Frontline and forgotten: Community nurses’ experience of shielding during COVID-19

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Abstract

In March 2020, the COVID-19 pandemic reached the United Kingdom. National and local lockdowns became the new reality as the pandemic had a significant effect on morbidity and mortality, especially amongst vulnerable groups of the population. It was people in these groups in particular that were advised to shield at home. There are a number of studies focusing on the psychological effect of this enforced isolation on the general population; however, to the researchers’ knowledge, the effects shielding on healthcare professionals has not received a similar level of attention. The general population has expressed its appreciation to frontline healthcare professionals, with the majority of praise directed towards doctors and nurses working for the National Health Service. It must be noted that community nurses working for the private sector do not appear to have been officially afforded the same recognition, and research on the psychological effect the pandemic had on these healthcare professionals is lacking. The primary researcher identified this gap in the literature which became one of the reasons for the present study. This study enlisted the participation of ten community nurses working in the private sector who experienced shielding due to a long-term health condition. Participants were all female and aged between 24 and 63 years, and each attended a semi-structured interview. These interviews consisted of nine open-ended questions exploring these nurses’ experiences and the psychological effects COVID-19 and shielding had on them. Grounded Theory was favoured as the analytical technique, identifying eleven core themes. Social Identity Theory informed the evaluation of the data. Nurses reported an array of psychological effects, varying from mild to severe. According to participants, employer recognition and staying connected with colleagues are vital for the maintenance of their social and professional identity and, psychologically well-being.

Background

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the microorganism identified as being responsible for the coronavirus disease 2019 (COVID-19) (Schneider, Piening, Nouri-Pasovsky, Krüger, Gastmeier & Aghdassi, 2020) and was declared by the World Health Organisation (WHO) as a “public health emergency of international concern” in January 2020 (World Health Organisation, 2020, p. 2). It is believed to have originated in China in December 2019, and on 11 March 2020, it was declared a pandemic (Cucinotta & Vanelli, 2020) with heterogeneous infection rates. This was the beginning of a global change that affected every aspect of human life, from functioning members of society to being furloughed or shielding, from waving goodbye to children at the school gates to home-schooling and working in an office to working from home. The situation’s impact has been unprecedented; a word rarely used before the pandemic is now referred to in everyday language and was elected by People’s Choice as the 2020 word of the year (Eubanks, 2020).

COVID-19 and the enforcement of strict lockdown rules, shielding, furlough, or forced redundancies of employment may have unconsciously resulted in a mental-health crisis, of which we are only scratching the surface of understanding the severity (Rettie & Daniels, 2020). The WHO states that good mental health is the foundation for positive well-being and the ability to function effectively as individuals and as a society. It is a state which enables the realisation of individual abilities, including coping with everyday life stresses, working productively, and contributing to the community (WHO, 2004).

The economy itself has been affected by COVID-19, and many businesses have collapsed into administration, particularly independent businesses that rely on tourism for sustainability (Bartik et al., 2020). However, it has allowed many companies to reconsider business models and be creative with their working methods. Implementing hybrid working or solely working from home has observed improvements in well-being and work-life balance (Skountripidakis, Marks & Mallett, 2021). Our ecosystem has improved, even seeing wildlife visiting urban civilisation such as train stations and city centres (The Guardian, 2020).

However, the negative impact of the virus on the National Health Service (NHS) has been significant. This is, both in terms of socio-economics due to increased demand on services, as well as affecting our healthcare workers, particularly those working on the frontline (NHS England, 2021). There have been widespread disruptions, cancellations and delays to elective surgeries and oncology treatments. Thousands of patients have died in their hospital beds without having their families or loved ones by their sides. In addition to this, healthcare professionals (HCPs), primarily nurses, were redeployed to work in clinical areas they were unfamiliar with and to support the heavy demand on the intensive care units (ICUs). Nurses came out of retirement to support their colleagues during the crisis (NHS England, 2020a), and student nurses were asked to opt into extended clinical placements to increase care staff levels in the acute environment (Swift et al., 2020). In addition to these exponential pressures, HCPs were required to wear invasive, often skin-damaging personal protective equipment (PPE) to keep themselves and their patients safe from contracting the virus. Our healthcare workers have been coping with the unimaginable, and the psychological consequences are likely to be significant.

What do previous pandemics and virus outbreaks tell us?

Previous research has determined that sudden outbreaks of disease are connected to increased rates of mental illness such as depression, poor well-being, and other psychological conditions and disorders (Rettie & Daniels, 2021). Following the H1N1 pandemic, post-traumatic stress disorder (PTSD) symptoms were reported in 30% of children and 25% of adults who experienced quarantine (Sprang & Silman, 2013, as cited in, Rettie & Daniels, 2021). Similarly, research performed on individuals who experienced the SARS outbreak in 2003 found that 35% were suffering symptoms of moderate to severe depression and anxiety, and healthcare workers were more susceptible to greater levels of distress (Cheng, Wong, Tsang & Wong, 2004). The increased rates of doctors and nurses ending their lives through suicide, and greater rates of PTSD diagnoses amongst the HCPs support these findings (Greene et al., 2021).

Suicide and PTSD rates

Pre-pandemic research states that nurses are four times more likely to take their own lives than any other UK profession (Davies, 2020). Female nurses, in particular, are at greater risk, with suicide rates being 23% higher than the national average (Office for National Statistics, 2017, as cited in, Maben & Bridges, 2020). During the first year of the pandemic, at least 226 nurses, 79 paramedic and ambulance crew, and 17 student doctors in the UK attempted suicide (Ford, 2021). However, as suicide remains a taboo subject, these figures are probably underestimated.

Suicide is not the only mental health concern amongst nurses and HCPs, as depression, anxiety, and PTSD diagnoses are increasing and are most prevalent in nurses. A study performed by Greene et al., (2021) found that 22% of UK frontline healthcare and social work (HCSW) employees met the criteria for PTSD,
47% met the criteria for depression, and 47% met the criteria for anxiety. This is suggestive that mental health issues amongst HCPs are a pandemic in itself.

**Thank You NHS**

The media’s focus has been on HCPs employed by the NHS and working on the frontline. The impact that COVID-19 has had on community nurses and those working in the private sector has been overlooked. This is evident by the lack of research literature in this area and was the drive for this study. Societal appreciation was given for NHS HCPs through clapping on doorsteps to daubing *Thank you NHS* rainbows in the front windows of houses (BBC Newsround, 2020). Skipp (2020, p. 1) wrote, “the rainbows stand for something so hopeful and positive” as he trawled the streets of Bristol, England, taking photographs of the children's artwork in their home windows. The Clap For Our Carers initiative ran for ten weeks commencing on 26 March 2020 to capture the spirits of the nation and unite communities on their doorsteps every Thursday evening (Clap For Our Carers, 2020). This was set to return on the 7 January 2021 with the revised title of *Clap For Heroes* and aimed to re-lift the nation's spirits; however, this did not come to full fruition. Nurses responded by stating the recognition was insulating when society was not seen to be adhering to COVID-19 safety rules, and concerns were raised around the label *hero*, wrongly implying invincibility (Mitchell, 2021). Community nurses, particularly those working in the private sector, were given no such attention, and even the appreciation for the NHS was short-lived. NHS workers were soon labelled super-spreaders of the virus and abused when seen in public wearing their uniforms (Somerville, 2020). Nurses were advised not to wear uniforms or ID badges to and from their way to work for their safety (Somerville, 2020), a novelty not permitted to all community nurses. Free hospital parking was introduced in March 2020 for all NHS workers however ended two years later further adding insult to injury (Waters, 2022). The financial year prior to the pandemic estimate that NHS workers paid £90.1m in parking fees and with increased cost of living, this figure is expected to significantly rise (NHS Digital, 2019-20, as cited in, Waters, 2022).

**The implications of shielding for the general population**

It has been imperative that countries across the globe do all they can to protect the population, reduce the risk of the virus spreading, and protect those deemed clinically extremely vulnerable (CEV) (Office for National Statistics, 2020). In addition to national and local lockdowns, many individuals were advised to shield by the UK Government due to a long-term health condition (LTHC) that deemed them high-risk if they became contaminated with the virus. High risk relates to the increased likelihood of becoming seriously ill and the need for intensive care treatment (Fisher, Roberts, McKinlay, Fancourt & Burton, 2021). Associated health conditions included (but were not limited to) diabetes, pregnancy, asthma, and chronic heart disease, of which 3.7 million people in England were identified and subsequently advised to shield (Office for National Statistics, 2020).

Shielding instructions differed significantly from general lockdown advice, and the restrictions were even more significant. Individuals were instructed not to leave their homes for any reason and avoid other household members wherever possible (Kemp, Horne & Souter, 2020). The UK Government and local councils worked hard to implement support services such as free food boxes, priority supermarket deliveries, medication to doorstep initiatives, and even provided accommodation for 90% of rough sleepers within the first two months of the pandemic (Local Government Association, 2020a). Local NHS volunteer responders were a fundamental resource for vulnerable people, providing community support such as welfare checks (Local Government Association, 2020b).

Initially, the UK Government attempted to unite the country with slogans such as “We are all in this together” (Nolan, 2021, p. 102). However, inequalities soon became apparent, with ethnic minorities, lower socioeconomic status groups, and those living in low-income households becoming severely psychologically affected (Fancourt & Bradbury, 2021). Inconsistent and indistinct Government instruction led to feelings of fear and intolerance of uncertainty regarding the future, a concept linked to many emotional disorders (Rettie & Daniels, 2021).

**Community nurses are people too.**

The CEV was not limited to the general population as some HCPs also have LTHCs, rendering them high risk. Anaesthetists, doctors, and nurses were among many HCPs advised to shield, with the psychological impact of shielding on HCPs still not receiving significant attention. Our literature search revealed no studies examining the psychological effects of shielding amongst community nurses working in the private sector. Doctors in Distress (2021) have supported HCPs employed by the NHS who have shielded, providing online support groups during the pandemic. The preliminary analysis of these support groups suggests that nurses felt an incredible amount of guilt and identity loss, feelings of being forgotten and devalued by their peers and managers. In addition, nurses also experienced the same emotions as the general shielding population, such as stress, anxiety, and loneliness (Fisher et al., 2021).

Community nurses did not face ICU working conditions; whilst still being on the forefront of the fight, but were not commonly recognised for this due to frontline workers’ stereotypical image (Grimmette, 2021). Nevertheless, they were under extreme pressure to prevent hospital admissions and provide clinical care in the patients’ own homes. This became more important than ever, as admitting a patient to a hospital could expose more people to hospital acquired infections, including COVID-19. Donning and doffing PPE on the doorsteps of patients’ houses was a complicated and challenging added ritual to these nurses daily workload. Evidence suggests that the number of visits increased to include a new cohort of housebound patients and the provision of psychological support due to isolation-induced loneliness (Green, 2020).

Emphasis has been placed on how the pandemic has psychologically affected the acute-based HCPs and the general population; however, similar information on the effects of the pandemic on community nurses (particularly those working outside the NHS) is lacking. Many community nurses were advised to shield themselves and would often support their colleagues remotely; however, others were furloughed and even made redundant. This was an additional motivation for the present study which aimed to shed more light on a seemingly forgotten nursing population.

**Method**

**Participants**
Participation was open to registered nurses over the age of 18 working in the community and experienced shielding due to a LTHC. A total of ten participants were recruited, all of whom were female aged between 24 and 63 ($M = 43.3$), (see Table 1 for full demographics). The study was advertised via an email outlining the inclusion criteria, the scope of the study and a contact number to call if interested in participating. This email was sent to all nurses employed by a large private nursing organisation in the UK, including those that did not shield to ensure individual nurses were not singled out. A full explanation of the study was provided verbally over the phone and participants were able to make an informed choice on participation.

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<tr>
<th>Participant</th>
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Note: Advanced Diploma (A.Dip), Bachelor of Arts (BA), Bachelor of Science (BSc)

Materials

Participants were emailed a participant information sheet detailing what was involved, including the potential for distress due to the topic's sensitive nature. A consent form and demographics form were also provided. Once all forms had been completed, an appointment was scheduled to perform a semi-structured interview via Microsoft Teams (MS Teams). Each participant consented to the interview being recorded for transcription and analysis purposes. The interviewer ensured the virtual meeting room was locked, earphones were worn, and they were situated in a confidential environment.

A debrief form was provided at the end of the interview for each participant and included free contact numbers for mental health support lines should these be needed. All participants stated they felt fine at the end of their interview, which lasted an average of 45 minutes. Data analysis was supported by NVivo, a software program designed for qualitative research. NVivo supports the researcher in categorising unstructured text into themes and is particularly beneficial for analysing interviews transcribed verbatim (Charmaz, 2014).

Data collection and analysis

The interview schedule consisted of nine open questions and prompts. This data collection method was deemed the least restrictive to participants’ answers affording the interviewer a better and deeper understanding of the participants’ own perspective on the psychological effects shielding had on them. Each interview was manually verbatim transcribed. This was followed by the initial, focused, and theoretical coding processes outlined by Charmaz’s Constructivist Grounded Theory (Charmaz, 2014). Line-by-line coding of transcriptions was uploaded to NVivo to support the construction of themes, and once saturation was reached, eleven core themes were identified.

Results

The analysis revealed eleven dominant themes (outlined below). Participants were given pseudonyms to maintain confidentiality, and interview citations are emphasised in italics and wrapped with quotation marks.

Theme one: Community Nurses are People-People

Participants were asked to describe what being a nurse means to them. Responses were similar, focusing on the care, compassion, and empathy felt for their patients. The notion that nurses are people-focused professionals, committed to putting the interest of people requiring nursing care first, was prominent in the data. This value is embedded early in a nursing career and forms the first of four core themes of the Nursing & Midwifery Council (NMC) Code, “Prioritise People” (Nursing & Midwifery Council, 2018, p. 6). Figure 1 clearly demonstrates this when participants were asked what being a nurse meant to them.

Visiting patients time and again is considered a luxury reserved for community nursing. Staying with patients until the end of their journey, whether due to a full recovery or the patient passing away is considered an honour (Liu & Chiang, 2017). Participants expressed how privileged they felt to be a part of their patient's journey.
"I love the fact that I can make a difference for somebody else's life, so that you're there to support them when they're struggling, and then you kinda get to share the moments when they're better. Especially in our role, we get to see them at the end, where ern, you know they're managing and they're confident, and you've done that. So for me, it's about kind of that. I think it always has been really; I think even whatever job you're in, it's always a journey with the patient, isn't it, but I think in ours, we get a better chance to build that." (Naomi).

Theme two: Hands-on care is better care

Although virtual technology has been beneficial at times, enabling participants to continue an element of their nursing role, it does not replace the need or meet the desire for hands-on physical care. Several participants expressed how being hands-on and face-to-face with their patients is an essential part of their nursing vocation, and having this taken away from them due to shielding was extremely difficult. Remote working removed human touch and as discussed during Doctors in Distress (2021) support groups; goes against the reasons why people choose to become a nurse. The inability to provide physical care left some participants feeling like they had lost part of their identity, and were no longer real nurses.

"Really, really difficult, not going out, it was awful. Massive impact on my role, especially being a community nurse. Technology was available to help, but the kind of nurse I am, this was difficult. In paediatric nursing, face-to-face is better. It was difficult, a huge impact, and I really struggled with this." (Beth).

and

"It was difficult because only being able to speak to people over the phone or virtually was, erm, it's just different to being like hands-on and being in their home and stuff, especially like the patients that you build a relationship with." (Melanie).

Theme three: Guilt and Secret Relief

Guilt is a prominent emotion amongst shielding HCPs, feeling as though they are letting their colleagues, patients and health organisations down (Rimmer, 2020; Doctors in Distress, 2021; Chattopadhyay, Davies & Adhiyaman, 2020). This was evident amongst participants as they expressed feelings of guilt for being safe at home when their colleagues continued to nurse in the community during the pandemic. Some participants who were shielding felt they were not doing enough to support and longed to be in a position to do more.

"Felt like I wasn't doing enough, I saw nurses on the tele and in the media in ICU, nurses on the frontline, and I felt like I wanted to go and help them. Felt that I wasn't good enough, I couldn't even do my own job. I felt like I should be doing more. It was really difficult. I wondered if I could sign up to work on the wards. I wanted to do more, felt like I needed to do more. It was tough." (Beth).

Several participants who supported their teams by triaging, delegating, and performing virtual appointments (VAs) felt guilty for putting their colleagues at risk when they were protected at home. One participant felt that guilt came hand in hand with secret relief suggesting a feeling of shame.

"I remember being relieved, but the guilt does not stop. You still look back and think I missed all of that; I feel guilty about it. Guilt and secret relief, feeling guilty that you're safe and your team are not. Guilty for sending them to places that might not be safe." (Naomi).

Another participant felt that the guilt and mental health effects of isolation were so immense that after a short time of shielding, a decision was made to disregard the shielding advice and return to face-to-face nursing.

"The mental effect has been feeling guilty, and letting everybody down; would have been worse than actually going through Covid. I mean, it was my choice, but it forced me to go out, to have interaction; otherwise, I would have been at home 24/7, that would have put me over the edge." (Phoebe).

Theme four: Shielding induced emotions for community nurses

The number of negative emotions associated with nurses shielding was vast, whereas positive emotions were in short supply. The following diagram (Fig. 2) is representative of the diversity of emotions expressed by participants in this study.

The emotions uncovered during the interviews reflect those of the general population (Fisher et al., 2021). Fear and paranoia of contracting COVID-19, becoming severely ill or dying were particularly prominent amongst participants.

"Paranoid that if I got Covid, I would die! If not dead, I would end up in intensive care; I didn't want to leave the house. I was fearful to leave the house, so I was relieved I didn't have to." (Naomi).

Theme five: Prison without bars

Feelings of being trapped and claustrophobic were shared amongst many participants. One participant likened this experience to being in a prison without bars.

"Every day rolls into one, like being in prison. Like being in prison. I can remember one day towards the end of the three months, I remember sitting there, just sitting there, and I screamed out loud, ARGGGH! I thought I can't stand this any longer. I felt claustrophobic, trapped, everything. A prison without bars, it was horrible." (Megan).

Several participants reported how isolation contributed to low mood and depression due to the loss of physical contact and lack of control, both factors of deteriorating mental health (Rettie & Daniels, 2021).
"I found it really difficult to kind of be trapped in the house, on my own all day, staring at a computer screen. I found that that was really, really difficult for me, and I got quite down.” (Lizzie).

and

"Having freedom taken away. Not just freedom to work but freedom in general. Being 'told' you can't go anywhere or do anything. Usually, I don't want to get up for work; as soon as someone says you can't, I'm climbing the walls. So yeah, having freedom taken away from you, a loss of control.” (Beth).

**Theme six: Shielding was bad, but not all bad**

Participants shared numerous undesirable consequences of shielding, such as missing families, experiencing early labour alone, and concerns over the future of their careers. Career concerns were common for many HCPs shielding during COVID-19 (Iliff, Simpson, Tomlinson & Webb, 2020) along with frustrations about the vague Government guidance. Participants explained how they felt grief over a nursing career as it was once known, sadness over losing something of significant importance.

"It's a bit like the five stages of grief, really, cos that is, it was like grieving for the end of my career as I knew it at the time. I mean, I didn't know how long it was gonna go on, but you do at the end come to some sort of acceptance.” (Jane).

and

"Difficult like going to every scan by myself, all the appointments by myself, erm, you know, having to sort of get to five centimetres and sent to the delivery suite before anyone could come in and be with me.” (Melanie).

Although many negative emotions and experiences were associated with shielding, some positive features also emerged. Having a garden and the warm weather was a common theme as to why shielding was not all bad. Spending more time with children, enjoying new hobbies and in particular canine companionship was considered benefits. A study conducted by Westwood, Hafford-Letchfield & Toze (2021) also revealed how a dog helped to enhance the shielding experience.

"I would only walk the dog; this was my therapy. Had time with the kids, dog, time in the garden. There was a key change at some point with regards to shielding; we were allowed out of the house for one walk a day. Still had to stay away from people outside and had to walk alone. Loved this time; one hour outside, husband looked after the kids, and I would take the dog for a walk. Would walk miles and miles and miles. I loved walking with the dog and just me, my thoughts.” (Suzanne).

Feeling lucky to stay safe and continue working from home was salient throughout and, for some, prevented loneliness.

"I felt lucky that I'd got him (husband) because it felt like we were having a little mini holiday at home because we had some bizarre weather in the April didn't we, so we sat outside going, this is really weird.” (Asha).

and

"The team were great because I spoke to them every day. Lucky I didn't feel loneliness.” (Naomi).

Likewise, the community demonstrations of togetherness and camaraderie (Clap For Our Carers, 2020; Nolan, 2021) were a positive aspect of shielding for some.

"A nice thing about the lockup was everybody seemed to be nice to each other, everyone was helping each other. Facebook videos with singing, uplifting spirits, videos of communities in the Grove. People just seemed to be nice, Thursday night clapping for nurses.” (Megan).

**Theme seven: Virtual care was the next best thing**

Participants who were able to contribute to their team while working from home were able to maintain an element of nursing care. Although hands-on is the preferred method, virtual care was the next best thing and for some health organisations, telehealth may become the new norm (Ervin, Weller-Newton & Phillips, 2021).

"I have adapted things so I could contribute from home, such as virtual training. Still spoke to the wider team too, so I still felt like I was doing my role. This communication really helped; if I hadn't been able to develop my role the way I did, it would have been really difficult.” (Naomi).

**Theme eight: Team and manager support matters**

The majority of participants felt overwhelming support from their teammates and managers. Regular contact from others is important for reducing loneliness (Cruwys et al., 2014), and having this meant that the participants felt included and part of the team.

"Yes, definitely. My manager was brilliant; they would always phone and check in on me.” (Sally).

and

"I was always included in the conversations and the emails and invited to WebEx's and things like that, erm, and like yeah, and like erm, my managers always checked up on up.” (Melanie).
However, some participants felt their teammates and managers provided very little support. Interestingly these participants were community nurses working for a different employer at the time that shielding were enforced and were furloughed without the option to work from home. Their experiences resulted in feeling devalued, marginalised, and forgotten.

"I offered to work from home, said I could do audit work, phone calls, support other departments, help in any way needed. I offered to type notes also but was told no. I had no support from peers or nurse friends during shielding, no, very little contact." (Asha).

and

"I was assured weekly contact to check on my well-being and to see how I was. There was no contact until the end of June, approximately 12 weeks. I appreciate that she (manager) was busy, but this had been promised. I felt out of the loop, isolated from the team and from work." (Suzanne).

The negative feelings of not being supported by the team or the manager were scarce compared to the ample positive feelings of inclusiveness. However, a small number of participants expressed concerns and scepticism over the authenticity of this support.

"They would all go, 'oh no, but it's great, cos the phones aren't ringing, and you're doing all of that, you're taking that off us,' and I used to think, 'you don't really think that'. That's the other thing, you talk to yourself with 'awe, they're just saying nice things to make me feel better, they don't mean it'." (Jane).

Theme nine: Our employer forgot us

Many HCPs expressed feelings of being forgotten by employers, including the NHS (Chattopadhyay et al., 2020; Doctors in Distress, 2021; Iliff et al., 2020). Employer support during this study was disproportionate to managers and teammates notably support for mental health and well-being. A sense of inequality was felt by nurses shielding due to perceived unrecognition from the employer compared to the praise given to colleagues who continued to visit patients. Some participants felt that the employer did not consider shielding a potential psychological issue

"I had to shield, and then obviously all these incentives were coming out for the staff working in the field like, you know, let's give you something extra for working through this hard time, and I'm sat here at home, not allowed to go out and work, but I'm not getting any recognition for the fact that I'm still going, despite you know, doing all that I can, despite not being allowed out for something that's wrong with me." (Lizzie).

and

"A practical approach was taken, which was fine by me, but I understand that some people need others to reach out to them and offer mental health support. There was no such support from higher up, mental health and well-being was not addressed by the company. The company didn't consider shielding as a potential issue." (Jane).

Some felt that mental health and well-being support was available if nurses wanted it and appreciated that the employer enabled shielding nurses to stay safe while continuing to contribute from home.

"It was there if you wanted it; it was always there. I always knew mental health support is available. It helped me more that there was no stress for being off, and no pressure to come back. And the employer did quite a lot of work on well-being, lots of surveys about well-being and asking what can be done to support. So yes, my employer was very much aware of it, I just personally didn't feel I needed it, but I was always aware that it was there." (Naomi).

Theme ten: Future suggestions

Stay connected

When asked what their employer could do differently to support nurses who may need to shield again in the future, a common theme of staying connected unfolded. Many suggested how it would have been beneficial for shielding nurses to have had informal virtual meetings. Providing support, sharing ideas, and coping strategies would have meant shielders’ could support each other and reduce feelings of being alone and forgotten.

"WebEx once a week, just a half an hour WebEx with everybody that was working from home, just chatted on you know, even just sharing ideas about how they're staging their day." (Lizzie).

and

"Easy to forget that there are many other people in the same situation, probably having the same thoughts and feelings as you are. A support group would be valid." (Beth).

Recognition for Shielders’

Many HCPs who experienced shielding felt that their efforts working from home had gone unnoticed by their employer (Iliff et al., 2020; Doctors in Distress, 2021). Participants in this study mirrored these feelings and felt that had they received recognition, it would have gone some way to improve psychological health and well-being.

"Just making the people that are shielding more visible to the wider team, you know, like... I don't know, just some sort of shout-out, you know, 'check-in with your working from home friends' or something like that. Just so people are reminded that there are people still trying to work remotely that do feel a little bit kind of forgotten." (Lizzie).
and

“So it did feel like the company was saying, well, we know that you’ve worked really hard, but it doesn’t count cos you’ve not left your house. Even though we were supporting the nursing service, probably better from home than what we were if we’d been out and about.” (Naomi).

**Theme eleven: Lasting Psychological Effects**

The lasting psychological effects of shielding are yet to be fully determined (Rettie & Daniels, 2021); however, it is reassuring to find that severe psychological effects were reported in the minority of participants in this study. Many shared how they remain paranoid and will continue practising increased protection behaviors; however, participants viewed this as a personal choice and not a psychological issue.

“Now we don’t have to wear masks all the time when you go to the shop; I can’t do it. I can’t leave my mask; I think I feel naked when I go in public, outside, not wearing my mask. I think that’s not going to change for a long time.” (Phoebe).

and

“Yeah, I will (continue wearing masks), I’m paranoid. That’s the lasting... because I didn’t know that I was on the shielding list and somebody tells you you’re on it, you’re then paranoid.” (Naomi).

For one participant, the lasting psychological effects are more profound. Obsessive-compulsive behaviours were triggered, and social anxiety is still debilitating at times. Extreme mood episodes were also experienced during isolation, leading to Bipolar Disorder (BD) diagnosis.

“I found it incredibly frustrating, and I was just over-reacting to it, and then obviously I had no motivation, sometimes I couldn’t get out of bed. I would still work, but I would just work from bed. So it does kind of piece together a story for me. If I got anything out of it (shielding), you know, that’s what I got out of it, I suppose (bipolar diagnosis).” (Lizzie).

and

“I was constantly snappy, constantly fury, constantly angry and everything. Erm, you know it turned into me obsessively cleaning and tidying, erm, cos I couldn’t work if something was out of place. Like if I sat on the sofa and something was out of place, I could not focus on what I was doing until it was in its right place again.” (Lizzie).

And another

“As soon as I was allowed out of the house, I wanted to be out of the house. But what I didn’t realise was that I was horrifically anxious and I didn’t know it until I went to physically go and do something, erm, and I’ve still not got over that. I still really struggle with going to shops, shopping centres, town. I just don’t like anywhere with lots of people anymore.” (Lizzie).

**Discussion**

Grounded Theory analysis of these results permitted the understanding of social identity importance and how there are significant psychological implications when this is under threat (Cruwys et al., 2014). Social Identity Theory (SIT) (Tajfel, 1974; Tajfel & Turner, 1979, as cited in, Hogg & Vaughan, 2014) is best suited to explain this phenomenon and will be referred to throughout this discussion.

Social identity is prevalent for individuals to maintain a sense of belonging and to furnish a sense of self (Cruwys et al., 2014). Being a member of a group which we associate with is how this achievement is accomplished (Baron & Branscombe, 2014). Individuals categorise themselves into groups that make them feel good about themselves, defined by SIT as the in-group. As a result of community nurses shielding, separation between them and the nurses who remained patient facing inadvertently created an out-group, one that does not comply with the culture and norms real nursing (Hogg & Vaughan, 2014). Being a member of the out-group puts social identity at risk, resulting in adverse psychological health and well-being implications (Crabtree et al., 2010).

Themes one and two (Nurses are people—people, and, Hands-on care is better care) are closely interlinked, focusing on what it means to be a nurse. The results demonstrate how people are at the heart of everything nurses do.

“To me being a nurse, it’s always been people focused and patient focused. I like to be out there interacting with people, erm, a lot of the reason why I love this job is because I get to meet new people every day.” (Jane).

The need to provide hands-on care is perceived as a fundamental part of nursing. Without this ability, the shielders’ social identity as a nurse was jeopardised.

“I missed that physical contact; missed being with that person and touching their hand for reassurance.” (Megan).

Very early in nurse training, the four themes of the NMC Code (2018) are preached to student nurses and infused into the behaviours and beliefs, embedding the nursing culture from day one. The first theme outlined in the NMC Code is to “Prioritise People” (NMC Code, 2018, p. 6), a belief that was evident during data analysis. In order to meet the professional standards of expertise which allow entry to the nursing register, student nurses must outwardly demonstrate and uphold their understanding of the NMC Code and exhibit the desired behaviours.

“So for me, a nurse is somebody that cares for people and looks after them, and that’s what it means to me, just helping people in need.” (Sally).
Comments similar to this one were verbalised by almost every participant. Some expanded to explain how nursing is a vocation and more than just a job, sentiments echoed by HCPs participating in support groups led by Doctors in Distress (2021). Nurses are accountable for their actions and invest time, energy, and emotion into their patients, which cannot be switched off at the end of a shift.

The second theme relates to how hands-on care is better care. Physical interaction with patients is necessary for a nurse to feel like a nurse. The power of touch should not be underestimated, and when physical care is removed, nurses feel that a part of their identity is lost.

“Nursing is about being hands-on, which might be considered old-fashioned these days. Nursing is about being face to face, not at the end of a phone. Nursing had gone, could no longer see patients. Virtual technology such as Apps is not the same. I need to physically see and look at something close up.” (Jane).

As a result of shielding nurses no longer seeing patients face-to-face, social categorisation occurred, leading to an out-group formation of ‘shielders’. The in-group was nurses who could continue hands-on nursing duties and were considered the real nurses, superior to the newly formed out-group. Social comparisons led to the out-group feeling substandard, less of a nurse, and guilty for letting their profession, teammates, and patients down.

This innate desire for physical support may be linked to self-esteem enhancement, closely linked with social identity (Baron & Branscombe, 2014). If the groups we identify with carry high status and respect, adhesion to the individual’s perception of themselves occur, thus enhancing self-esteem (Hogg & Vaughan, 2014). Consequently, involuntary social mobility to an out-group may lower self-esteem, reinforcing feelings of being disposable and increasing inter-group tension.

The third theme coded during analysis is dedicated to guilt and secret relief. Guilt is an emotion experienced when we view ourselves behaving in ways that are not consistent with our usual self, either physically or morally (Signs of Guilt, 2020). Participants felt highly guilty for not providing physical support during the height of the pandemic. The excessive media coverage of frontline nurses working in ICU with images of bruised faces and wearing PPE in demanding environments reinforced this guilt (Chattopadhyay et al., 2020). Even though most participants could work from home and support their teams remotely, many reported that this did not ease the guilt, moral injury or prevent social identity loss.

“Even though I worked from home, I didn’t feel like a nurse anymore. Just talking to people on the phone. My daughter even said I’d turned into a receptionist.” (Naomi).

Shame and guilt often come hand-in-hand, resulting in a meta-emotion whereby feeling guilty is not always associated with negative emotions; positive emotions such as relief can be equally prevalent (Signs of Guilt, 2020). Hiding the relief could suggest that shame is felt for having this emotion; however, it could also be a considerable action. Being openly relieved around colleagues who are donning and doffing PPE numerous times a day and working in dangerous conditions may be immoral, unkind, and perceived as gloating. Non-disclosure of relief forms a dual purpose; prevention of colleagues becoming dismayed and prevention of shielders’ being frowned upon and ostracised by in-group members. This behaviour may be perceived as prototypical as not sharing emotive differences may help maintain an in-group association and reduce animosity (Hogg & Vaughan, 2014).

In addition to guilt and shame, many other complex and varied emotions were uncovered during data analysis and formed the fourth theme. The majority of emotions were negative, ranging from fear, loneliness, anger, and depression. One participant shared how their General Practitioner (GP) instilled them with panic and trepidation during a routine telephone review.

“They asked if I became unwell with Covid would I want admitting to intensive care. I was only 39; of course I would want to be admitted; I’m not old enough to die. Then asked if I would want intubating, and if the worst-case should happen, did I want resuscitating! This phone call from the GP was the worst bit out of all the pandemic. Being asked if I wanted resuscitating sticks with me the most.” (Suzanne).

Following this phone call, the fear of dying from COVID-19 became very real, and the media’s daily reports of climbing death rates and images of overcrowded ICUs reinforced this. Many people suffering this turmoil would benefit from the support of friends, families, or groups with which they identify. With social networks not readily accessible due to the shielding regulations, individuals like ‘Suzanne’ were left with high anxiety and reduced psychological support. Research undertaken during previous pandemics has determined that isolation increases loneliness, depression, anxiety, and even triggers psychosis in those susceptible to such mental health disorders (Rettie & Daniels, 2021). This is unsurprising considering the lack of psychological support and resources available during such unprecedented circumstances.

Not all emotions were negative in connotation. Relief was a complex emotion due to the aforementioned association with shame; however, less compound emotions were also disclosed, such as feeling protected, safe and grateful for having the opportunity to continue working from home.

Humans are social animals who live and work in social groups, and a shared sense of social identity is essential for good mental health (Hogg & Vaughan, 2014). Physical interaction is crucial as it helps build trust and connectedness, both essential elements of social identity. When positive social identity is compromised, good mental health is under threat leading to disconnection and feelings of alienation (Cruwys et al., 2014).

Feeling trapped, claustrophobic, and having no control over the situation were frequently discussed. One participant described this feeling as being in a prison without bars and formed the fifth theme of analysis. Having freedom taken away felt like a punishment for having a LTHC. However, prisoners have cellmates, social interaction, visitation rights, and time spent each day outdoors; therefore, in this respect, shielding restrictions might be considered more punitive than being incarcerated when it comes to an individual’s own perception of the psychological impact it has on them. Shielding was more atone to an innocent victim in homely solitary confinement. One participant who lived alone was so traumatised by this experience that a decision was made to break the shielding regulations and escape, regardless of how severe the consequences might have been.
“I remember sitting here towards the end of the three months and just getting in the car, drove to the supermarket; I just wanted to do something normal. I didn't know what I was supposed to do, the rules. I didn't realise I had to line up outside; I had to ask for help. Something simple, walking round a supermarket, it was like being on holiday. It was absolutely lovely; it just boosted me up. A prison without bars, it was horrible.” (Megan).

Haney (2003) states that when prisoners in solitary confinement are deprived of human contact, they often lose their minds, as relationships with other people are vital in the creation and maintenance of social identity and a sense of self. Whilst shielding nurses’ realities are not quite identical to prisoners in solitary confinement, data from this study suggests that the feeling of isolation that can result from shielding could have similar effects.

The sixth theme highlights that shielding was an unpleasant experience; however, it was not bad all the time. Many challenges mirror those of the general population, such as missing families, boredom, and loneliness (Matias, Dominski & Marks, 2020). Participants expressed how they grieved their career, their social identity and were concerned about the future.

“Uncertainty of how long it is going to last. Is this now life forever? Is my nursing career as I knew it over? Not knowing when they would let me back out. A long 11 weeks!” (Jane).

and

“Scared, a lot of unknown. How will I stay up to date? NMC revalidation...it did bring my career into question.” (Asha).

Shielding was predominantly a negative experience for participants involved in this study; however, there were some positive affirmations of being lucky compared to others. Associations with those in worse situations may be considered self-serving bias and self-esteem enhancing (Hogg & Vaughan, 2014), but it is also a form of social change/creativity, as portrayed in SIT literature, an element important for positive distinctiveness. Direct comparison with those in a worse situation makes people feel better about themselves, and acknowledging the positive things in life helps build mental assets and improve well-being (Positive Psychology Centre, 2022). This comparison and positive distinctiveness may go some way towards explaining why for some, shielding was not all bad.

The community spirit and Thursday night clapping were considered a positive aspect of shielding; however, some participants felt that this was NHS-focused and private nurses were unacknowledged. In addition, many felt undeserving of any appreciation as they did not associate the support they provided remotely as the frontline.

“I remember the first Thursday I went outside, didn't think anyone would be out there, but everyone was out clapping. This choked me up. People bonded; it was nice.” (Megan).

and

“All the love being shown to frontline workers, I didn't feel like I was one of them because I wasn't out there in the thick of it.” (Melanie).

The seventh theme was formulated around virtual technology and how this enhanced the participants’ remote working experience. Technology such as VAs was considered fundamental for continuing an element of nursing duties. By performing VAs, participants felt they had delivered an aspect of nurse care, and seeing a patient at the other end of a video call enhanced morale and self-esteem, making them feel more like a nurse and closer to the in-group.

“Luckily, we had the App for virtual visits. I still felt useful, would have hated being at home not being able to do anything to help. I was able to do part of my role because of the App; I could do virtual training and things like that, training patients.” (Megan).

and

“It was brilliant when you actually spoke to a patient and helped them; it felt like I'd done an actual visit. The App enabled me to still feel like I was doing something nursey. The App probably stopped me from going mad” (Naomi).

Virtual technology was the closest thing to physical contact and became a lifeline to the outside world. Numerous studies on the effectiveness of this technology have been conducted throughout the pandemic (Maffoni et al., 2021). Although some felt VAs were less personal, and some patients missed the reassurance of a physical examination, the benefits of contact-free consultations during the pandemic were appreciated (Parkinson et al., 2021). Virtual appointments have increased accessibility to HCPs, reduced travelling times, and protected CEV patients due to less exposure to others (Maffoni et al., 2021). Participants in this study felt VAs were not a form of real nursing but it was better than nothing. Research suggests that patients have valued the option; many felt that care was not negatively impacted, and for some, it even improved (Ervin, Weller-Newton & Phillips, 2021).

Support from managers and teammates were reassuringly positive overall and formed the eighth theme during analysis. Many participants felt included due to their managers and teammates keeping in regular contact. This contact was considered mental health support (albeit indirectly) for many participants and was imperative to prevent loneliness and maintain a connection with the in-group.

“The team were locking me up if needed. My manager was a good support, always there to support when things got too much.” (Beth).

However, there was scepticism around this support, and some regarded it as inauthentic. The following excerpt is from a participant who decided to return to working in the community after a short time shielding.
"Do you have any advice how I feel less negative about people that actually shielded and let everybody down in my eyes? When you consider that you have very limited specialist team who can do what we do, considering the effect it can have." (Phoebe).

This statement demonstrates that the out-group feelings of subordination were, to some extent, valid. The attitude toward "people that actually shielded" highlights the self-esteem hypothesis and the positive distinctiveness of SIT (Li, Xu, Fan, Zhang, & Yang, 2021). Pre-judgments are being made that all shielders' are the same and not viewed as favourably as those who continued their regular duties. Shielders' are stereotyped as selfish and traitors, putting themselves before patients and breaking the norm of the nursing culture. Here the out-group is perceived as letting the nursing profession and patients down, negatively impacting the already limited resources. This participant may have an increased sense of self-esteem, deeming themselves superior and viewing their in-group more favourably than the out-group, thus reinforcing positive distinctiveness (Baron & Branscombe, 2014). In addition, the advice is requested from the participant, for the participant and the statement fuels in-group bias, ethnocentrism, prejudice, and discrimination (Hogg & Vaughan, 2014). The out-group homogeneity effect is also evident in this statement. People that shielded are generalised, suggesting a negative association with all people who shielded. Upon further probing of this question, it was determined that the participant was referring to only one person they felt let down by. However, this overgeneralisation suggests a more profound resentment to all shielders; the out-group.

This participants' perception that shielders' have let the nursing profession down reinforces the guilt and shame felt by many. Knowing that colleagues have these stigmatised judgements, whether inwardly or outwardly, helps explain why guilt is so profound. For this participant, the need for self-esteem enhancement and belonging to a group that psychologically matters (Cruwys et al., 2014) outweighed the risks of severe illness or death should they contract COVID-19. It is striking to learn that the need to belong to the in-group is so extreme that for this participant, the risk of death by COVID-19 (which may be considered suicide) was not enough to deter them from social mobility (Hogg & Vaughan).

With regards to the employer, feelings of being forgotten, judged, devalued, and fraudulent were prominent during data analysis and formed the ninth theme of this study. These statements are echoed by NHS nurses and HCPs who were required to shield, therefore, are not directly associated with nurses in the private sector (Nolan, 2021). The following statement is an example of how the perceived lack of recognition from the employer fuelled inter-group conflict and a sense of us and them. Recognition is required to boost morale, self-esteem, and motivation, and when this is not received in ways that are meaningful to the individual, feelings of resentment will transpire (Hogg & Vaughan, 2014).

"I just think that everything was so focused on the nurses in the field that were doing such an amazing job, which they always do, that they kind of just dismissed, you know, the good ones are out in the field, and they left the bad ones behind cos they had no use for them cos they were working from home."

(Lizzie).

Not all participants felt animosity towards their employer. Some were grateful for the protection and option to work from home. Performing an element of nursing care was better than doing nothing and staying safe outweighed any other incentives. Those that were able to adapt their roles appeared to have better experiences of shielding than those who were furloughed. Furloughed nurses felt significantly devalued however they were not in direct competition with an in-group of other nurses. Being furloughed may have resulted in less pressure to be part of the in-group, and arguably, furloughed nurses may have had a better experience of shielding than those working from home.

A repetitious response formed the tenth theme of future suggestions when asked what could be done differently to support community nurses should they ever need to shield again. Many participants were unaware of whom the other shielders' were, resulting in a fragmented out-group. Weekly virtual gatherings for those who were shielding would have provided solidarity, psychological support, and a platform on which they could have their say.

"A group of everyone who was shielding getting together may have helped. Support for each other all going through the same thing. Informal support and a coffee together." (Suzanne)

and

"It would have been nice to have a drop-in where you could chat. I wouldn't have been the only one feeling guilty, guilty for not being able to support your team. It would have been nice to chat with others, to support each other when we were struggling." (Naomi).

Participants also suggested that shielders' should be recognised for their efforts if shielding is ever enforced again. The lack of recognition had significant psychological effects on participants, and many were passionate that this should not re-occur. Not only recognition for individual nurses working from home but the entire nursing cohort who are in the same situation.

"Those more able bodied, or don't have anything autoimmune or anything like that, who were going out and doing their regular job, you know were getting more recognition that what, you know, than us and that was that was quite difficult I've got to admit." (Lizzie).

This would go some way towards raising the out-group profile, make them feel valued, boost self-esteem, increase motivation, and feel like they are still a part of the wider team. Doctors in Distress (2021) launched virtual support groups for shielding nurses (amongst other HCPs); however, they are aimed at NHS employees. The inter-group conflict between NHS and private sector staff warrants further discussion than word count allows; however private nursing companies should follow this example.

The final theme concentrated on the lasting psychological effects of shielding, most of which were considered non-problematic. Many participants shared how they remain paranoid, continuing to wear face masks and practice enhanced hygiene techniques; however, this was considered a personal choice rather than a psychological effect. This is debatable as choosing to continue these behaviours suggest that fear has remained prevalent and is likely to increase anxiety; therefore, the psychological effects cannot be fully dismissed (Matias et al., 2020).
"I still wipe things down, erm, especially when I go round the shops and see like loads of people not wearing masks and coughing all over the place and that. Yeah, I'll just wipe it all down when I get in, yeah, so we've never stopped, never stopped doing that, erm, and I've never been anywhere without a mask." (Jane).

For one participant, the lasting psychological effects have been more severe as they continue to suffer from social anxiety, OCD behaviours, and coming to terms with a diagnosis of BD.

"It is one of the things I really struggled with, after shielding; I could no longer do some of the things I used to like doing. Like, I could not walk into a cinema at all, don't know why… big dark room with loads of people, it's not my idea... even things like going to shopping centres, going into town, even going into a supermarket on a weekend when it's busy, sometimes I walk in and I've got to walk straight back out again, and that's one thing I haven't got over since shielding. It's funny how something can change in the space of three months, you know, three months of just being in the same house, and all of a sudden you can't do anything anymore. It's just crazy." (Lizzie).

Research to date suggests that shielding has resulted in mental health deterioration, with many reporting this to be severe (Rettie & Daniels, 2021). This participant felt that shielding-induced isolation was the trigger for these psychological issues, and the diagnosis of BD would not have been reached so soon if shielding did not occur.

Limitations

The findings of this study are interesting; however, some limitations exist. Participants were all female, which may cause bias in the results. The perception of male participants would have enriched the data and should be considered in future research. Virtual interviews were a necessity due to COVID-19 restrictions, and although they were successful, there is the potential for missing non-verbal cues, misreading body language, and feeling less personal. Occasionally, the internet connection would fail, causing brief disruption, resulting in potential frustration for the participant and missing important sentences mid-flow the conversation. Finally, some participants stated how time has been a healer, and had they been interviewed nearer to the time they were shielding; their answers may have been more emotive. Where possible, further research should be performed as close to the event as possible to ensure the data is raw and as authentic as possible.

Conclusion

The present study explored the psychological effect of shielding for a cohort of community nurses working in the private sector who were deemed CEV. Grounded Theory analysis determined that social identity threat was the underlying cause of psychological issues and distress, and a dichotomy of emotions was evident. The relief of being safe at home and the guilt of not fulfilling their full clinical role as a community nurse left many feeling marginalized and less like a real nurse. The need to keep feelings of relief a secret suggests associated emotions of shame and a desire to maintain an association with the in-group of real nurses. Shielders* felt forgotten by their employer, which reinforced social identity threat. Depression and low mood were felt by many and are closely linked with social identity loss. Fear and paranoia were prevalent amongst many participants, and they continue certain protective behaviours even though shielding has been discontinued. For one participant, the psychological implications were significant, ultimately leading to a diagnosis of BD. Participants felt that if their employer had given more recognition for the support they provided remotely and, virtual meetings had been organised with other shielders* whom they could reach out to for support, the adverse psychological effects are likely to have been less pronounced. The COVID-19 pandemic was unprecedented, and it is unlikely that such an event will happen again in our lifetime. However, if a similar event was to occur, these are the suggested actions to prevent psychological distress amongst community nurses working in the private sector.

Declarations

Author contributions:
The first author SS was responsible for the initial study conception and design, material preparation, data collection and analysis. The initial manuscript was written by the first author and then reviewed and revised by the co-author KA. Both authors commented on previous versions of the manuscript and approval of the final manuscript was agreed by both authors.

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All authors certify that they have no affiliations with or involvement in any organisation or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.

Ethics approval and consent to participate

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional committee and the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. Approval was granted by the Ethics Committee of Arden University, United
References


Figures
Figure 1

Word Cloud: the 75 most commonly used words when asked what being a nurse meant to them.
Figure 2

*Emotions community nurses experienced that are associated with shielding.*