



# The experiences of nurses during COVID-19 in British Columbia, Canada



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The Risk and Resilience Project identified the effects of COVID-19 on women healthcare workers' health and wellbeing in British Columbia (BC). This brief provides an overview of the findings from research with nurses. It identifies levers of change to strengthen gender-responsive health systems and better support women healthcare workers to ensure they can provide a high standard of care whilst protecting their own wellbeing and career progression. Our analysis highlights risks, challenges and inequities faced by women nurses during the pandemic in BC. The data indicates the need for systems-level change in terms of policies and procedures for women nurses during the pandemic to ensure the safety of both themselves and their patients.

*"I'm only staying for my colleagues and as soon as this pandemic is over, I'm no longer going to be a nurse."*

Nurse, focus group

### Policy recommendations

1. Supply frontline healthcare workers with continual access to adequate, high-quality Personal Protective Equipment (PPE) to reduce the risk of COVID-19 infection
2. Provide paid leave and benefits to healthcare workers who experience COVID-19 infection or mental health problems or have to provide care to dependents affected by COVID-19.
3. Offer training and education opportunities for healthcare workers to keep up to date with changing protocols while minimizing potential increases to their work burden, such as by providing paid education days.
4. Hire more nurses to help reduce workloads and burnout and ensure healthcare workers can take time off when needed.
5. Increase women healthcare workers' representation in health care leadership and participation in decision-making opportunities to enable them to advocate for policies that meet their needs and those of their patients and clients.
6. Arrange childcare support in a manner that is accessible and considers the schedules and needs of frontline healthcare workers, such as by offering onsite childcare.
7. Encourage flexibility in working hours and opportunities to work from home whenever possible to allow healthcare workers to better balance their paid and unpaid caregiving roles.



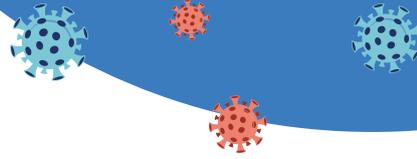
8. Run public awareness campaigns that combat misinformation around COVID-19 to reduce stigma towards healthcare workers.
9. Establish programs and opportunities for healthcare workers to access fresh and healthy meals during their work shifts.
10. Offer proactive support to tackle mental ill-health and burnout, such as burnout prevention activities or providing mental health professionals onsite for debriefing and counseling.

### Background

Previous studies have established that pandemics and other natural disasters play a major role in exacerbating gender disparities in the healthcare workforce<sup>1-4</sup>. However, there is a lack of research that critically analyses the drivers of differential gendered impacts. Our study addresses this gap by focusing on how gender dynamics shape the experiences of women healthcare workers in BC.

90.2% of nurses in BC identify as women<sup>5</sup>. In addition to this, Canadian women often occupy the primary care role in their families, engaging in nearly double the amount of unpaid work than their male counterparts<sup>6</sup>. Due to these intersections, women nurses are responsible for a large bulk of COVID-19 related care work both in home and in health facilities.

In January 2020, the first COVID-19 infection was confirmed in BC. The province had a steady increase in infection rates, and a public health and provincial state of emergency was declared in March 2020. By March 2021, the province had reached 90,000 COVID-19 infections, with 7.3% of the infections among healthcare workers. Nurses and licensed practical nurses made up 17% and 5.6% of the infected healthcare workers in BC, respectively<sup>7</sup> - the second most infected group provincially, following care aids. A survey<sup>8</sup> conducted in July 2020 showed that among 3,676 working nurses, 47% met the criteria for PTSD, 38% for anxiety, and 41% for major



depression. These mental health issues were largely attributed to a rapid increase in workload due to staff shortages, limited access to appropriate PPE, and concerns around infecting family and friends with COVID-19<sup>8</sup>.

In 2010, the Canadian Nurses Association (CNA) and the Registered Nurses' Association of Ontario (RNAO) carried out a research project to explore the impacts of fatigue and burnout among Canadian nurses<sup>9</sup>. Results showed that 68% of nurses reported experiencing the effects of sleep deprivation. Systemic issues such as heavy workloads and staff shortage, shift work, restricted time for professional development, lack of leadership opportunities, and increased patient expectations were all reasons for nurse fatigue. The existing challenges faced by nurses placed them at a high risk of being negatively impacted by the pandemic.

## Methods

As part of the Risk and Resilience Project, 11 nurses participated in four focus groups, and two participated in individual semi-structured interviews. All data collection was conducted virtually over Zoom between January 2021 and February 2021. Ethics approval was provided by Simon Fraser University, and all participants provided informed consent prior to participation. Themes explored during analysis related to impact at the individual, household, community, and health systems level and associated coping strategies and support.

## Findings

Nurses faced numerous challenges while working during the COVID-19 pandemic. These included the risk of contracting COVID-19, increased scope of practice and responsibilities, constantly changing protocols, and difficulties balancing work-life responsibilities. Concerns about burnout, long-term mental ill-health, and impact on career progression were also prevalent. Despite these concerns, participants also highlighted a high level of commitment to patient care and pandemic response.

Our findings are grouped to explain the health system, community and household, and individual level factors that impacted women nurse healthcare workers in BC during the COVID-19 pandemic. The implications of the pandemic on the nursing profession in BC over the longer term are also discussed.



Anxiety  
Resilient Exhausting  
**Stressful**  
Transformative Chaotic  
Disheartening Uncertainty

**Above:** Nurses shared one word that most accurately captured their experience as a frontline healthcare worker in BC during the COVID-19 pandemic.

### 1.0 Health system level factors

How the BC health system as a whole responded to the COVID-19 pandemic had a major impact on women nurses in terms of their risk of infection, access to resources, and working conditions.

#### 1.1 Risk of exposure to COVID-19 and access to PPE

Nurses are frequently in close physical proximity to the patients they treat. Despite this close contact, many participants reported that they did not have adequate access to PPE. Participants described sanitizing, recycling and reusing gloves and masks, including N95 masks, to conserve them due to limited supply. Lack of protection was particularly a concern for nurses who were immunocompromised or pregnant. Nurses were aware of their risk when procedures did not go as planned or PPE failed.

Being able to contribute to decision-making regarding the types of PPE used increased nurses' sense of being supported by the health system. This also held true in situations where PPE was consistently available. Open communication from management regarding the availability of PPE increased positive feelings of accountability and transparency among nurses. On the other hand, instances where employers would lock up PPE and only allow access at designated times or under supervision increased tension within facilities.

**“The first thing that they did at my workplace was lock up all the PPE, so we didn't have access to masks right off the bat, even just plain masks or gowns or gloves... Twice a day the door would be unlocked for an hour, somebody stood in that room and watched us count each and every glove that we took.”**

Nurse, focus group

Additionally, the lack of access to PPE sometimes felt specific to the nursing profession, as other essential workers were perceived to have a steady supply.

**“Our paramedics [are] in N95 masks... a shield, gloves up to here, a full suit, and we’re running around with a little mask on our face. And the police, the same. They have filtered masks. And [we] are your healthcare providers. And so, I totally feel like our whole profession was disrespected.”**

Nurse, focus group



## 1.2 Difficulty adhering to COVID-19 protocols

Protocols for COVID-19 safety while caring for patients were developing and changing throughout the pandemic. When it came to implementation of the protocols, practical issues regarding patient care and workload arose. Nurses noted that many safety practices increased risk or wasted time, such as placing swabbed patients in the same room before obtaining the results from their COVID-19 test. Additionally, nurses mentioned that the new policy documents were at times lengthy, and they did not have the capacity to absorb all the new information due to increased responsibilities while maintaining a high standard of care. Participants noted that the disconnect between designing and implementing protocol occurred because the management made decisions at a level distant from patient care and did not consult with nurses. This disconnect caused confusion as well as apprehension towards the new protocols.

**“On some days we would have changes three, four times in one shift... If you were wearing an isolation gown to this room, the next day you weren’t supposed to anymore, and then again you were. So, it just felt like, ‘Wait, am I exposing myself?’ Are the policies based on best practice, or are they based on supply and demand?”**

Nurse, focus group

**“When you’re in that office space, I think a lot of people... just don’t know what nurses go through or what we’re dealing with on a daily basis, and they kind of forget about... Is this practical, is this going to even work? Is it even going to be implemented?”**

Nurse, focus group



## 1.3 Increased workload

Participants took on a heavier workload to rapidly respond to the needs of the health system during the pandemic. In many cases, COVID-19 responsibilities were added on top of already high workloads. Even nurses who were not providing direct COVID-19 related care experienced increased workloads. For example, those working with people who use substances or are experiencing homelessness saw their caseloads increase due to greater pressures on their patient populations and restricted access to community services, all of which led to increased social isolation among their patients.

**“The acuity of my clients changed rather rapidly. There was a toxic drug supply, the borders were closed, clients were using toxic substances and due to stress, they relapsed on those substances. So, my caseload went completely sideways within about two weeks... We would have five to ten clients a week sent to my team. The first three weeks of the pandemic we had 75 referrals and that’s on top of the caseload of 39 clients that I was already carrying.”**

Nurse, focus group

## 1.4 Moral obligation: Providing a high quality of care

Although workloads were heavier and circumstances were more stressful, participants described a moral obligation to continue providing care during the COVID-19 pandemic. Participants explained that they and their coworkers feel guilty for calling in sick or taking a mental health day, and that COVID-19 related absences were the only justified reasons for missing work.

**“I was willing and able to go to work in that completely broken state because I’m a nurse and that’s what nurses do.”**

Nurse, focus group



Those participants who did take time off to manage their own mental health and/or COVID-19 infection voiced guilt due to the perceived impact it would have on patients.

***“The immense guilt of having to make that choice to step away during a global pandemic and an opioid crisis, I think that guilt was the hardest. It absolutely killed me to make that choice. It was the hardest decision I ever made in my life and I still regret it and feel immense guilt and shame that I couldn’t do it despite doing the very best that I could.”***

Nurse, focus group

Additionally, feelings of moral obligation resulted in participants pushing the boundaries of COVID-19 regulations to provide more care to their patients. Although policies required nurses to reduce the time spent with patients to diminish the risk of COVID-19 transmission, many found it difficult to deny patients’ requests for emotional support. When COVID-19 protocols inhibited patient care, nurses often blamed themselves.

***“It’s upsetting because there’s a few moments, on my last couple of sets, where I couldn’t get into the room on time... I have to properly protect myself with a mask and the gloves. But meanwhile, the patient is crashing. And I just can’t get there on time. So, she ended up dying. And so, I’ve gone into counselling, so I can make sure I don’t feel the guilt.”***

Nurse, interview

### 1.5 Lack of financial support

Although there was a slight increase in the hourly salary of frontline workers for 16 weeks beginning in March 2020, this was only a temporary measure. A participant explained that this supplementary pay ended early in the pandemic, but their work with COVID-19 patients did not. Nurses were concerned about the repercussions of taking time off for childcare,

as unpaid leave was the only option. There were also financial implications related to taking time off work for a COVID-19 infection, as they were forced to take sick or unpaid leave. One nurse described receiving the following message from her supervisor regarding taking time off after a COVID-19 infection:

***“If you have to go off of work because you might be positive for COVID, we’re not going to pay you for that either. It’s going to come out of your sick [leave] or you get unpaid leave. So sorry about your luck.”***

Nurse, focus group

### 1.6 Exclusion from decision-making

There were varying levels of involvement in decision-making about the pandemic among participants. Many described never being asked for their input by management, while those who were asked for their input often described that they did not feel their insights were listened to or influenced policy. This was a major issue for participants, as new protocols and policies have a major impact on their lives.

***“I would like to at least be involved. If they’re going to implement a new change or policy, I would love for my opinion to be heard, or my thoughts, just because I think that a lot of the initiatives taken sometimes aren’t taken from the frontline staff’s considerations – like, how much time that adds to our day. Or how much that small change affects patient care or time management.”***

Nurse, focus group

***“It’s almost like, ‘I’m asking because I’ve been told I have to ask you as an employee what you see or feel or want to do. But I’m going to do what we’re going to do anyway.’ That’s basically it.”***

Nurse, focus group

## 2.0 Community and household level factors

Nurses described many increased risks and pressures at the household and community level that impacted their families, their ability to care for dependents, and their community presence.

### 2.1 Misinformation and stigma towards nurses

Participants described feeling a sense of frustration with the misinformation and conspiracy theories present among the public as well as their families and friends. They felt invalidated when the work they were doing, and the risks they took, were undermined by the public.



***“To hear of all the conspiracy theories and to hear about the people thinking it’s just a way for the government to control us and these anti-maskers... It was just very disheartening and difficult to digest all of that misinformation and everything that was happening and then what I was actually experiencing every day.”***

Nurse, focus group

Stigma was also consistently experienced among nurses due to their proximity to COVID-19 patients. Nurses working with priority populations, such as those who use substances or were experiencing homelessness, faced another layer of stigma. This was mainly because these patients were perceived as having a higher risk of acquiring COVID-19 and were labelled as “dirty” or at fault for their complex health needs.

***“I was saying how we were helping out a COVID patient or whatever that morning. And one of the people in the office had overheard me and had gone to the manager and said ‘Well, if she was dealing with a COVID-positive patient, why is she even in this office?... So, I even experienced my own stigma from another healthcare worker. And that wasn’t the only time. So, you had healthcare workers against healthcare workers, as well.”***

Nurse, focus group

## 2.2 Fear of infecting friends, family, or community with COVID-19

Almost all participants reported a strong fear of acquiring COVID-19 in the workplace and subsequently spreading it to others. One nurse described feeling guilty for putting her elderly family members at risk simply by going to work. Nurses described constantly cleaning themselves and surfaces to prevent the spread of COVID-19. While aimed at keeping family members safe, such procedures also strained relationships as, for example, children found it difficult to understand why, after work, their parents had to wash their hands and change clothes before playing or hugging. The need to balance family safety and care needs caused persistent anxiety.

***“We’d have to shower and change at work and then I would be literally bleaching every single thing that I could possibly touch...It was just a constant anxiety for me to clean everything. So, that was kind of where my head was at constantly. My brain wouldn’t stop ever.”***

Nurse, focus group



## 2.3 Increased challenges with childcare

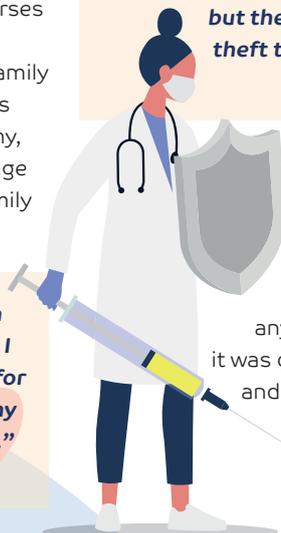
As many participants were also mothers, many reported challenges accessing childcare support during the pandemic. Schools and daycare services were either extremely limited or completely closed, meaning that participants had increased childcare responsibilities. This was exacerbated in circumstances where the participant was a single parent, or their partner was also an essential worker and could not participate in childcare responsibilities. At times, participants had to assess the risk of having an older or immunocompromised family member watch the children, or they had to take time off work to support their children. Some participants requested more flexible work schedules in order to accommodate for childcare, but these requests were often denied.

***“I could have juggled a bit more with my husband and it would have been a little less of a crisis situation sometimes. And it was totally unnecessary, I could have got my work done at different hours of the day and it would have been fine for all of my patients. It would not have impacted their care at all, but they were so obsessed with time theft that they couldn’t be flexible.”***

Nurse, focus group

## 2.4 Difficulties maintaining work-life balance

Participants described that as their responsibilities increased both at home and at work, it became harder to achieve any sort of work-life balance. On one hand, it was difficult to focus at work due to the stress and anxiety participants felt for their family’s well-being. On the other hand, longer and more strenuous hours at work were impacting familial relationships due to



limited time and exhaustion. In addition, as COVID-19 was constantly discussed in all facets of their lives, many felt overwhelmed and unable to cope.

***“As nurses, we’re so good at compartmentalizing... You see a lot of traumatic things, you sometimes are dealing with patients that are just in the aftermath of trauma and you got to put that in a box or in a room inside your mind and that’s your work box, right? And when your home life is out of kilter and you don’t have your support people, you don’t have things to put back into your emotional bank, then you start to run on empty and then you take Benadryl and wine and hope that everything goes away.”***

Nurse, focus group

### 3.0 Individual level factors

Participants consistently described experiencing negative physical and mental health impacts due to the increased challenges and responsibilities in the workplace and at home. This ultimately led to burnout among nurses.

### 3.1 Physical health impact

Nurses described an array of physical issues caused by working during the pandemic. Issues such as insomnia/difficulty sleeping, digestive issues (nausea and diarrhea), and obstacles to healthy eating were discussed by many. Although restaurants and catering companies donated meals and offered discounts to healthcare workers, these efforts largely halted after the first month of the pandemic. Due to the busy nature of shifts and the lack of breaks, nurses ate very little or nothing at all during their shifts. In addition, in some workplaces, the management restricted access to refrigerators, dishwashers, microwaves, and other cooking spaces in order to reduce COVID-19 transmission. One nurse noted that due to the strenuous conditions, she was forced to rely on leftover food from used patient trays.

***“We’re healthcare heroes, but no. We’re not actually treated as heroes by our actual employer. Not like you want to be treated like a hero... [but] we don’t even have access to free coffee and tea, or a fridge.”***

Nurse, interview

### 3.2 Mental health impact

Participants described their experience during the pandemic with words such as stressful, anxiety, and disheartening. They described worrying about many of the issues noted above including family safety and securing childcare, increased workloads and scope of role, fear of being infected and spreading COVID-19, and social isolation and stigma from the community. These factors all contributed to the nurses’ ability to cope. Some participants described being diagnosed with major depression, anxiety, and/or post-traumatic stress disorder for the first time in their lives, during the pandemic.

***“I was diagnosed with severe depression, severe anxiety in the context of post-traumatic stress disorder. I have never had mental health issues in my entire life. I can actually talk about that today without crying, but seven months ago if you asked me how was work, I’d burst into tears and shut down.”***

Nurse, focus group

Nurses also expressed feelings of trauma, stress, and grief while caring for their patients during the pandemic. This held especially true for nurses working with priority populations, as they were unsure if their patients would survive the pandemic. The extremely heavy workloads made it nearly impossible to decompress and process the traumatic situations, making their situation even more challenging.

***“Sometimes you go through second-hand grief almost, going through a difficult situation at work, and you feel really overwhelmed. But the department is busy, so you can’t go for a walk for 30 minutes; you can’t really decompress... You’re in a full assignment and doing things while your head is somewhere else, and you’re just trying to function and do all the tasks and not make any mistakes.”***

Nurse, focus group





A few participants either increased their counseling sessions or began therapy during the pandemic. These services were not connected to their workplace. Some participants discussed the interrelationship between their mental health and their physical health. Difficulties sleeping and/or eating were often deemed as physical manifestations of the mental stress they were facing. In addition, substance use such as alcohol, antidepressants, and over-the-counter medications increased as a method of coping.

***“I had sleeping pills, anti-anxiety medication, antidepressants whatever you want to call them. I had to go through multiples of them before I could find one that worked for me.”***

**Nurse, focus group**

Nurses mentioned the need to de-stigmatize mental ill-health and increase services for healthcare workers, particularly personalized services that take an active rather than passive approach. While virtual counselling was available to some participants through the Employee Assistance Program, it was not seen as providing appropriate or active support for the nurses.

***“They keep sending you emails and ‘By the way, look after your mental health, here’s a link.’ That’s about the extent of it... ‘You’re not busy enough, you’re not stressed enough. Here you go, you also need to manage your mental health better... It’s on you.’”***

**Nurse, focus group**

### 3.3 Occupational burnout

As the scope of nurses’ roles increased, staff shortages continued, and participants felt unsupported, many identified themselves as at high risk of occupational burnout. Participants described undergoing traumatic situations wherein decompressing at home would be the standard

procedure, but they were not able to due to staff shortages and/or feelings of guilt.

***“We have personal days we can take, and I’ve tried to take six and been denied those six just because we don’t have staff coverage... People are burnt out, but I’m not tired of nursing. I love nursing; I just think I’m overworked.”***

**Nurse, focus group**

### 4.0 Long-term implications

Participants noted that the pandemic had major long-term implications for their careers, and those of their colleagues. Multiple nurses described that both themselves and their colleagues had to take extended time off from work, seriously considered quitting their jobs, or actually did resign due to burnout, mental health conditions, or COVID-19 infection. As there were already staff shortages, the fact that nurses were leaving the profession was even more alarming.

***“We were not prepared. They all talked about ‘Oh, pandemic planning, we’re all prepared from the start.’ No, we failed. We sucked. We did a horrible job, and the healthcare workers are going to pay for it mentally for many years after this. We even have nurses at stake... There’s a lot of people who are like, ‘I’m only staying for my colleagues and as soon as this pandemic is over, I’m no longer going to be a nurse.’”***

**Nurse, focus group**

### Conclusions

The findings of this study point to a need for change on both a macro and micro level. There needs to be improved strategies to support nurses in BC, both in times of calm and during times of crisis. Systemic changes should revolve around supporting nurses by combating gender inequities in the health system and the home. Given the integral role that nurses have played in crises, it is crucial to ensure that all systems and policies in place that impact nurses are developed with their input and safety in mind.

Fair compensation and benefits need to be guaranteed for nurses working in essential healthcare during times of crises, and between crises. Pandemic pay and funding to implement COVID-19 safety measures in their facilities are a necessity. Additionally, paid sick leave should be provided, especially during a pandemic. Lastly, expansion of job scope should be accompanied by fair compensation.

Family-friendly policies and work environments are necessary for women nurses, as they often have to balance increased childcare responsibilities. This can be in the form of providing onsite childcare, improved access to childcare in the community, flexible work schedules, and paid care days. PPE needs to be accessible, appropriate, and available to all nurses.

Lastly, mental health resources should be accessible to all healthcare workers to assist them in coping with anxiety, stress, depression, and burnout. More specifically, these resources should be active rather than passive, engaging more with workers who may not have the capacity to seek out these resources themselves. Additionally, there should be the promotion of self-care, with frameworks in place to make this possible for healthcare workers. Lastly, nurses should be involved in decisions that affect their work environment and livelihoods.

## References

1. Davies SE, Bennett B. A gendered human rights analysis of Ebola and Zika: locating gender in global health emergencies. *Int Aff*. 2016 Sep 1;92(5):1041–60.
2. Connor J, Madhavan S, Mokashi M, Amanuel H, Johnson NR, Pace LE, et al. Health risks and outcomes that disproportionately affect women during the Covid-19 pandemic: A review. Vol. 266, *Social Science and Medicine*. Elsevier Ltd; 2020. p. 113364.
3. Power K. The COVID-19 pandemic has increased the care burden of women and families. *Sustain Sci Pract Policy*. 2020 Dec 10;16(1):67–73.
4. Bali S, Dhath R, Lal A, Jama A, Van Daalen K, Sridhar D. Off the back burner: Diverse and gender-inclusive decision-making for COVID-19 response and recovery. Vol. 5, *BMJ Global Health*. BMJ Publishing Group; 2020. p. 2595.
5. Canadian Institute for Health Information. Health Workforce Database [Internet]. 2019. Available from: <https://www.cihi.ca/en/health-workforce-database-metadata>
6. Statistics Canada. Time Use: Total work burden, unpaid work, and leisure [Internet]. 2018 [cited 2021 Apr 20]. Available from: <https://www150.statcan.gc.ca/n1/pub/89-503-x/2015001/article/54931-eng.htm>
7. BC Centre for Disease Control. COVID-19 Cases in Healthcare Workers in BC, January 2020-March 19, 2021.
8. Havaei F, Ma A, Staempfli S, MacPhee M. Nurses' Workplace Conditions Impacting Their Mental Health during COVID-19: A Cross-Sectional Survey Study. *Healthcare*. 2021 Jan 16;9(1):84.
9. Canadian Nurses Association. Nurse Fatigue and Patient Safety [Internet]. 2010. Available from: [https://cna-aiic.ca/-/media/cna/page-content/pdf-en/fatigue\\_safety\\_2010\\_report\\_e.pdf?la=en&hash=AB24ABDD277F83524AA6F7083298FC3B35221070](https://cna-aiic.ca/-/media/cna/page-content/pdf-en/fatigue_safety_2010_report_e.pdf?la=en&hash=AB24ABDD277F83524AA6F7083298FC3B35221070)

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