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'Both assistant and specialist': Nurse Anaesthetists' experiences of being relocated during the COVID-19 pandemic: A qualitative study

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Abstract

Aim: The aim of the study was to explore the experiences of nurse anaesthetists being relocated during the COVID-19 pandemic.

Design: The study has a qualitative design.

Methods: A total of 12 nurse anaesthetists from four different hospitals were included. Data were collected using individual semi-structured interviews and then analysed using content analysis. The Consolidated Criteria for Reporting Qualitative Research checklist was used.

Results: The 12 respondents, of whom three were men, were between 46 and 64 years old and had 7 to 30 years of experience as NAs. Two themes emerged in the analysis: (1) 'Diverse experiences' with the sub-themes 'Preparedness' and 'Insecurity' and (2) 'Both assistant and specialist' with the sub-themes 'Exhausting' and 'Meaningful'.

Conclusion: This study shows that the NAs competencies made them prepared to handle many of the situations. They also experienced situations where they were uncomfortable being pressured to take responsibility. They were regarded as a uniform group without considering their prior experiences. Mapping the personnel's former experiences is required to utilize best possible matching of personnel to assignments and create less stress and insecurity among them.

KEYWORDS
COVID-19 pandemic, nurse anaesthetist, qualitative study, relocation

1 | INTRODUCTION

The first patient diagnosed with coronavirus disease 2019 (COVID-19) was registered in Norway in February 2020. Experiences from other countries implied an urgent need for beds with respirators in intensive care units (ICUs) and specialized nurses (Norwegian Institute of Public Health, 2020). Hospitals had to increase the number of on-call personnel and cancel elective surgeries. Furthermore, they had to reorganize wards and personnel to meet the new challenges of taking care of this new patient group.

Norwegian nurse anaesthetists (NAs) typically have a master's degree with 120 European credits transfer. They are advanced practice nurses who take care of patients before surgery, administer anaesthesia and monitor their vital signs throughout the pre-, intra- and

postoperative care process. NAs also serve as resource persons in cardiopulmonary resuscitation, respiratory care and other acute situations (International Federation of Nurse Anesthetists, 2016). From early on, NAs were relocated to ICUs and specialized wards taking care of patients with COVID-19, many of whom had unstable, complicated, acute respiratory distress with poor oxygenation.

A Norwegian survey ($N = 35,143$) reported that 40% of all nurses were relocated from their usual wards. At hospitals, the NAs experienced the most changes in their working hours due to these relocations (Melby et al., 2020).

The new and unfamiliar coronavirus created confusion regarding how it was spread. There was a lack of personal protective equipment (PPE) in the hospitals, and a fear of being infected or bringing the virus home emerged (Melby et al., 2020). This was most prevalent in the first wave of the pandemic.

According to a Swedish study, when the NAs' working situations rapidly changed, the lack of information, inadequate introduction to the implemented changes and unfamiliar colleagues created feelings of uncertainty and frustration (Hallgren et al., 2022). A survey of Norwegian NAs reported that they thought their competencies were useful but not sufficient in taking full responsibility for COVID-19 patients in the ICUs (Leonardsen et al., 2021).

Prior studies have found that working or being relocated without adequate information and preparation may create frustration and a feeling of moral distress (Foli et al., 2020; Hallgren et al., 2022), which in turn may lead to increased turnover among specialist nurses that is already scarce. The working conditions during the COVID-19 pandemic varied between countries and there is little knowledge on how Norwegian NAs' work changed and how they managed their professional roles and responsibilities during the COVID-19 pandemic. Therefore, the aim of this study was to explore how NAs experienced being relocated during the pandemic.

What does this paper contribute to the wider global clinical community

- Healthcare institutions must have better routines for storage of infection control equipment.
- When relocating personnel, both education and former experience should be considered to match their competencies to assignments and reduce stress.

2 | METHOD

This study is part of a larger study that investigated the working experiences of NAs as well as paediatric, intensive care and operating theatre nurses during the COVID-19 pandemic. The current qualitative study aimed to explore the experiences of 12 NAs. Individual interviews were conducted to obtain in-depth knowledge of the respondent's experiences.

2.1 | Recruitment and respondents

To achieve maximum variation, a purposeful sample of 12 NAs from four different hospitals, two local (6 NAs) and two university hospitals (6 NAs), were recruited. The hospitals handled the pandemic differently, as some had large ICUs and more specialized personnel, while others were small community hospitals without the same capacity to take care of patients who require intensive care. A sample size of 12 NAs was considered to give a rich description of the NAs experience during the pandemic. The inclusion criteria were NAs who had experienced working with patients with COVID-19 or who were relocated to other wards due to the pandemic. NAs fulfilling the inclusion criteria were invited to participate by a contact person at each hospital.

2.2 | Ethics

Upon recruitment, eligible nurses received written information about the study from the contact person. Each participant was provided with further oral information when they arrived at the interview session. This information included their right to refuse participation or to withdraw at any point in the study. Written informed consent was collected before the interviews started.

Any audiotaped identifying information was deleted from the transcripts to safeguard the confidentiality of the respondents. The link between information concerning respondents and the anonymized transcripts was kept separately in accordance with applicable rules and guidelines for storing research material.

The project was approved by the Norwegian Centre for Research Data (Redacted). The local data protection officer and the management at each hospital gave their permission to perform the study. According to local regulations, no formal ethical scrutiny was required.

2.3 | Data collection

A semi-structured interview guide (Table 1) was developed to cover the objective, including work tasks and experiences regarding taking care of patients with COVID-19 and their families and friends. The interview guide was built in cooperation with NAs working during the pandemic and the research team. The interviews took place between January and June 2021. The audiotaped interviews lasted from 30 to 80 min and were performed at the hospital where each participant worked. Only the respondents and the researchers were present during the interviews. The respondents were encouraged to talk freely about their experiences and follow-up questions were asked when clarification was needed. Four of the authors are experienced NAs, two working as professors and two working part-time at hospitals and at

TABLE 1 Interview guide.

Responsibilities	• Please tell how you experienced your work situation during the pandemic • Please tell us what tasks and responsibilities you had during the pandemic you do not normally have? • If you were given tasks other than normal, how did you make use of your skills? Please give some examples (use/not use of competence) • Have you had colleagues other than the usual ones during the pandemic? • Please tell us about your experiences working together during the pandemic
Patient and relatives	• In your opinion, how have the patients been taken care of during this period? • Please tell about a situation where a patient was well taken care of and a situation where a patient was not so well taken care of • What experiences do you have with caring for relatives during the pandemic (information, participation and support)? • What role did the patients relatives play during the pandemic?
Concluding questions	• Thinking back, can you highlight something that was particularly nice or something that was particularly difficult? • Thinking back, is there anything you wished had been done differently? • Finally, is there anything you want to say more about—something you have not told us?

TABLE 2 Thematic analysis as described by Braun et al. (2019) and authors' contribution.

Data analysis	Description	Carried out by
1. Familiarization with the data	All transcribed interviews were read and reread, and possible interpretations of the material were discussed	All authors
2. Open thematic coding	Meaning content was extracted from each interview	All authors
3. Construction of initial themes	Themes were identified and discussed across interviews in line with the research questions and our interpretations	All authors
4. Revision of initial themes	Avoiding overlaps, discussions	ML, BTV
5. Defining and naming themes	Themes were given more clarifying names to convey their essence and reflect the results	ML, BTV
6. Wrapping up the analytical work	Themes were reduced and clustered under two main themes followed by two sub-themes Quotes were selected and agreed upon to illustrate each theme	ML, BTV

a university. Three of the authors were NA students in the last period of their masters' degree. At the time of the study, none of the authors were employed at any of the hospitals where the respondents were recruited. The authors had various experiences performing individual interviews.

2.4 | Data analysis

After each interview, the researchers in charge of the interview discussed how it was performed, their first impression of the content and the emergence of possible themes. The audiotapes were transcribed verbatim by the authors and a professional transcriber, who had a duty of confidentiality. There was an acknowledgment that the transcribed text from the audiotapes could never totally capture the complexity of an interview situation or be free of errors. Furthermore, 'ahs' and 'ohs', as well as breaks from the respondents' replies were excluded, focusing only on actual verbal descriptions (Kowal & O'Connell, 2014). Reflexive thematic analysis (TA) was used, as described by Braun et al. (2019). This methodology provides accessible guidance in performing TA research in six phases. The first step in the analysis was to ensure the quality of the transcripts by listening to the audiotapes. Then, the recordings were compared with the transcribed interviews for accuracy. All authors read the transcribed interviews to get familiar with the empiric material. Possible interpretations were discussed. Secondly each author conducted an open thematic coding separately. All authors met and discussed the open coding and initial themes were identified. The first and last authors extracted comparable codes across all interviews. These were put in a table and reanalysed to find sub-themes and overall themes. Lastly, all authors were asked to read and comment whether the sub-themes and overall themes were in line with the interviews, initial coding and research questions. Table 2 illustrates how the analysis was conducted, and Table 3 gives an example of the analysis process.

The interviews provided rich data representing different perspectives and opinions based on the NAs' experiences while working in different types of wards. However, we found many similarities across the 12 respondents and the sub-themes and themes are representative for the NAs experience during the pandemic.

2.5 | Trustworthiness

The study is compliant with the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007). These criteria enabled us to ensure the following quality criteria of the study:

TABLE 3 Examples of quotes, codes, sub-them and main theme.

Text from interviews	Code	Sub-theme	Main theme
We are used to work under different conditions. We are like a potato, can be used for anything	Flexible	Preparedness	Diverse experience
Use our clinical gaze when the patient deteriorates, capture it, describe what we see....	Observation competency		
The versatility a NA have is also a kind of competence	Versatility		
In relation to the airways, I feel that others have confirmed our competency	Management of airways		
To have the combination of both experience and an advanced specialist nurse … that you are used to thinking ahead of what to do if worst-case scenarios occur, about what to do if....	Worst-case scenarios		
It is easier to learn how to manage the respirator when you already know the anaesthetic workstation and the physiology	NAs competency makes it easier		
I felt that everybody had the same expectations to us as a group. That is not the case. When you entered a room—you get a 'tag' saying you are a NA and your supposed to manage most situations	Looked at as a homogeneous group with the same competency	Insecurity	
It was terrible to be afraid whether we had enough personnel, if the doctor would come. They were hardly there	Feeling abandoned		
I am used to cope and handle all the equipment, but they use different equipment, medications, pumps	Not knowing the equipment		
Nobody knew who the other person was, and their competencies were unknown. I need to know who I work with, their competencies and their attitudes	Uncertain about others competence		
Everything is unknown (routines and the digital management system), nothing. The preparation beforehand was very superficial and suddenly you stand there....	Inadequate preparation		
It was not a good situation when you did not know how sick the patients would be, for how long it would last and whether we could be contaminated	Insecurity		

Credibility: all interviews were conducted with the same semi-structured interview guide. This ensured that the objectives and research questions were covered in each interview. The credibility is enhanced by the description and examples of open coding and initial themes from all authors.

Transferability: All interviews were audiotaped, and the quality of the transcripts was ensured by listening to the audiotapes. Then, the recordings were compared with all the transcribed interviews for accuracy.

Confirmablity: By using reflexive thematic analysis (Braun et al., 2019) enabled the authors to compare and discuss data and results to establish consensus of the final themes and sub-themes throughout the entire analytical process.

3 | RESULTS

The 12 respondents, of whom three were men, were between 46 and 64 years old and had 7 to 30 years of experience as NAs. Uncertainties about what damages the coronavirus could bring created insecurity for all respondents as well as new routines and how work was organized. They further discussed poor education and preparation from the hospitals due to the urgency of the situation when the pandemic struck. This made them feel unprepared and insecure, and these feelings were most prevalent in the first period of the COVID-19 pandemic. However, they also described how their competencies were useful, how they felt appreciated, and their sense of pride in being able to contribute to the COVID-19 efforts.

TABLE 4 Sub-themes and themes.

Sub-themes	Themes
Preparedness	Diverse experiences
Insecurity	
Exhausting	Both assistant and specialist
Meaningful	

Two themes emerged in the analysis: (1) 'Diverse experiences' with the sub-themes 'Preparedness' and 'Insecurity' and (2) 'Both assistant and specialist' with the sub-themes 'Exhausting' and 'Meaningful' (Table 4).

3.1 | Diverse experiences

On the one hand, NAs possessed competencies in securing patient airways, handling acute situations and observing critically ill patients. On the other hand, the environment was unfamiliar, and they felt insecure regarding new routines, what damages the coronavirus could bring, new colleagues, different medical treatments and new equipment. Some were pressured to take primary responsibility for ICU patients and expressed that they were unprepared to make critical decisions in certain cases.

3.1.1 | Preparedness

The NAs described the importance of their competencies in managing new and uncertain circumstances, as well as being flexible and ahead of the situation. They are also specialized in taking care of ventilation and securing patients' airways. This sentiment was shared by one NA, who said: 'The versatility I think a nurse anesthetist possesses is also a kind of competency. As such, I think we were at the right place' (#8). Two respondents expressed similar ideas: 'We are like a potato; useful in all situations' (#4, #5).

Similarly, several respondents described being prepared and having competencies in taking care of critically ill patients. They were trained to be ahead of the situation and to make plans for uncertainties. As one respondent said: 'It is an advantage to have the combination of both experience and an advanced specialist nurse … that you are used to thinking ahead of what to do if worst-case scenarios occur' (#3).

The NAs expressed how their solid knowledge base gave them the ability to learn and adapt to new situations. By taking care of patients' airways and ventilation, several respondents expressed how their competencies were confirmed, saying: '… and I felt that it was easier to learn how to use the respirator when you already know the anesthetic workstation and the physiology' (#11).

Overall, the respondents highlighted the importance of their competencies as NAs.

3.1.2 | Insecurity

Several respondents stated that the feeling of being able to contribute satisfactorily and the education, preparation and guidance they needed in their new working environments were insufficient. Furthermore, they described having feelings of uncertainty when they were transferred from a familiar environment in the operating theatre to the ICUs and postoperative units. When the pandemic struck, their work environments changed without any forewarning. As one respondent stated:

> [It was] unclear and not planned. You were thrown into a situation like, on Friday, we were operating as usual, and then you arrive at work on Monday, then…. everything is closed and you had to work in the intensive care unit.
>
> (#4).

Especially in the first wave of the pandemic, several respondents described feeling insecure about the possibility of being infected by COVID-19 and were concerned about both themselves and their families, especially their children. As one respondent stated: '… and it was difficult regarding your own family. How close could one be to your family and friends? Some had kids….' (#12).

The NAs had several experiences regarding feeling insecure about their environment and having uncertainties about how long the situation would last. They shared that such insecurity affected their ability to learn new procedures. Being transferred to new units meant that they had to work with new colleagues, which also heightened their experience of insecurity. Furthermore, the constant use of PPE limited body language and facial expressions, which increased insecurity when working at bedside.

To provide quality and secure care, the NAs described the mutual dependency of knowing their colleagues, saying: 'Nobody knew who the other person was, and their competencies were unknown. I need to know who I work with, their competencies, and their attitudes' (#9). Furthermore, the NAs described insecurity in receiving the help they needed while taking care of their patients: 'It was disturbing to be afraid of whether we had enough personnel if we had… if the physician came. They were almost absent all the time' (#5).

They also expressed being pressured to take the main responsibility for patients they felt they were not competent enough to handle. Usually, most ICU patients require two intensive care nurses (ICNs) to provide the necessary care:

> Suddenly, we had to take main responsibility for the intensive care patient. I told them several times, "You know, I am not competent to take the main responsibility for these patients alone. I want to be number two (not the one with the main responsibility)." I had to repeat this several times
>
> (#10).

In summary, all the respondents reported that the most insecure situations were related to new and unfamiliar environments and procedures. They also felt insecure when they were expected, and sometimes pressured, to take the main responsibility for ICU patients.

3.2 | Both 'Assistant and Specialist'

Previous work experiences and competencies influenced how the respondents expressed whether they felt the situation was meaningful or exhausting. Some of the NAs only worked with day surgery patients, and it had been a long time since they had worked

with critically ill patients. Others worked at hospitals with trauma patients and other major surgeries, while others had former experience working in ICUs.

3.2.1 | Meaningful

NAs with prior experience working in ICUs described being relocated to ICUs as positive and meaningful:

> …they [intensive care nurses] were happy to have us there, as in the intensive care unit, the greatest fear is how to "loosen" the airways. When we arrived, the intensive care nurses felt relieved that they could give the responsibility of securing patients' airways to the NA. This became an unwritten rule
>
> (#4).

Another NA described that, in many ways, she worked like an apprentice at the ICU and that it was meaningful to be able to help in a stressful situation, while at the same time doing the unpleasant or difficult task, saying: 'I worked together with the intensive care nurse as an assistant, and yes I took care of the patient on a respirator when the nurses needed a break' (#3).

NAs who were transferred to postoperative units expressed that their skills and competencies were considered important and useful. In the postoperative units, they acted as supervisors. They were responsible for educating other groups of personnel who had little experience with seriously ill patients and experienced being the resource persons for nurses relocated from other parts of the hospitals in which they work. One of the NAs said: 'I think that my competency has been useful all the time and every day. You just use it in a different way' (#12).

Several of the respondents also expressed how their competencies as NAs became important and useful, especially in difficult and critical situations. As one NA shared: 'I think it has been nice in a way to know that you are part of a profession the society is dependent on. That we are valuable and do an important job' (#6).

Most of the respondents similarly described the situation as meaningful and felt that they were appreciated. The NAs reported that it was meaningful when they could work both as an assistant for the ICNs while simultaneously being regarded as specialists in other areas.

3.2.2 | Exhausting

The respondents described how their colleagues had unrealistic expectations of their ability to cope with and handle every situation. Normally, NAs are called for when acute incidents occur because they have the necessary skills to handle these situations. Upon relocation, our respondents experienced being regarded as a uniform group without considering their prior experiences. It was exhausting to feel a lack of control—something the NAs usually had in their normal workdays. As one of the NAs indicated: 'Normally, you know what to do, and suddenly you don't … They use different medications, equipment … syringe pumps were different. It was a lot of new things to learn and handle' (#10). Another respondent expressed: 'As an NA, I am used to working with much independence. [I am] used to managing anesthesia. [I am] used to handling the patient. [I] have full control…. This was put aside (not the case anymore)' (#6).

Furthermore, most of the NAs were unable to have a full overview of an intensive care patient compared with the ICNs. This was described as one of the most exhausting experiences they had. Several of the respondents expressed feeling 'squeezed'. They had much competence and could contribute to taking care of the patients, but different routines, equipment and lack of control made the job difficult.

4 | DISCUSSION

All the respondents summarized their experiences by saying that it had been a challenging and educational period. Nevertheless, they all expressed that they were proud of their contributions in a difficult situation, regardless of whether their experiences were positive or negative. Overall, based on their experiences, they believed that their competencies and expertise were useful and necessary.

The NAs experienced high expectations from their 'new' colleagues concerning what they were able to perform. In many ways, they felt that they had adequate competencies to meet most expectations. However, unfamiliar routines, new technical equipment and new medications resulted in situations that undermined their competencies, making it difficult to perform in ways that they felt were satisfactory. The respondents felt more secure when they could assist the ICNs in charge. At the same time, they had some skills that the ICNs appreciated, such as taking charge of patients' ventilation.

4.1 | Diverse experiences

Their education and experience made them feel prepared to fulfil many of the new tasks assigned to them when they were relocated to the ICUs and postoperative units during the COVID-19 pandemic. A Swedish study (Nilsson & Jaensson, 2016) described NAs as 'being one step ahead' in their clinical work by always keeping in touch and watching over their patients during anaesthetic procedures. Being one step ahead implies maintaining awareness of information that might be associated with potential problems. All NAs are required to have the competency to quickly identify critical incidences and intervene during a patient's rapid decline (International Council of Nursing [ICN], 2021). The respondents described that versatility, flexibility and being ahead of situations prepared them to take on the new challenges they faced. Another study reported that NAs fulfilled many different roles during the COVID-19 pandemic due to their education, experience and skills (Everson et al., 2021). An American study also described how NAs were able to identify subtle

changes that other personnel not trained in critical care would otherwise miss (Rollison et al., 2021).

The respondents had different experiences of being transferred to ICUs. In particular, the NAs with previous ICU care experience did not feel the same insecurity as those with less experience. This is in line with the findings from a previous study (Hallgren et al., 2022).

Uncertainties about what damages the coronavirus could bring created insecurity for all respondents. Some were especially concerned about the safety of their families and friends. Other studies confirmed that the primary concerns associated with working with COVID-19 patients were uncertainties, the lack of protective equipment and a fear for their family and friends. This resulted in a fear of going to the workplace (Arnetz, Goetz, Arnetz, & Arble, 2020; Arnetz, Goetz, Sudan, et al., 2020). The respondents also reported that this insecurity influenced their ability to learn new skills, which is essential when they are relocated.

The pressure they felt from their colleagues to take primary responsibility for some ICU patients enforced their feelings of insecurity, and these were exacerbated by uncertainties about whether help would come when needed. Swedish NAs described the same feelings of pressure and challenge (Hallgren et al., 2022). It is crucial that health personnel stand up for themselves and avoid taking charge of situations with which they are uncomfortable. If they do not advocate for themselves based on their knowledge and scope of practice and instead are pressured to take risks, patients' safety may be jeopardized. Pressure may also increase moral distress (Foli et al., 2020). Safe health care depends on each professional being honest, speaking out and seeking assistance when needed.

During the pandemic, the NAs interviewed in the current study had to work with unfamiliar personnel and environments, and the feeling of insecurity increased when they were uncertain about their colleagues' competencies. Others have described how a safe working environment is crucial in providing safe and secure care to COVID-19 patients (Hallgren et al., 2022). Indeed, there is mutual dependency when working in teams, and a need to acknowledge the other team members' competencies and skills to achieve the best outcomes when taking care of patients. The study showed that the NAs experienced insufficient time to familiarize themselves with their new surroundings and become acquainted with their new colleagues. A Grounded Theory based on American nurses' experiences from the COVID-19 pandemic described how nurses coped with similar experiences. Moral distress was handled with self-care techniques and support from the other team members within the healthcare organization they worked in (Kelley et al., 2022).

4.2 | Both assistant and specialist

NAs are used to having full control of most situations during normal practice. Furthermore, safety is described as a hallmark of nurse anaesthesia practice (ICN, 2021). Our respondents expressed how this feeling of control was disturbed when they were abruptly relocated to ICUs from 1 day to another and were expected to take full responsibility for COVID-19 patients. ICNs typically handle patients on a 24/7 basis and have a full overview of what is needed to provide care for these patients over time (Norwegian Nurses Organisation, 2017). Furthermore, each patient has a long-term trajectory in the ICU. In comparison, NAs are used to taking care of patients within shorter timeframes and are less accustomed to developing long-term plans.

Whether the respondents were relocated to ICUs or postoperative units influenced how they perceived their work experiences during the pandemic. In particular, the NAs relocated to postoperative units felt much more confident and took on leadership roles while gaining mastery of their new responsibilities. Some mentioned that teaching and guiding other team members made their work especially meaningful. This finding is in accordance with other studies (Everson et al., 2021) in which NAs reported being consulted frequently by other team members regarding medications based on a patient's condition (Everson et al., 2021; Rollison et al., 2021).

When the respondents worked in the ICU, they described that their skills taking care of patient's airways were appreciated. This is in line with another study in which NAs given the responsibility for patients' airways are perceived as performing manageable and safe procedures (Hallgren et al., 2022). The role of being an assistant also felt meaningful when they could relieve the ICNs in managing defined tasks and making it possible for the latter to take a break. The NAs' experiences and competencies were described as useful when caring for patients with COVID-19, although they cannot take full responsibility for caring for ICU patients like the ICNs do (Hallgren et al., 2022; Leonardsen et al., 2021). When the work in ICUs continued in the second phase of the pandemic, the respondents were able to build on their former experiences, thereby strengthening their perceptions of belonging to their workplace. Initially, feelings of unpredictability and uncertainty were present, but these eventually changed to a feeling of confidence as they became acquainted with the environment of the ICU.

4.3 | Strengths and limitations

The qualitative interviews ensured detailed and rich descriptions of how the NAs experienced working during the COVID-19 pandemic. The respondents used good illustrations and appeared to be prepared for the interviews. They were also recruited from four different hospitals, thus securing a variety of organizations and accounts of how challenging situations were resolved during the pandemic. This strengthened the respondents' informational power (Malterud et al., 2016).

The interviewers had varying levels of research experience, ranging from 0 to 20 years. This may have influenced the quality of the interviews they conducted. However, the two most experienced researchers took care of the final three phases of data analysis to ensure consistency between the data and findings.

We did not use analysis software, and this makes the analytic process less transparent, but all authors participated in the initial analysis and gave feed-back whether the results was in correspondent

with their understanding of the interviews and if something was missing in the result.

5 | CONCLUSION

This study shows that overall, the NAs experienced in many ways that their competencies made them prepared to handle many of the situations and felt appreciated. They also experienced situations where they were uncomfortable being pressured to take responsibility and had to put their foot down. They experienced being regarded as a uniform group without considering their prior experiences and making relocation very stressful for some while others felt more at ease. Mapping the personnel's former experiences is required to utilize best possible matching of personnel to assignments and create less stress and insecurity. Insights into other professions may contribute to improved collaboration with other nurses. Further research should explore if hospital wards have an overview of the staffs' experience beyond what is needed in the daily work. This knowledge would be useful when matching the staff's competencies to assignments—to be able to use the 'right person in the right place'. Other research areas could be to explore how to prepare NAs and other nursing professions for sudden relocation and task shift tasks.

AUTHOR CONTRIBUTION

Berit T. Valeberg is the project manager, contributed to conceptualization of the project, interviewed participant and main responsible for the data analysis and writing and editing the manuscript. Lindis Meland Tangen, Anne-Line Kjos Sollie, Silje Kristine Borgersen, Lars von Heimburg and Cecilie Eide interviewed participant, initially data analysis and critically review of the manuscript. Marit Leegaard interviewed participant, main responsible for the data analysis and writing and editing the manuscript.

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FUNDING INFORMATION

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CONFLICT OF INTEREST STATEMENT

None for any of the authors.

DATA AVAILABILITY STATEMENT

The transcribed interview may be available, but they are in Norwegian.

ETHICS STATEMENT

The project was approved by the Norwegian Centre for Research Data (Nb. 566062). The local data protection officer and the management at each Hospital gave their permission to perform the study.

PATIENT OR PUBLIC CONTRIBUTION

Nurses with experience from working with COVID-19 patient were included in the development of the interview guide.

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