you will do things for me that you hate. That is what it means to be family.
—Jonathan Safran Foer

The first case of COVID-19 was identified on December 12, 2019, in Wuhan China (Centers for Disease Control and Prevention. 2023). The virus spread rapidly and on March 11, 2020; after infecting 118,000 people in 114 countries and contributing to almost 4300 deaths, the World Health Organization declared the outbreak a pandemic (Cucinotta and Vanelli, 2020). The pandemic designation set in motion a list of actions intended to limit the spread of infection: cities employed stay at home mandates, employees shifted to remote work, schools closed. People were instructed to wash hands frequently, and to wipe down surfaces in the house, and anything entering the house, with disinfectants. Contact with members outside of your house was strongly discouraged by health officials. (City of Philadelphia, 2022). During the same time nurses went to the hospital each day to care for patients with COVID. They received extensive training and education on COVID infection prevention. While they did have concerns about getting infected, nurses were more worried about the welfare of their families.

John, RN stated,

In March, I had shut my family off completely. I'd leave for work at 5:30 in the morning and get home at 8:30 at night and then had to shower and decontaminate. There were times where I would pull up in the driveway and there was a towel waiting for me because I had to strip down, run in the house, run right up to the bathroom. It really separated me from my family. My worst fear was bringing it home to them.

Kelsey, RN, shared

I worried all the time [about bringing COVID home to my family]. I was such a freak. My clothes, shoes, my watch; like rubbing myself down every single day. I would come home, jump right in the shower, wash everything again.

Many nurses considered alternate living arrangements, for themselves or for their family.

Rose, RN explained,

When they [a nurse] did realize that they had an actual exposure to somebody with COVID, they're already home with their family. If that other nurse they interacted with two days prior came down with COVID, you thought well, I just now probably infected my children and my husband.

Edwin, RN noted that:

Everybody was worried about protecting themselves and their families a lot. The wife and child of one of our nurses went to stay in Virginia with the wife's family while he stayed alone in their house for months because he didn't want to expose his family.

Jackie, RN stated,

A group of us were chatting and wondering "should we get an apartment to protect our families?

The COVID pandemic impacted the families of nurses. In most households, the stay-at-home mandate resulted in families having little interaction with anyone outside of the home. Nurses were caring for patients with COVID and then coming directly home. This direct interaction with patients with COVID sometimes contributed to family fears of getting the virus and contributed to strains on family relationships.

Christine, RN described the impact to her family:

My daughter is 3 and we weren't sure how COVID was going to affect kids. My husband was the one that was scared that I was going to bring it to my daughter. He asked, 'Can you guarantee me that that she won't die?'. The health system had rooms reserved for us at the local hotel. And because I couldn't give that guarantee, I checked in at the hotel. I lived there from April 20th to July. My husband is a psychologist and had been working from home, taking care of her [daughter] since April May, June, July without his wife who prepares every meal, so it was a big culture shock for him. Towards the end he just he couldn't take it anymore. I went back home in July; I would shower before I came home.

John, RN explained,

It was scary. My wife did not want to spend much time with me because she knew I could bring it home to her. I think it was all going to be over soon so it's OK if you need to go stay somewhere. She bought me an air mattress so I could sleep at work. I was like no, I don't want to live at work.

Janine, RN describes an interaction with her mom:

COVID happened in March and my sister was pregnant and we had a gender reveal outside with four of us present. I hadn't seen my mom for a whole month and we're outside and I said, 'Mom don't hug me, don't kiss me.' She was literally running chasing me, trying to hug me. I said 'mom you don't understand how COVID works. She's said, 'I don't care if I get COVID!

Nurses were a conduit of information between the hospital and the community, a resource for family and friends.

According to Christina, RN,

One good thing is I feel like I learned a lot about COVID and the progression. Friends with families who were getting sick would call me and I could help them through it a little. I talked to them about what they could do to help their families or what to look out for. I felt like I was a comfort to some people. My best friend's mom got COVID, and she passed. She was in an ICU in New York, and they were allowed to have visitors. Every day my friend would tell me the ventilator (breathing machine) settings and you know it was really torturous for her. I think she felt that I understood what was happening a little bit.

Margie, RN described:

Information came from various sources and often that information was conflicting. Each day my family would ask, and I would explain that their risk of getting COVID was exceptionally low. They were young, healthy and took precautions. Most of the people hospitalized were older and had many comorbidities. I told them I was not scared of getting COVID because we had all the proper protective equipment to keep me safe. I lied. I remember going into a freshly cleaned room after a patient with COVID had been discharged, afraid to touch any surface, afraid to breathe the air. Several months after COVID first hit, my family and I were reminiscing about those first weeks, and I mentioned how terrified I was. My oldest daughter called me out: 'Mom, you told us everything was going to be ok. You told us you were not scared and that we would be fine'. Inside a Mother's Day card was a note from this same daughter: "Thanks Mom for all you do to protect this family during these crazy times." I cried.

Nurses faced challenges in their personal lives that affected the very relationships where they previously sought and received support:

Eric, RN explained,

I wouldn't say anything to my husband. [that I was caring for COVID patients while I was at work]. I would wait until I got home. One time I did tell him all day he was nervous all day constantly asking 'are you all right' or 'what's going on? I'm so nervous for you and I and I couldn't do that to him.' I wanted to have some bit of normalcy. I would only tell him when I would come home that I took care of COVID patients because he would make sure that the laundry bag was at the front door and my robe was there so that I could take my scrubs off and stuff.

Janine, RN described a sentiment shared by many nurses, even prior to the pandemic:

I don't really share [the experience of caring for patients with COVID] with my family because I feel like they never really understand because they're not there, so they can't understand. I've been a nurse for eight years and my mom still thinks I should get home at 7. I'm like no mom like we have report until 7:30.

Rachel, RN described her experience with a change in her own personal health:

I had a hard time. I got diagnosed with polycystic kidney disease a couple weeks before COVID hit, so I was freaking out about that in general. I was already not dealing well. I am single and I live alone. Nobody wanted to be around me in the beginning, because people were terrified, not in a mean way. I completely understand they were afraid of getting COVID. I just felt like it was hard. For a while, I really did feel isolated and that was not pleasant.

Nurses get support from other nurses, as described by Kelsey, RN:

Our saving grace is that we can talk to the people at work. They can relate to what you are going through and they're really the only people you feel comfortable talking with. A lot of us don't even feel comfortable going home to our spouses or our families because we feel bad for putting that burden on them. This is my job, what I chose to do…so it's not fair for me to put all of this on them [family].

As Ashley, RN describes, even as the larger community started to open back up, nurses were still concerned about exposing their families to COVID: