

A Nurse, is a Nurse, is a Nurse: A Qualitative Descriptive Study of Nurse Redeployment During
the COVID-19 Pandemic

by

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Abstract

“A nurse, is a nurse, is a nurse.” This adage has permeated the nursing profession for decades asserting that nurses are interchangeable with one another: any nurse can perform any function in health care. No phenomenon put this adage to the test more than the redeployment of nurses during the COVID-19 pandemic. The purpose of this exploratory descriptive study was to understand redeployed nurses’ perspectives regarding the phenomenon of redeployment during the COVID-19 pandemic. One on one virtual interviews were conducted with 10 participants who were registered nurses (RN) and redeployed during the COVID-19 pandemic. Semi-structured interview questions were developed on the basis of the Conditions for Work Effectiveness Questionnaire (CWEQ) and Kanter’s theory of Structural Empowerment and utilized to gather the data. Three themes emerged from the data analysis: i) redeployment: ‘the ask’, ii) managing redeployment, and iii) consequences of redeployment. Further, ambiguity related to participant redeployment was interwoven throughout the three themes. This study addresses a gap in the literature regarding the perspectives of redeployed nurses, and how nurse leaders can address these perspectives to improve nurse redeployment strategies and outcomes. Recommendations will be made for further nursing research, education, and administration to improve nurse satisfaction, wellbeing, and retention.

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Chapter 1 – Statement of the Problem

Background

“A nurse, is a nurse, is a nurse.” This adage has permeated the nursing profession for decades. In essence, this statement deems nurses interchangeable with one another, suggesting any nurse can perform any function within this portfolio in the health care industry. Kennedy et al. (2022) drew attention to the issue that nurses undergo extensive education and time to develop expertise in various avenues of health care to develop a unique skill set. Hence, with the breadth and scope of nursing practice today, and the many avenues and specialized education in which nurses engage to further their development, does this statement have merit? Nelson et al. (2023) emphasized that nurse qualifications for providing care across health services is not an adequate sole factor for determining redeployment; expertise in a particular clinical area should be considered. In doing so, nurses are viewed as interchangeable and not acknowledged for their experiential knowledge, continuing professional growth, and education throughout their careers. Thus, it is time to dismiss the adage that generalizes and demeans the complexity of nursing practice. No phenomenon has put this adage to the test more than the redeployment of nurses during the COVID-19 pandemic. The focus of this research is to investigate redeployed nurses’ experiences throughout the course of their redeployment.

Nurse leaders must not overlook the diversity of nurses and understand nurses’ perceptions of redeployment to gain an understanding on how to support nurses through the redeployment process. The global emergence of COVID -19 brought significant impacts to health care systems and the care providers who worked in them (Byun & Westfall, 2022; Devane et al., 2021). COVID-19 contributed to high flux in the health care systems, leaving health care providers struggling to keep up with the frequently changing landscapes and practices (Clements

et al., 2021). During the pandemic, health care workers also faced increased workloads, unfamiliar environments and tasks, and fear and anxiety related to potentially contracting COVID-19 (Ezzat et al., 2021). Globally, COVID-19 produced devastation throughout 2020-2022 that saw a mass influx of patients into health care systems and high death rates (Bleich et al., 2021).

Supply chain issues that permeated health care during COVID-19 further impacted nurses, with insufficient personal protective equipment (PPE) supplies contributing to infections among front line workers, placing their health at risk (Snowdon & Saunders, 2021). In Canada, by the beginning of 2021, over 65,000 health care workers were infected with COVID-19, resulting in 43 deaths. This personal risk further stressed front line nurses caring for COVID-19 patients.

There is also evidence of disparity in pandemic experiences and outcomes of Canadian health care workers compared to other countries. In a study that compared adverse mental health outcomes as a result of the pandemic among Canada, the United States, Brazil, and Italy, Canadian health care workers suffered a significantly higher degree of anxiety and depression compared to the other countries (Turna et al., 2022). Substance use was also reported to have the highest increase amongst Canadian health care workers. Canada's health care workforce was also the only of these four countries to report greater mental health severity than the general population, suggesting greater impact than other countries' health care workers.

Despite the impact of COVID-19 on multiple front-line workers, nurses required special consideration as they comprise the largest subset of health care workers in hospitals. A study of Canadian critical care nurses indicated that all participants described feeling at least one symptom of psychological stress, fear, anxiety, concern, or distress during the early phase of the

pandemic (Crowe et al., 2021). Further, symptoms of post-traumatic stress disorder and varying degrees of depression were also reported (Crowe et al.). Another Canadian study found nurses were at greater risk of burnout than physicians and reported significantly greater levels of anxiety (Lou et al., 2022). Notably, participants more frequently utilized maladaptive coping strategies and suffered greater impact from work related stressors, health concerns, stigmatization, and conflict. Importantly, younger participants suffered greater instances of anxiety and stress than their more experienced colleagues. Staggeringly, half of the 64 nurse participants in the Lou et al. study reported intentions of quitting (p. e47).

Detrimental mental health impacts and burnout permeated the health care system prior to COVID-19 and the pandemic further exacerbated the burden of an already overwhelmed health care work force (Limoges et al., 2021). Snowden and Saunders (2021) warn there may be a mass nurse exodus from the profession across Canada related to the impact of the pandemic that exacerbated an already severe nursing shortage. Despite measures to reduce health care burden, such as reinstating retired nurses, COVID-19 still produced staffing deficits due to exposure and illness. Further, staffing levels were impacted when front line workers required leaves of absence or left their profession entirely (Dupe et al., 2022; Tardif et al., 2022).

Redeployment

Within the context of the pandemic, redeployment added a new level of burden to health care professionals. In response to rapidly rising patient care needs resulting from COVID-19, redeployment of staff became a necessary means to meet the nursing care demands of the pandemic (Westry et al., 2022). Intensive care units were particularly impacted by the crisis, requiring an increase in capacity by expanding medical and surgical units, and onboarding additional staff, many of whom were not familiar with intensive care practices (Ezzat et al.,

2021). As a result, redeployed nurses were exposed to unfamiliar care environments and nursing practice issues.

Redeployment presented an additional burden to nurses by thrusting staff into unfamiliar environments and situations with the expectation they adapt and learn to function quickly, whilst carrying the stress of redeployment (Piercy et al., 2022). The impact of the pandemic was particularly difficult for nurses due to the direct risk of becoming infected, the potential of transmitting the illness to loved ones, and the inherent difficulties of caring for unfamiliar patients (Khajuria et al., 2021). Kennedy et al. (2022) drew attention to redeployment as a phenomenon that occurred before the pandemic; however, redeployment pre-pandemic was often on a smaller scale, usually to address insufficient staffing in other patient care areas. Further, earlier efforts were also made to redeploy nurses to a unit similar to their home unit.

While redeployment was a necessary means to meet care demands, it is important to recognize that the stress and uncertainty related to redeployment had the potential to put nurses at risk for detrimental mental health effects (Walker & Gerakios, 2021). Further, during COVID-19 hospital environments were chaotic as a result of increased patient volumes, higher nurse patient ratios, and an entirely new, not understood challenge requiring rapid development of innovative care strategies. Moreover, inexperienced nurses immersed in an unfamiliar critical care unit resulted in discouragement and fears regarding their professional nursing competencies (Pilbeam & Snow, 2022).

Though redeployment impacted many health professions, the impact on nurses should be a priority as nurses are the majority of health care workers and provide 24/7 patient care (Ryder et al., 2022). As the largest health care group, nurses during the pandemic faced disproportionately increased redeployment as compared to other groups. As a profession, nurses

encounter stressful work environments and staffing issues that predispose them to negative outcomes such as burnout when compared to other health care professions; nurses historically suffer greater psychological impacts than other health related professions during periods of crisis (Couper et al., 2022). Additionally, significant staffing issues occurred during the pandemic related to absences as a result of self-isolation requirements and staff exposures to COVID-19 (Montoya et al., 2020). At a baseline, nursing staff experience high stress environments that impact them physically and emotionally; the COVID-19 pandemic exacerbated these precursors to unprecedented levels (Clements et al., 2021). Understanding staff experiences during the pandemic is integral for leaders to understand the impact of redeployment and develop strategies to improve outcomes for their staff (Limoges et al., 2021). Therefore, understanding nurses' perspectives regarding their experiences with redeployment is critically important to determine its impact on nurses, potential long-term consequences, and leadership strategies to promote the wellbeing and retention of redeployed nurses.

Purpose of the Study

The purpose of this exploratory descriptive study was to understand redeployed nurses' perspectives regarding the phenomenon of redeployment during the COVID-19 pandemic. Results of this study will inform nurse leaders on strategies to support redeployed nurses to optimize nurse wellbeing and retention.

Research Questions

In this study, the overall research question was: what are redeployed nurses' perceptions of their redeployment experiences during the COVID-19 pandemic?

The following questions were explored in this study:

1. What were nurse's overall perceptions of their redeployment experiences?

2. How were redeployed nurses informed of their redeployment by their nurse leader?
3. How did the nurses frame the redeployment experience?
4. What resources supported the nurse's transition to the redeployed unit?
5. What were their experiences with communication and dissemination of information from nurse leaders during their redeployment?

Definition of Terms

Nurse redeployment: The movement of a nurse from their usual clinical setting to another for the purpose of supporting increased patient care demands in those areas (Couper et al., 2022; Piercy et al., 2022). Movement to these new environments often require nurses to quickly adapt and learn new skills due to unfamiliarity with the care unit, tasks, and patient population (Ezzat et al., 2021; Piercy et al.). Displacement to these new environments also removes nurses from their everyday peers and supports (Piercy et al.). For the purpose of this study, a redeployed nurse was considered any registered nurse who was redeployed from their home unit to an unfamiliar clinical setting for a minimum of 6 weeks in Manitoba between 2020 – 2023, as a result of the COVID-19 pandemic. A minimum 6-week timeframe was chosen as this is the length of a standard nursing rotation.

Theoretical Framework

The theory of structural empowerment was used as a framework to study the phenomenon of nurse redeployment. The theory of structural empowerment was initially proposed by Kanter (1977; 1993), in which she argued attitudes and behaviors of employees are not a product of personal attributes, but rather are molded by structures of the environment in which they work. She claims perpetuating cycles of disadvantage experienced by staff can be broken by altering negative environmental factors, since structural constraints contribute to these

cycles, not intrinsic factors. According to her theory, there are three key concepts that influence behaviour: opportunity, power, and numbers related to distribution of attributes. Opportunity pertains to the ability to mobilize within an organization, ascend the hierarchy, or experience progress. Kanter states when employees have access to opportunities they lead to a greater sense of accomplishment, increased ambition, and organizational commitment. Central to Kanter's theory is the concept of power, defined as the ability of an employee to access the resources, information, and support necessary to effectively function in their job. Resources refers to accessibility to tangible materials, time, and human resources to effectively carry out work (Laschinger, 2012). Information refers to accessibility to knowledge required for efficacy in one's role (Laschinger). Lastly, support pertains to access to effective guidance and advisement by colleagues and leaders (Laschinger). Kanter argues employee satisfaction is derived from having access to what they need to do their job effectively. According to Kanter, monopolization of power decreases efficacy since few have the autonomy and access to necessary resources for productive work.

Kanter's (1977; 1993) third concept, numbers, is related to the distribution of characteristics, such as gender, race, and ethnicity, in a workplace and the tendency towards adverse outcomes for those in a minority. In her initial research, this concept was largely related to gender and ethnic inequalities. Although these disparities are still present today in many organizations, current research predominantly focuses on the concepts of opportunity and power. In addition, when Kanter revisited the theory years later, gender inequalities were not as prominent in her work as in her initial research. Therefore, this study will focus on the constructs of power and opportunity due to their greater relevance.

Kanter's theory of structural empowerment has garnered much interest in the field of nursing. Heather K. Laschinger (1996) found evidence to support the validity of the theory of structural empowerment following review of results from a series of studies in various nursing settings designed to test Kanter's theory. A strong correlation between nurse perceptions of empowerment and access to the structural determinants of opportunity and the power structures of information, support, and resources were demonstrated in these studies. Laschinger (2012) organized Kanter's theory into a diagrammed theoretical framework, providing a visual representation of the theory (see Appendix A). Later, Laschinger et al. (2001b) produced an expanded model of the theory, which added psychological empowerment (see Appendix B).

According to Laschinger et al. (2001b), structural empowerment pertains to the impact of work environments, whereas psychological empowerment addresses how people respond to their environment, thus asserting psychological empowerment should be a natural consequence of structural empowerment. Their study demonstrated psychological empowerment was a mediating mechanism between empowering structures and positive organizational outcomes. Relevance and breadth of structural empowerment impacts are demonstrated by the program of nursing research developed by Laschinger using Kanter's theory studying the mediating role of structurally empowering leadership behaviours on engagement, burnout, job satisfaction, respect, and trust to name a few (Cziraki & Laschinger, 2015; Greco et al., 2006; Laschinger & Finegan, 2005; Laschinger et al., 2001a).

Nurse leaders are integral to creating empowered environments that promote nurses' organizational commitment (Laschinger et al., 2009). Research studies on structural empowerment as a leadership strategy demonstrated many positive outcomes, notably improved satisfaction at work, greater commitment to organizations, and retention of nurses (Dwyer et al.,

2019; García-Sierra & Fernández-Castro, 2018; Khan et al., 2018). Therefore, utilizing the framework of structural empowerment to study nurse redeployment offers insight to current nurse perceptions regarding the phenomenon of redeployment and how nurse leaders can support their staff through this transition.

Relevance of Structural Empowerment to Nurse Redeployment

Although some nurses may have welcomed redeployment as an opportunity to further their nursing skills, others viewed redeployment as an involuntary disruption to their career, rife with trepidation and fear (Agyekum, 2022). Nurses' fears extended beyond contracting the virus to how redeployment impacted their personal lives and their perceived capability to carry out unfamiliar nursing care (Woodford et al., 2020). Concern over unfairness in redeployment decisions, and even resentment over individual circumstances compared to others also surfaced among staff (Wheeler et al., 2021; Woodford et al.). Some of the distress felt by nurses during the pandemic was related to issues with communication, frequently changing information, and fear for their personal safety (Crowe et al., 2021). Further, feelings of role ambiguity and expectations among redeployed nurses were discussed (O'Donoghue et al., 2021). Investigating redeployed nurse perceptions of redeployment can facilitate how nurse leaders understand redeployment and their role to facilitate transitions and maintain wellbeing of redeployed nurses.

Though some nurses volunteered to be redeployed, many had no choice being relocated from their current position. Lack of control was a common feeling among health care providers throughout the pandemic. Limoges et al. (2021) assert engagement of staff by nurse leaders can facilitate redeployed nurses to regain a sense of power through involvement in decision making to improve wellbeing. Providing opportunities of choice for redeployed nurses, no matter how small, may restore some nurse autonomy and improve outcomes. Determining the current state

of redeployed nurses' experiences can help identify issues or exemplars to aid in empowering redeployed nurses.

Assessment of resources for redeployed nurses is important. Nurses and midwives in the UK found 62% of those redeployed reported experiencing either none or not enough education to practice safely in the new clinical unit (News Focus, 2020). Insufficient education was an issue discussed in the literature, nurses frequently cited concerns regarding clinical competence while redeployed (Agyekum, 2022; O'Donoghue et al., 2021; Shah & Alaouabda, 2021; Wheeler et al., 2021). Limited access to physical and human resources necessary for job efficacy were a concern, with better resource management argued as a mechanism to improve outcomes for redeployed nurses (Li et al., 2022a; Miljeteig et al., 2021). Therefore, better understanding and management of resources for redeployed nurses can facilitate an understanding of the foundation they need to feel successful in their nursing care and confident in their new roles.

Lastly, in any situation, support by leaders is important for nurse wellbeing. Unsurprisingly, moral distress among nurses during the pandemic was related to the degree of genuine concern and support they experienced from leaders and their ability to address staff concerns (Miljeteig et al., 2021). Furthermore, nurses who were redeployed were isolated from their usual supports on their home unit, making follow-up from home unit leaders with redeployed staff essential (Clements et al., 2021). Devane et al. (2021) observed only half of the nurses redeployed in their study felt supported by their supervisor or manager. Assessment of leaders' support among redeployed nurses can aid in determining the current state and identify any issues that can be addressed moving forward to improve relationships between nurses and their leaders.

Summary

COVID-19 presented a unique challenge to health care particularly related to an increase in the use of nurse redeployment. As many nurses were dislocated from their home units and placed in different environments with unfamiliar patient concerns and tasks, studying the impact of this phenomenon on nurses during the pandemic is integral to understanding their unique experiences and implications for the health care system. As part of the health care workforce, nurses are fundamental to maintaining services (Tardif et al., 2022). Issues with nurses succumbing to stress and burnout related to their work were apparent in health care during the pandemic (Couper et al., 2022). Caring for vulnerable populations suffering from COVID-19 and pandemic restrictions caused further distress to those providing care (Limoges et al., 2021). Redeployment was another weight added to overburdened nurses. Mental health and burnout are large contributors to the efficacy and organizational commitment of health care providers (Lou et al., 2022). Utilizing the theory of structural empowerment to understand perceptions of the experiences of redeployed nurses, in particular access to information, resources, support, and opportunity provided insight to the nurses' redeployment experiences and will facilitate nurse leaders to improve nurses' wellbeing and retention.

Chapter 2 – Literature Review

Introduction

As a relatively new phenomenon, the literature regarding nurse redeployment is sparse. A review of the literature during the COVID-19 pandemic was conducted utilizing the CINAHL, Scopus, and PubMed databases. Search terms used to search were "Cov*," "Redeploy*," and "nurs*". Over 215 articles were found using the search terms indicated, of those articles, 128 were found relevant to nursing and included in the literature review. A review of the literature is important to understand the current state of the empirical literature and research on redeployment and its impact specific to the nursing population during the pandemic. The grey literature was also included in this review because it adds to the breadth of information on the topic and can aid in informing practice (Adams et al., 2017). Common themes in the redeployment literature including/specifically related to COVID-19 in the nursing population were nurses' perspectives of redeployment, mental health, burnout, fear, silent suffering, practice changes, redeployment as a strategy, and superficial analysis.

Nurses' Perspectives on Redeployment During COVID-19

The novelty of the COVID-19 virus and redeployment of nursing staff to address the rise in patient acuity and mortality introduced a new stress to the nursing workforce (Couper et al., 2022). Redeployment is not a new phenomenon in nursing, but prior to the pandemic, nurses were redeployed less frequently; often to areas where nurses had more immediate transferrable skills (Kennedy et al., 2022). Anecdotally, redeployment pre pandemic was occasionally for only one or two shifts. During COVID-19, not only did redeployed nurses face unfamiliar roles, environments, and chaotic work conditions, practice diverged from holistic care, with care measures deemed not essential in the chaos of the pandemic taking low priority (Pilbeam &

Snow, 2022). Pilbeam and Snow described that little time was available for redeployed nurses to understand care requirements due in part to a lack of protocols established for this new virus and the high patient volumes and elevated acuity environments associated with the pandemic. There was also conflict between normal nursing care standards and contradictory care requirements associated with the pandemic, such as inability to always maintain dignity and less time for compassion in care, that led to moral distress and divergence from nursing values. Further, these authors emphasized this chaos often rendered nurse's incapable of problem solving and the ability to provide optimal care. The only recompense nurses described was the emotional role of being a presence for dying patients in the absence of their families that helped strengthen their purpose and ascribed meaning to their role (Pilbeam & Snow).

A mix of negative and positive nurses' views on redeployment were prevalent in the literature. Li et al. (2022b) highlighted the chaotic care context experienced by those redeployed due to unfamiliarity of the new environment and roles, compounded by scarce resources. Further, the mental distress related to the fear of COVID-19 infections and containment efforts to prevent the spread of the virus left participants feeling isolated. In addition, patients who experienced severe decline in physical health exacerbated their feelings of distress. Despite initial challenges, the overarching theme for most participants in their study was that redeployment was a positive experience. As participants adapted to environments and information on COVID-19 increased, anxiety was replaced by a strong sense of efficacy and pride (Li et al.).

Using Gibb's Reflective Model to analyze experiences of redeployed nurses, Love-Mecrow and Parsons (2022) described mixed emotions experienced by four redeployed clinical nurse specialists. A nurse matron thought redeployment was a positive experience and an opportunity and challenge to gain new skills; whereas a consultant nurse, acute pain specialist,

and pain management nurse were anxious regarding their capabilities and believed they were ill equipped to care for patients in a critical care environment. Both pain nurses stated they would return to critical care should the need arise. However, one of the nurses feared being negatively perceived should they refuse another redeployment.

Discordance of participant perceptions were prevalent in other studies as well. According to Lukewich et al. (2024) some participants expressed they were given no formal direction on redeployment expectations. As a result, some participants felt underutilized and were working below their full scope of practice, whereas others expressed concern for their license due to lack of familiarity with the clinical setting and uncertainty whether expectations were within their scope. Kelly et al. (2025) found nurse confidence related to redeployment varied, some felt overwhelmed by redeployment and perceived a lack of support, conversely others had higher perceptions of support and greater comfort seeking help. Additionally, Kelly et al. indicated orientation and training were perceived differently over the course of the pandemic. During wave one of the pandemic, training was described as chaotic and brief, whereas during the second wave it was described as better organized and well-rounded.

In the literature, a desire to help was identified by many studies, with some nurses expressing a sense of duty and/or excitement at the prospect of redeployment and the opportunity to diversify their skills (Kelly et al., 2025; Kynø et al., 2024; Lukewich et al., 2024; Odetola et al., 2023; Taylor et al., 2023; Zimbudzi & Friginal, 2023). However, studies were often mixed in terms of nurse willingness to redeploy and/or whether participants volunteered for redeployment or were mandated to redeploy (Agyekum, 2022; Kelly et al., 2025; Lukewich et al., 2024; Taylor et al., 2023; Zimbudzi & Friginal, 2023). Silva e Silva et al. (2025) found variation in nurse tissue donation coordinators desire to redeploy. Some participants found it a rewarding, positive

experience, even wishing they had been called on to help more, while others feared redeployment. Fear and anxiety among nurses surrounding redeployment was a frequent finding in the literature, reasons included fear of the virus, insufficient orientation, lack of familiarity with care environments and/or tasks, concern over redeployment expectations and/or their capability to provide care in the redeployment setting, and the potential for adverse events (Agyekum, 2022; Odetola et al., 2023; Silva e Silva et al., 2025; Taylor et al., 2023; Woodford et al., 2020; Zimbudzi & Friginal, 2023). Scott et al. (2024) described how nurse participants redeployed to critical care units overwhelmingly experienced concern regarding the expectations that would be placed on them and what assumptions would be made regarding their skills. Separation from their unit colleagues and network of support was also concerning to them. Further concerns regarding redeployment were identified by nurses in Zimbudzi and Friginal (2023) related to lack of notice, travel, communication, and continuity of practice across settings. Concern regarding continuity of practice was also present in Kynø et al. (2024), however, they found though redeployed pediatric nurses harboured concern over appropriateness of their skills in adult settings they demonstrated adaptability.

Job security was an interesting positive theme identified by Woodford et al. (2020). In their study, some redeployed participants were grateful to have a job and the ability to make a difference during the pandemic. Conversely, other participants discussed a lack of fairness in their situation compared to others and concerns over stigmatization related to their proximity to infected patients, as well as concern over the units and patients they left behind.

Among positive outcomes in the literature were examples of increased nurse autonomy. In Taylor et al. (2023) majority of nurses redeployed had input and collaboration in their scheduling, however, it is important to note that despite this, participants perceived no choice in

their redeployment or how it was approached. According to Kelly et al. (2025) autonomy existed for nurses regarding where they were redeployed and further indicated it was within the nurse's power to end their redeployment if they found the experience too overwhelming. In Lukewich et al. (2024) participants claimed redeployment offered flexibility in their work schedule in certain instances as well as financial benefit. Further beneficial outcomes were identified by Kelly et al. (2025), describing how positive redeployment work cultures and environments led to participants feeling valued. Participants in Zimbudzi and Friginal (2023) noted positive aspects of redeployment related to personal development, collaborating as a team, as well as experiencing demonstrations of appreciation from the organization and locals.

Job safety and allocation of resources were another topic in the literature. Darchen et al. (2023) found there was disorganization or disparity between redeployment clinical placements. Some redeployment units were abundantly staffed to the point redeployed staff felt their displacement to these units was unnecessary. Conversely, other redeployment units were understaffed and undersupplied to the point redeployed staff feared for their safety. This uneven staff allocation led to participants' questioning leaders' effectiveness in decision making and planning. Job safety related to redeployment was also studied by Denning et al. (2020) in a UK trust utilizing the Safety Attitudes Questionnaire (SAQ). They stated higher safety scores occurred when redeployed staff had access to education and support in the new environment. Regrettably, their findings indicated nursing roles correlated with lower SAQ scores, which demonstrated nurses tended toward more negative perceptions of redeployment than other redeployed professions. Denning et al. discuss this may be due to less availability and/or efficacy of supports for nurses in relation to lower scores observed in this population for job satisfaction and conditions of their work environment. Work environment factors were also indicated as a

source of dissatisfaction in Chu et al. (2023). Their study indicated majority of participants had negative redeployment experiences and 44% were dissatisfied with redeployment. The three key influencers on participant experience were friendliness/welcomeness by unit staff, allocation of patients, and support.

A study by Womack et al. (2024) included perceptions of redeployed nurses and unit nurses. Redeployed nurses felt organizations did not value their unique expertise and viewed them as commodities. Further they describe experiencing low autonomy and asserted leaders were not actionable on nurse feedback or sufficiently supportive. Inefficacies were noted in redeployment due to varying competencies and unclear expectations. Both redeployed nurses and unit nurses indicated increased workloads and elevated stress. While redeployed nurses were distressed by shift in environment and expectations, unit staff struggled with the added burden of training redeployed nurses. Further, nurses remaining on units that had staff redeployed to other settings found themselves overwhelmed with additional responsibilities. Chaos of the pandemic, resultant policy changes, and high acuity of patients were impactful to all nurses. Experience of stress also continued past the end of redeployment with nurses expressing misalignment between their standards of care and what they were exposed to during redeployment. Negative outcomes of this study included nurse turnover and even intent to leave the nursing profession. Positive outcomes included enlightenment to new career paths, as well as improved confidence and professional relationships.

Some research focused on the impact of redeployment solely from the perspective of regular unit staff. Farley (2022) anecdotally discussed the strain of redeployment on nurses; before the onset of COVID-19, there were unrealistic patient ratios, redeployment exacerbated an already stretched workforce. They assert higher expectations were placed on nurses who

remained behind on units following redeployment of some of their staff. Hargreaves et al. (2022) reported specialist nurses faced greater difficulty meeting care needs and worked extra hours to support care on their home units due to redeployment of colleagues away from their usual role.

In a cross-sectional survey, Hennis et al. (2021) assessed the impact on ICU educated nurses who were tasked with the role of supervising non-critically educated redeployed staff, in addition to their usual role. Trust was required by ICU participants supervising inexperienced redeployed staff, as they needed to determine readiness of redeployed staff to perform various critical tasks in the absence of formal measures to assess competencies. Hennis et al. indicated that when ratios of redeployed to regular staff were too great, the needs for supervision of inexperienced redeployed staff distracted regular staff from patient care. Thus, Hennis et al. argue significant numbers of redeployed staff who require continual supervision are deleterious to care and this practice should not continue. Nyberg et al. (2025) similarly noted that failure to effectively onboard redeployed staff to intensive care units caused increased stress in the environment and was an impediment to care.

Unique to other redeployment reviews, Scott et al. (2022) discussed experiences of nurses redeployed to a COVID-19 negative unit. This study specifically assessed preparation of redeployed nurses and their views on patient safety. Seventy-seven percent of participants in this study identified the 2-week orientation program prepared them sufficiently to be successful in their new role and were satisfied with the care they were able to provide. The authors asserted that patient safety was not compromised by staff redeployment, with reports indicating staff were practicing within their competencies. A point of interest may be whether success and satisfaction in this study were more related to the absence of COVID-19 on these units, and the associated chaos and acuity that accompanied COVID-19 care environments.

Though nurses were commonly redeployed to critical care environments, a couple of studies in the literature studied the redeployment of critical care nurses to different units. Abdulmohdi and Huang (2025) studied the redeployment of critical care nurses to general medical-surgical wards. Redeployment of critical care nurses in this study was for shift coverage versus long consecutive periods of time. Participants described insufficient support and anxiety related to redeployment. White et al. (2025) also studied redeployment of critical care nurses to general wards. Majority of participants had negative experiences with redeployment. Among indicators for negative experience were lack of choice, disorientation, distress, and being reduced to a number. However, some positive perceptions of redeployment existed; participants felt benefit from helping during the pandemic, some had positive experiences, and an understanding of the necessity for redeployment was expressed. Notable consistent findings in the studies by White et al. and Abdulmohdi and Huang included participants asserting transitions to an unfamiliar setting were difficult, concern over the safety of redeployment relative to patients, and feeling devalued.

Leader perspectives on nurse redeployment were also present in the literature. Hartley et al. (2025) studied both leader experiences redeploying nurses and experiences of nurses that were redeployed. Leader participants noted a disconnect between higher levels of leadership and the needs of nurses. Outcomes of this study indicated concerns regarding retention, with findings identifying an intent to leave for some nurses. Further, in studying the management of nurse redeployment, Hartley et al. (2024) found high levels of inconsistency in approaches to nurse redeployment and disconnect across hierarchies of nurse leadership. Leaders themselves were not supported or guided in redeploying nurses. Consistent across both studies, leaders found the task of redeploying nurses functionally and emotionally difficult, exacerbated further by the

distress experienced by the redeployed nurse (Hartley et al. 2024; Hartley et al. 2025). McGillis Hall et al. (2023) also studied combined perspectives of frontline nurses, both redeployed and unit nurses, and nurse management on a teams-based model of care during the pandemic. Positive outcomes were unit staff appreciation for those redeployed, efficacy of the model in organising care and integrating redeployed nurses into the unit. Challenges were identified in terms of workload, patient acuity, ambiguity over redeployed nurses' skill level, challenges making the model work in real time care leading to reverting to typical ICU models, and moral distress over inability to meet care demands. Future recommendations advised debriefing with nurses on strategies, improved preparation/planning to support proposed care models, transparency surrounding redeployment practices, and for leaders to be more visible/supportive.

Important nurse perspectives on redeployment were present in the grey literature; a poll of nurses and midwives taken in the UK indicated nearly two-thirds of those redeployed expressed receiving minimal to no education to support their redeployment (News Focus, 2020). Generalized results of this poll also indicated detrimental mental health impacts on nurses during the pandemic, but it is unclear if this pertained solely to redeployed staff.

Detailed anecdotal personal accounts were also present in the grey literature. Although these accounts are not formal studies, they do add to the depth of experiences nurses have gone through while redeployed during the pandemic and should not be ignored. Waddington (2021) illustrated a vivid picture of life in a day as a redeployed nurse, recounting their experience during a 12-hour shift describing the distress of redeployment to the emergency department in both their work and home life. Waddington described experiencing a constant uncertainty of whether redeployment from their unit would occur and how sudden redeployment resulted in disorientation. They reported redeployment from their unit was frequent and the remaining

nursing staff were cumulatively exhausted. They expressed discomfort while redeployed due to unfamiliarity, constant flux of roles and staff, missed breaks, as well as physical pain from personal protective equipment (PPE) and hygiene practices. Harmer (2020) mirrored these concerns, reflecting on their experiences while redeployed from a pediatric ICU to an adult ICU, including out of scope practices and the burden of personal protective equipment (PPE). Harmer also stated the lack of justice in health care staff being left out of added compensation while other public sectors received high pay raises in the UK related to pandemic efforts.

In another anecdotal testimonial, Griffiths (2021) discussed the stress role changes caused during redeployment. However, the overall tone of their reflections was positive, focusing not on lingering negative impacts of redeployment, rather on how they overcame the challenges of dynamic, unfamiliar care environments and the pride they felt aiding colleagues in the pandemic efforts. Griffiths stated from their perspective, redeployment meant reframing personal worry and impact on themselves to prioritizing others and their needs. Similar positive anecdotal personal accounts of redeployment were shared by Spence (2020). These accounts were provided by two nurses who had previous intensive care experience; one who volunteered to be redeployed, and a nurse specialist who was redeployed to a non-COVID-19 ward. Whilst stress, fear, and other negative outcomes related to redeployment were expressed, the reflections primarily celebrated the adaptability of staff and their strength in overcoming obstacles. It is important to note previous critical care experience and voluntary status could be factors influencing adaptability to this transition. For instance, one of the nurses redeployed to intensive care with prior critical care experience noted transitions may be more challenging for those redeployed without critical care experience. Comparably, the nurse redeployed to a non-COVID-19 unit may not have faced the same dissonance in care environment and acuity as nurses redeployed to COVID-19 care areas.

In an informal report, Forbes and Finch (2020) also discussed positive aspects related to COVID-19 and redeployment, celebrating nurses for their strength and adaptability during redeployment, only briefly describing minor stress related to unfamiliarity and elevated psychological support needs. They explained a flattened hierarchy facilitated improved team environments and rapid decision making without the usual checks and balances to impede them.

Anecdotal reports by public health nurses describing redeployment experiences and redeployment's impact on patient care were also discussed in the literature. In "An Experience That Will Haunt Me Forever" (2021) a public health nurse detailed their harrowing experience of redeployment to the intensive care unit, noting the distress of high patient morbidity and mortality, in addition to needing to rapidly relearn dormant skills. Although this experience inspired them to continue professional growth, they emphasized the fear they felt for their families and resulting isolation related to shielding their colleagues from the truth of their experiences. Other reports in the grey literature focused on the impact of public health nurse redeployment to pediatric population's health and wellbeing ("Professional Update," 2020; "Services Asked Not to Redeploy Health care Workers," 2021). Adams (2020) emphasized these unsustainable public health nurse caseloads and the resultant burden led to increased public health nurses' intentions to leave the profession.

Although some nurse experiences of redeployment were positive, it is important to note that perceptions were predominantly negative. Further, positive reports of redeployment experiences were often discussed by nurses whose prior experiences facilitated their redeployment transition. Unfortunately, the majority of those redeployed either lacked the necessary experience and knowledge to be successful or had not worked in care roles congruent with COVID-19 units for a long time. Evident in participants' perspectives in the literature were

lack of timely information, educational and human resources, and leader support. Structural empowerment is a valuable framework to assess nurse perceptions of redeployment and inform future leadership strategies since empowered environments promote higher job satisfaction and are linked to nurses' abilities to face and conquer challenging situations, such as restructure of organizations (Laschinger, 2008).

Silent Suffering

Another theme prevalent in the literature was redeployed nurses experienced a lack of voice and were silenced by their organizations. Silent suffering can occur as a result of not speaking up for fear of negative consequences or a perceived indifference from others (Abrams et al., 2023). In this study, Abrams et al. explored nurses' ability to communicate formally and informally to leaders. One of the key concerns participants experienced was difficulty communicating their concerns regarding redeployment. Findings unfortunately indicated that participants' attempts to communicate concerns were not heard and often met with hostility. As a result, participants felt devalued by their organization's leaders and left to silently suffer. Further, Abrams et al. described a lack of autonomy experienced by study participants. Participants explained that many nurses were willing to volunteer to be redeployed, yet instances of leaders asking for volunteers were minimal. When participants raised concerns regarding redeployment, they were frequently met with negativity by leaders. Further, participants were often directed to desist from complaining instead of being heard and supported by leaders; responses by leaders often insinuated a threat of disciplinary action. Therefore, participants believed it was perilous to speak up to express their concerns.

Ballantyne and Achour (2023) found communication related to redeployment was inadequate, with lack of clarity from leaders. Little autonomy was provided to nurses, with no

aspect of redeployment negotiable. Participants were often informed on short notice about their redeployment, often only the day before or the day when redeployment occurred. Nearly half of the 55 participants were not informed of their redeployment in person by their leaders, rather through electronic communication or word of mouth. Unsurprisingly, half the participants felt unsupported by their leaders, citing feelings of disconnect and a sense of abandonment leading to a lack of trust in the leaders.

Leader shortcomings were described in a study of pediatric nurses redeployed to adult care units during the pandemic, where failure of home unit managers to remember and acknowledge their redeployed nursing staff was viewed as indifference (Darchen et al., 2023). Additionally, leaders who failed to greet redeployed participants on arrival to the receiving unit indicated lack of support by the leaders.

Foster (2022) discussed leaders' alienating approaches to redeployed staff in a summary of ongoing research studies, particularly unfairness for younger staff who were sent most often and treated more as a number than a person. Many participants in studies stated there was little to no communication regarding the length of their redeployment, nor any means to escalate their concerns (Foster; Kennedy et al., 2022).

Lack of visible leaders was a prominent theme in a study by Maben et al. (2022), with nurses feeling completely disconnected from their leaders. Across the 27 participants, they all indicated feeling isolated from their social supports outside of work and expressed they did not want to burden family and friends with their experiences. Therefore, they bore the weight of the pandemic experiences alone. In addition to being separated from their usual units, working in critical care with COVID-19 patients added additional feelings of isolation (Montgomery et al., 2021). Ultimately, many redeployed participants had negative experiences, feeling completely

abandoned, displaced, and anxious, further exacerbated by extreme changes to their work rotation, patient population, and tasks (Ralph et al., 2022).

The abundance of nurses who were voiceless while suffering isolation and abandonment is a disturbing finding. Further, feeling concern for being open and honest with their leaders upon whom they should rely, is unsettling. It was abundantly clear in the literature that leaders needed to make efforts to be visible and accessible to their redeployed nurses. Assessment of leaders' support utilizing structural empowerment as a framework can facilitate identification of issues and supports needed for redeployed nurses to inform leaders how to effectively guide nurses through crisis and change associated with redeployment.

Mental Health

COVID-19 brought chaos to health care systems, exacerbating stress levels of health care providers and deterioration in their mental health (Ménard et al., 2023). Redeployment was cited as a concerning factor related to the impact on mental health (Wood et al., 2022). In a scoping review to determine the impact of COVID-19 on nurses working in the ICU, Kissel et al. (2023a) reported both permanent and redeployed staff suffered negative mental health impacts, regardless of redeployment status. However, they did reference stressors unique to redeployed nurses caring for critically ill patients, particularly perceived lack of competency, requirements to take on patient assignments, and the prevalence of death. Yeter et al. (2024) found redeployment of pediatric critical care staff to adult critical care units during the pandemic contributed to distress due to lack of familiarity with the patient population, tasks, and environment. Robinson and Madge (2024) found over half of their participants experienced anxiety over their redeployment and felt there was inadequate support from leaders and senior staff. Further a quarter indicated their intent to leave or change jobs. However, a beneficial outcome was also noted, 74% of

participants indicated collaboration and support from frontline staff had a positive influence on their nursing.

Nurses participating in the study by Kelly et al. (2025) found visitor limitations distressing, particularly at end of life. Distress was also felt over deterioration in care standards that resulted from the burden of the pandemic, it was challenging when patient populations and care differed from their normal practice. Fear of the virus and the possibility of infecting loved ones also existed among their participants. Some felt they took work home with them and experienced flashbacks to events at work, which consequently caused disruption to sleep.

Post-traumatic stress was prevalent in literature on nurse redeployment. Couper et al. (2022) found that redeployed nurses identified having no or inadequate education for the care required in the redeployed area and was associated with higher instances of post-traumatic stress disorder. This issue was mirrored by other studies which found redeployment was associated with increased risk of anxiety and/or post-traumatic stress disorder (PTSD) in nurses (Greene et al., 2021; McCallum et al., 2025; Wu et al., 2025). Greene et al. (2021) also indicated the nurse and midwife participants in their study were significantly more likely to experience PTSD than the other participating care professions. Their analysis indicated participants who felt unsupported by leaders, had unreliable access to PPE, were fearful of spreading COVID-19 to others, and felt stigmatized due to their proximity to COVID-19 were at greater risk for negative mental health outcomes; previous illness with COVID-19 and redeployment indicated increased likelihood for PTSD. Rattray et al. (2024) studied the impact of the pandemic on critical care nurses and redeployed nurses in critical care environments. Their findings indicated critical care nurses and redeployed nurses were equally at risk of negative mental health outcomes. A third of the participants had concerning indicators for PTSD. Unlike Rattray et al., Melander et al. (2024)

found nurses that were redeployed had higher symptoms of post-traumatic stress than those that were not redeployed.

Other negative health outcomes pertaining to mental health included moral injury and moral distress, related to nurses' perceptions of barriers to provision of ethically appropriate care, often resulting in negative mental health impacts (Romero-García et al., 2022). Sydor et al. (2026) found a correlation between nurse redeployment and high levels of moral distress. Williamson et al. (2023) found redeployment a contributing factor to moral injury among health care staff, inclusive of nurses. They argued suitability of staff for redeployment should be considered and under ideal circumstances, should be voluntary. Romero-García et al. assessed moral distress in critical care environments during the pandemic. Findings indicated redeployed participants experienced greater degrees of moral distress, anxiety, depression, and intent to leave their job than regular unit staff. Maben et al. (2022) also found moral distress related to redeployed nurses who believed they had abandoned their usual patient care populations and left them without appropriate care. A study by Wood et al. (2022) discovered advanced practice nurses in secondary care experienced significantly higher moral distress than those in primary care related to barriers to effective patient care and concern over the mental health of their redeployed colleagues. This was reflected by Yeter et al. (2024) who found pediatric nurses that were not redeployed felt morally distressed for their redeployed colleagues and what they were going through.

Creedon and Trace (2025) studied resilience of nurses redeployed during the pandemic. Redeployment was overwhelming and participants needed to develop mechanisms to protect their psychological health. Moral distress existed surrounding end of life and ethically distressing situations where they felt the need to choose which patients to save. To cope, some nurses

became detached from their care environment, becoming task focused, while others sought to make sense of their experiences and liken them to disaster-based nursing. Participants found a sense of unity and support in each other, and their shared experience fortified bonds. However, participants felt isolated from other healthcare workers, the public, and even family. Participants faced different turning points in accepting and facing their anger and fear regarding redeployment, related to acceptance, positive affirmations, future thinking, and developing coping mechanisms, reconciliation, and pride in their work. Ji et al. (2021) described nurses as a profession, demonstrated a greater degree of distress as measured by the Impact of Event Scale-Revised categories as compared to physicians. Nurses also used more confrontive coping mechanisms, such as denial, self-blame, venting, and emotional approaches to redeployment, arguing that nurses required greater support to help negate distress experienced while providing care in unfamiliar clinical units.

Negative psychological impacts were a prevalent reason for dermatology nurses requesting premature termination of their redeployment in a survey by Wheeler et al. (2021). Respondents also expressed experiencing fear, alienation, lack of preparedness, and asserted tasks requested of them were out of their usual scope of practice, leading to concerns regarding the potential for making errors. Consistent with this finding, qualitative data in a study by Nelson et al. (2023) demonstrated lack of information and proper preparation for redeployed staff as a contributing factor to elevated stress. They found redeployment was a pressure point impacting nurses personal health and their ability to provide care. Rogers et al. (2024) studied the wellbeing of advanced practitioners, redeployed nurses made up 17% of the sample. Wellbeing outcomes specific to redeployment were not apparent, however the study did note how wellbeing was

lower in those working emergency, critical care, or directly with COVID-19 patients compared to primary care.

The literature demonstrated mental health outcomes did not disappear when a nurse returned to their home unit. Clements et al. (2021) discussed leader and nurse reflections on the initial surge of the pandemic at a Boston medical facility. In addition to describing isolation and removal from home units and lack of usual supports as key stressors among redeployed nurses, Clements et al. highlighted that many nurses felt guilty about their absence from their home units, making their return to their home unit a complicated adjustment. These authors emphasized returning nurses require time to reflect on and process their redeployment as well as the impacts on their mental health. According to these authors, open communication forums for reflection on redeployment will promote closure and optimize redeployed nurse's ability to provide quality care. They asserted these sessions were valuable opportunities that validated nurses' feelings and fostered a sense of community due to shared experiences that were frequently viewed as stressful and/or traumatic.

Lastly, Maben et al. (2022) described the culture shock many nurses experienced who were unfamiliar with dealing with critically ill and dying patients. Due to unfamiliarity with care of critically ill patients care, deaths posed more of a trauma to those redeployed. Though supports, such as sessions with counsellors and psychologists were available, participants expressed time and the potential judgement of their professional resilience were barriers to accessing these supports. Further, because of the chaos and burden of the pandemic, redeployed nurses perceived standards of care plummeted due to scarcity of resources and overburdened staff, stripping away the essence of nursing, and the ability to provide compassionate, wholistic care.

Detrimental mental health impacts were clearly linked to nurse redeployment. Failure to address and prevent deleterious mental health outcomes were harmful to nurses and the populations they served. Further research into mobilization of resources and support by leaders are required to aid them to be proactive in providing nurses with the tools necessary to safeguard staff from suffering mental health issues/problems prior to redeployment. Failure to act will result in further discontent, staffing issues, and attrition.

Burnout

Relevant to mental health, a particular concern in the literature was the strong association between nurse redeployment and burnout (Denning et al., 2021; Ferry et al., 2021; Hartley et al., 2025; Kennedy et al., 2022; Li et al., 2022a; Piercy et al., 2022). Unfortunately, work as a nurse was identified as a predictor of burnout (Denning et al.). Insufficient staffing levels and subsequent burnout were prevalent in nurses prior to the pandemic; COVID-19 was an accelerant to an already overburdened profession (Ménard et al., 2023). Key aspects of burnout were identified among the redeployed nurses in the study by Maben et al., (2022), particularly exhaustion and depersonalization. When some nurses were asked to redeploy a second time, they refused due to their personal health risks. Nurse participants frequently referred to colleagues who changed jobs, left the profession entirely, or expressed desires to retire as soon as it was feasible related to redeployment and the pandemic.

Studies of nurses working in and redeployed to critical care environments indicated burnout was prevalent and participants also exhibited psychological distress (McCallum et al., 2025; Rattray et al., 2024). Kissel et al. (2023b) studied burnout levels of team lead nurses, intensive care unit nurses, and redeployed nurses working in critical care units during the

pandemic. Though the team leads and intensive care unit nurses had the highest degree of burnout, all three nurse categories experienced high levels of burnout.

Recognizing the impacts of redeployment on nurses, Dunning et al. (2024) studied how nurses coped with redeployment and how coping related to wellbeing, burnout, performance and retention. They found a strong professional and organizational identity was most protective against negative outcomes, deterioration of organizational identity had moderate negative impact for redeployed nurses, while devaluation of both personal and organizational identities had the most significant negative impact on wellbeing, burnout, performance and retention. Importantly, Alkattan et al. (2025) identified a link between nurse redeployment and higher levels of burnout not only during redeployment, but after redeployment as well, suggesting nurse struggles with burnout do not automatically cease when redeployment does.

The impact of structural empowerment on burnout has been studied broadly demonstrating that lack of structural empowerment had significant negative effects on burnout (Doré et al., 2018; Guo et al., 2016; Hayes et al., 2014; Nursalam et al., 2018; O'Brien, 2011; Orgambidez-Ramos et al., 2017; Orgambidez & Almeida, 2019). Therefore, understanding redeployed nurses' experiences can assist in determining which proponents of structural empowerment were deficient and contributed to perceptions of burnout. Leaders can utilize this knowledge to better facilitate nurses' access to necessary resources, information, support, and opportunity when redeployed.

Fear

Though a simple concept, the overwhelming theme of fear was present in the redeployment literature (Agyekum, 2022; Darchen et al., 2023; Wheeler et al., 2021; Woodford et al., 2020). In Darchen et al. all pediatric nurses described anxiety and fear during their

redeployment, worrying about their capabilities and what they would encounter in a different work environment. Though fear dissipated for some participants through increased familiarity and routine while redeployed, others remained fearful. For many redeployed nurses, lack of preparation for redeployment led to fear of losing their license when pressured to do tasks for which they felt ill equipped, while feeling ignored and judged for refusing to complete duties they believed were out of their scope of practice (Maben et al., 2022).

A lack of knowledge and skill was a common theme among those redeployed, particularly those from an operative background (Montgomery et al., 2021). These participants emphasized the fear and distress they experienced, describing breakdowns and outright terror regarding their work life, in large part due to unfamiliarity with critical care environments and processes. In addition, culture shock for those with minimal exposure to death and dying led to increased difficulty caring for the critically ill.

Bogdán et al. (2024) found nurses that were fearful of recurrent redeployment were more likely to leave the profession. Although, findings also indicated fear of redeployment subsided the more participants had been redeployed to provide care on a COVID-19 unit, suggesting confidence was gained through experience. This was mirrored by Whelan et al. (2025) who found redeployment caused initial stress and anxiety for nurses, however, this improved as nurses became more familiar with the environment and through communication, education efforts, guidance, and support. Importantly, though not specific to redeployed nurses, the motivation study by Bogdán et al. to determine the 5-year probability of nurses staying in the profession during the COVID-19 pandemic indicated a small portion (4.5%) intended to leave the profession, almost 14% were undecided, while nearly 40% firmly planned to stay in the

profession. Although the percentage may be low, the fact nearly 5% of nurses indicated intent to leave the profession, with another near 14% undecided, is still concerning.

Fear is a powerful emotion, and as demonstrated above, not all nurses possess the resilience to overcome or manage fear. Therefore, it is important for leaders to not only acknowledge these fears, but address causes and provide nurses adequate support and resources to promote confidence in their care. Empowering structures lead to higher levels of organizational commitment. Laschinger et al. (2000) observed there is evidence that affective commitment to organizations builds resilience among nurses, making them better equipped to handle the challenges associated with restructuring and changes in the health care systems. Better understanding of lack of underlying resources, information, and support can highlight areas for leaders to focus their efforts to facilitate staff resilience when faced with redeployment.

Practice Changes

Out of necessity, COVID-19 spurred practice changes for health care practitioners who were required to adapt to emergent patient volumes and acuity. For example, to facilitate greater working capacity in response to the burden of COVID-19, an American medical centre removed physician supervision requirements of certified registered nurse anesthetist's (CRNAs) (Rollison et al., 2021). CRNAs were increasingly available to be redeployed to aid in the care of critically ill patients due to reduced surgical cases. CRNAs described redeployment as professionally satisfying, emphasizing the strength of teams and collaboration, although fear of the unknown, exhaustion, and risks for burnout were listed as concerns. Unlike most nurses, CRNA redeployment was voluntary, with almost half choosing either ICU or respiratory therapy. This difference in approach leads to the question whether autonomy of choice led to more positive and satisfactory experiences for redeployed staff.

Practice changes often impacted redeployed nurses in more subtle ways, with differences perceived by nurses between practices on their home units versus units to which they were redeployed. Darchen et al. (2023) found a conflict for some nurses who believed they were not providing sufficient care. Further, many faced culture shock of end-of-life care with concomitant decisions, stating feeling uneasy and ill equipped to handle discussions and decisions regarding death.

Ultimately, in the chaos of COVID-19, it is not surprising that practices changed and evolved. Unfortunately, there was a lack of time for the redeployed nurses to adapt to the new clinical practices and environments. Though change and change management were not prevalent in the literature, this issue is rooted in power since it demonstrates the need to provide redeployed staff the resources, information, and support they need to be successful in facing rapid change.

Redeployment Strategies

Redeployment of nurses during the pandemic was a common strategy discussed in the literature (Camilleri et al., 2022; Cha & Yun, 2025; Clayton et al., 2022; Cosper et al., 2023; Esser et al., 2023; Gibney et al., 2022; Kang et al., 2023; Kennedy et al., 2022; Mhawish & Rasheed, 2022; Oakley et al., 2020; Tashkandi et al., 2021; Topple et al., 2023). Some studies focused on the effectiveness of various education methods to prepare nurses for redeployment. For instance, one study posited the effectiveness of implementing an electronic education platform for redeployed nurses (Camilleri et al.). Feedback from participants was predominantly positive, with results indicating their program fostered confidence and was informative for redeployed nurses. Similarly, Kang et al. (2023) studied the efficacy of a training program to improve core competencies of nurses, their findings indicated that nurses who took the program

had increased confidence in providing care to COVID-19 patients compared to those that did not take the program. Cosper et al. detailed how clinical nurse specialists and clinical nurse leaders collaborated to promote patient and staff wellbeing during redeployment. Clinical nurse specialists and leaders determined competencies nurses who were redeployed required and tailored education to different scopes of practice in different clinical areas. Tashkandi et al. discussed nurse redeployment as a strategy to approach rising care needs of acutely ill hospitalized patients during the pandemic. These authors discussed redeployment strategies, education, and team-based approaches. Importantly, nurses' perceptions regarding redeployment were lacking in this literature.

Other literature focused on redeployment strategies largely as a tool to support facility operations. For instance, Cha and Yun (2025) studied workforce management and redeployment as a mechanism of response to the pandemic, whereas Esser et al. (2023) reviewed the efficacy of addressing adult patient care pressures through closures of pediatric programs and redeployment of pediatric staff. Dhaliwal et al. (2024) reviewed records of administrative strategy surrounding the pandemic, including redeployment of nurses. Although importance of nurses and their wellbeing are discussed, there were no nurse specific perspectives on the efficacy of the facilities strategies on guidelines, strategy, training, support, or physical and mental protective measures. A study by Phillips et al. (2022) reviewed leadership strategies undertaken to meet pandemic care demands and safeguard nurses. Though redeployed nurses were not the focus of this study, it did demonstrate leader investment in understanding outcomes of early pandemic strategies and implementation of improvements during the second wave of the pandemic to improve wellbeing of nurses.

In a strategy review of a site education plan Clayton et al. (2022) detailed planning and redeployment of perioperative staff following cancellation of surgeries. Team based nursing care models were implemented in which redeployed nurses assisted unit nurses with tasks within their scope of practice instead of taking on a patient load. Many perioperative nurses did not have current bedside care experiences. A 2-week program consisted of theory and practice components with buddy nurses for redeployed nurses not prepared to practice in an unfamiliar clinical area. A skills checklist was completed indicating they were mostly independent or required some assistance with identified tasks. In addition, a leadership strategy was implemented, in which a specific redeployment leadership team, liaised between redeployed staff and their home unit. This team held weekly huddles to discuss concerns of those redeployed and identified continuing education needs. Although this initiative appears robust, it is important to recognize that redeployed nurses' perspectives were not shared. Therefore, the effectiveness and receptivity of this strategy were not apparent, nor whether the education initiative was well received or impactful. Withall et al. (2023) studied perceptions of perioperative nurses, as well as ambulatory care nurses, redeployed to COVID-19 inpatient units during the pandemic. Participants related their experiences to a context of fighting weaponless in a war. Participants highlighted the importance of team building, augmenting personal capacity, and courage to success in redeployment. Challenges described by participants were fear of the virus, changes in work schedule, and unfamiliarity with the redeployment setting.

A study by Oakley et al. (2020) approached nurse redeployment as a mechanism to meet care needs, focusing on how the redeployment strategy used to manage the influx of patients during the pandemic in their UK ICU was effective and how their model may be transferrable to similar settings. This study was operations based, and no perspectives specific to nurses were

included to corroborate effectiveness of this strategy from the perspective of front-line staff.

Mhawish and Rasheed (2022) studied the effectiveness of team-based nursing as a redeployment strategy to address COVID-19 and how ratios of critical care nurses to patients was increased from the norm of 1:1 to 1:9 with the aid of two to three redeployed nurses supervised by a critical care nurse. Notably, nurses' distress related to the pandemic was only briefly discussed in their review, documenting common concerns raised by nurses, such as barriers to performing usual standards of care, fear of being stigmatized and passing illness to their families, as well as concern for their own health and wellbeing. Topple et al. (2023) also examined how redeployment impacted nurse ratios in intensive care units. They posited that failure to redeploy nurses would have resulted in insufficient staff to maintain appropriate care ratios in nearly all ICUs in Victoria, Australia for 15% of care days over the 5-month course of the study. Topple et al. concluded this indicated the necessity of redeployed staff to maintain sufficient nurse ratios. However, as the pandemic burden increased in hospitals, skill mix was often skewed, with not enough nurses with critical care experience as compared to those nurses without this experiential knowledge and practice, which could pose a risk to overall patient mortality rates in these areas. Similarly, a report by Gibney et al. (2022) discussed redeployment as an effective tool to increase capacity in critical care; however, they noted that greater reliance on non-critical care educated staff posed potential safety concerns for patient care on redeployment units and led to diversion of care away from other clinical areas. These authors acknowledged that redeployment of nurses to ICUs was identified as a psychological health risk.

Jeffs et al. (2025) studied redeployment but from a logistical lens. Health care professionals, including nurses, and leader perspectives were shared related to the strategies involved in redeployment. Participants discussed the mechanisms and decision-making process

behind who was redeployed, such as redeployment based on clinical background, volunteering, skill assessment to inform tasks, whether participants were functioning to their full scope versus supporting, and prolonged versus shift-based redeployment strategies. Although participants detailed the strategies of redeployment, minimal insight to the feelings of redeployed nurses regarding the efficacy and/or satisfaction with these strategies was apparent. Only brief descriptions by nurses were present in the study, detailing feeling fear and/or anxiety over the possibility of redeployment, stress related redeployment orientation, and concern over quality of patient care in the redeployment setting as well as patient populations nurses were redeployed away from.

A study by Kennedy et al. (2022) regarding redeployment demonstrated more focus on nurses and their needs. During the pandemic, a main concern of nurses pertained to removal from their area of specialty (Kennedy et al.). Many nurse participants cited a lack of adequate education to care confidently and safely for a more acutely ill patient population. The authors argued that staff sharing, with a pool of nurses willing to be redeployed as needed, would be beneficial as these nurses would be up to date on requirements to effectively aid in crisis situations and decrease large scale educational needs of additional redeployed staff.

Results from a qualitative study by Asmaningrum et al. (2026) on nurse perspectives of redeployment helped inform key strategy recommendations in the case of future redeployment requirements, particularly criteria-based protocols accounting for clinical ability, recognition of physical/psychosocial factors, preparation and building capacity to bolster resilience, and provision of incentives and material resources to motivate nurses and promote retention.

Interestingly, a redeployment study by Scott et al. (2024) indicated while there were good intentions behind redeployment as a strategy, it was not necessarily entirely beneficial for the

redeployment unit, or the staff redeployed. Redeployed nurses were concerned over assumptions of their competency, clinical expectations, and their ability to provide care in the redeployment setting and fear of contracting the virus. Redeployment decisions also led to participants struggling with role importance, and why different nursing roles were prioritized over others. They also indicated that usefulness of redeployed nurses was significantly related to how recent critical care experience was. Familiarity with the setting and tasks played an important role in confidence and comfort for those redeployed. Those that were not as familiar and confident expressed feeling burdensome to unit staff.

Redeployment as a strategy was also present in the grey literature; an anecdotal report by Allen (2020) reflected on redeployment with foci on optimal redeployment approaches, particularly orientation to work environments and maintenance of scope of practice. However, nurse specific impacts were not discussed.

Overall, the above studies and reports highlight how nurses were frequently viewed as redeployment tools, with little consideration to nurses' perspectives of redeployment. Although some of these strategies may have been helpful, without an in-depth analysis of nurses' perspectives on the effectiveness of these organizational strategies, it is difficult to ascertain how beneficial they may or may not be. Failure to account for the front-line nurses' perspective is only part of the picture.

Impact to Programs

Nurse redeployments impact on health care programs was another key issue discussed in the literature (Arnold et al., 2020; Baswa et al., 2022; Billman et al., 2022; Dunk & Madge, 2021; Forster et al., 2022; Hall et al., 2022; Hardman et al., 2021; Hasson et al., 2022; Lokmic-Tomkins et al., 2026; Lord et al., 2020; McLuskey, 2023; Moussa et al., 2021; Nguyen et al.,

2020; Orr et al., 2023; Shaffi et al., 2023; Skiller et al., 2023). Some studies were primarily related to infection prevention and control. Baswa et al. studied redeployment as part of their survey of Australian Infection Prevention and Control (IP&C) professionals, only a quarter of whom were nurses. The focus was on key strategies to improve redeployment outcomes related to infection prevention and control, particularly, standardization of operating procedures. A program initiative-based study by Billman et al. detailed how nurses and other redeployed clinicians were educated to be safety officers to aid in infection prevention and transfer of COVID-19 to patients during the surge of cases. Neither study contained perspectives of redeployed staff.

Perioperative nurses were uniquely impacted by COVID-19 due to mass closures of elective surgeries that resulted in redeployment of perioperative nurses to other areas (Skiller et al., 2023). Their redeployment disrupted nurse education and skewed ratios of novice versus experienced nurses on perioperative units, observing an overall deleterious impact on learning. Similarly, Forster et al. (2022) discussed how a third of the clinical nurse specialists in their study were redeployed. However, the focus was how redeployment impacted the cancer care program in terms of practice changes, patient care, and extended hours to meet patient needs, rather than on the redeployed nurses themselves. Lord et al.'s (2020) review of the pandemic impact was more physician based, focusing on realigning the neurology services to aid in addressing Covid-19, whilst maintaining the care team structure during redeployment. Shaffi et al. (2023) focused on perspectives of the critical care nurses, not those redeployed on the efficacy of the Extracorporeal Membrane Oxygenation (ECMO) clinical support team.

Other specialty care areas were similarly impacted. In a report, McLuskey (2023) discussed the redeployment of HIV nurses to aid in care during the pandemic. The focus was on

changes to HIV services while nurses were redeployed and negative impacts to patient engagement noticed by nurses when they returned to their usual roles. Uniquely, in the review by Perry et al. (2024) redeployment referred to staff of an elderly care program deploying to provide their current role but in the setting of the patient's home. Additional services impacted by nurse redeployment included public health, community health/social programs for elderly, primary care, sexual health services, rural cardiovascular services, cystic fibrosis, bariatric services, heart transplants, hip fracture services, hospice, and stroke care (Arnold et al., 2020; Duncan, 2023; Dunk & Madge, 2021; Hall et al., 2022; Hardman et al., 2021; Hasson et al., 2022; Lukewich et al., (2024); Moussa et al., 2021; Nguyen et al., 2020; Orr et al., 2023; Rehackova, et al., 2025). Significantly, none of these studies assessed or mentioned redeployment impacts on nurses.

The above discussion demonstrates that COVID-19 did not discriminate about program area, and its impact transcends all professions and care areas, whether directly or indirectly. Redeployment throughout the pandemic had a broad impact on nurses across many service areas. Although all professional struggles related to the pandemic are valid and deserve attention, the lack of information surrounding the unique challenges experienced by nurses, who were most affected by redeployment, should garner more in-depth consideration since they comprise the largest health care group and are asserted to suffer greater negative health impacts than other professions during pandemics (Couper et al., 2022). While difficulties experienced by staff not redeployed remaining on home units are valid, redeployed nurses faced the added stress of unfamiliarity with environments and care practices, which require attention.

Superficial Analysis

Much of the academic literature on nurse redeployment during the COVID-19 pandemic offered only superficial analysis regarding nurse redeployment and its impact on nurses. For

instance, the impact on nurses completing advanced practice programs and barriers to nurse led research due to redeployment were discussed, but minimal reference was made to experiences of front-line nurses (Castro-Sanchez et al., 2021; Intinarelli et al., 2021). Other scholars briefly mentioned mental health detriments and adverse impacts to the wellbeing of redeployed nurses (Hamilton et al., 2022; Johnstone & Duncan, 2021; Kealeboga et al., 2023; Morton & Adams, 2022; Nune et al., 2021). In their study, Fosuhemaa Bossman et al. (2021) discussed redeployed UK diabetic specialist nurses' wellbeing in terms of access to mental health services; however, no specific detail or reference to mental health issues experienced by those redeployed were discussed. One study discussed redeployment or relocation in terms of determining whether health care professionals with personal health risks were moved to other clinical areas to decrease their likelihood of contracting COVID-19 (Jiménez-García et al., 2022). Overall, it is important to note that the wellbeing of nurses redeployed for supporting care during the pandemic was not a point of focus, but rather secondary in the above literature.

Education was a prevalent topic in the literature concerning education platforms, programs, and their efficacy in preparing redeployed nurses (Leibner et al., 2022; Ménard et al., 2023; Naik et al., 2020). Lokmic-Tomkins et al. (2026) studied the outcome of introducing a new digital technology used in nursing practice during the COVID-19 pandemic, redeployment was only mentioned superficially as an impactful factor on the technology integration. Additional topics and contexts related to nurse redeployment in the literature included the use of social media as a means for support, disruption to health care administration, redeployment as a means to augment pandemic efforts and its impact on increased workloads (Glasdam et al., 2022; Hovhannisyan et al., 2022; Moi et al., 2022; Munn et al., 2021; Savage et al., 2022; Seamark et

al., 2022). Noticeably however, there was little or no reference to the impact of redeployment on nurses.

These superficial analyses lack the voices of redeployed nurses and their perceptions, whether by failure to include this perspective, lack of clarity, or failure to incorporate experiences of those at the front line. Nurses were more an afterthought or contributing factor to another aim of COVID-19 management, instead of the area of focus. Although information on multiple outcomes related to redeployment and the pandemic are important, it is also imperative that researchers do not lose sight of those living the reality of redeployment. Without giving nurses on the front line a voice, these studies do not reveal the impact of redeployment on nurses.

Summary

Overall, though nurses' perspectives on redeployment exist in the literature, nurses are greatly underrepresented in the studies. Further, though many approaches and topics were discussed, none utilized structural empowerment as a framework to assess redeployed nurses perceived access to the resources, information, opportunities, and support necessary for them to feel successful during redeployment. Nurses in a qualitative study (Pilbeam & Snow, 2022) observed that reflection on their redeployment was beneficial to their health and helped ascribe meaning to their experiences, demonstrating reflection is a viable tool to help address and alleviate trauma experienced by redeployed nurses. A conceptual framework such as structural empowerment can guide nurses to reflect on redeployment and provide valuable insight into the experiences of redeployed nurses. Further, strategies for nurse leaders who manage redeployment in the future have the potential to improve the overall experiences, satisfaction, and retention of nursing staff.

Chapter 3 – Research Method

This chapter will provide an overview of the research methodology used for this study. Details are provided regarding the research design, ethical considerations of this research study, recruitment methods, study participants, and setting. Concluding the chapter, the methods for data collection, assessment, and analysis are described.

Research Design

A qualitative descriptive method was used to understand the perceptions of nurses who were redeployed during the COVID-19 pandemic. Qualitative descriptive studies examine phenomena to produce in depth narratives (Polit & Beck, 2021). Their focus lies in exploring experiences to closely interpret human interaction with the phenomena (Melnyk & Fineout-Overholt, 2019). Qualitative description also allows researchers the option of beginning with a theoretical framework to assess the phenomenon of interest (Sandelowski, 2000). This study investigated nurses' perceptions of their experiences during redeployment utilizing the theoretical framework of structural empowerment to better understand their experiences in an unfamiliar environment in the context of the pandemic.

Research Questions

The overall purpose of this study was to determine redeployed nurses' perceptions of their redeployment experiences during the COVID-19 pandemic.

The following questions were explored in this study:

1. What were nurse's overall perceptions of their redeployment experiences?
2. How were redeployed nurses informed of their redeployment by their nurse leader?
3. How did the nurses frame the redeployment experience?
4. What resources supported the nurse's transition to the redeployed unit?

5. What were their experiences with communication and dissemination of information from nurse leaders during their redeployment?

Positionality

Positionality in research is important, since the beliefs and experiences of a researcher can influence interpretation of findings (Holmes, 2020). The positionality of the researcher has implications for the validity and ethical soundness of data, therefore making it important for them to demonstrate reflexivity through disclosure of their assumptions and how they may impact the study (Holmes). Though true objectivity is not possible, constant reflexivity through reflective journals spurs awareness of the researcher's preconceptions and facilitate analysis of the findings that reflect the data rather than the perspectives of the researcher. Ongoing reflexivity was necessary as positionality can change over the course of study (Holmes).

Positionality Statement

Part of positionality is identifying how you as a researcher are an insider versus an outsider to the phenomenon under study (Holmes, 2020). Participants of this study were all registered nurses; therefore, as a registered nurse, I was an insider. Additionally, I experienced the phenomenon of redeployment personally, as I was redeployed to a COVID-19 critical care unit for 6 weeks, and a COVID-19 medicine unit for an additional 3 weeks. During these times of redeployment, I analyzed my experiences through the lens of structural empowerment, which helped me understand and make sense of my feelings and thoughts about my experiences in terms of access to resources, support, information, and opportunity. This analysis helped me understand my experiences and how the theory of structural empowerment can be used to understand redeployment. Importantly, this personal analysis facilitated identification of my assumptions related to the experiences of a redeployed nurse (see Appendix C). During the

research process, I kept a journal in which I was reflexive and reflected on the data gathering and analysis processes to ensure that I was true to the data.

Although I experienced redeployment during the pandemic similar to the study participants, they were from different facilities than where I was employed and redeployed. As such, work cultures and leadership structures varied from those I experienced. At the time of the study, I was in an administrative role and no longer working on the front lines. Nonetheless, I utilized the advantage of shared redeployment experiences to build confidence with the study participants through exhibiting empathy and interest in their redeployment experience. However, I was clear that my role was as a researcher endeavoring to understand their unique experiences.

Ethical Considerations

It is the responsibility of all researchers conducting studies involving humans to do so ethically (Polit & Beck, 2021). Ethics approval was obtained from the Research Ethics Board 1 (REB 1). In support of ethics, I completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE) (Appendix D) and Privacy Training for Researchers (Appendix E). This study posed minimal risk to participants that would not exceed risk experienced in their daily life.

Informed Consent was obtained from all participants (Appendix F). This process ensured all participants were aware of and understood all aspects of the study and what their participation entailed so they could voluntarily agree or disagree to take part (Polit & Beck, 2021). The Informed Consent also detailed that participants could withdraw from the study without penalty at any time and/or refuse to answer any questions. Confidentiality and anonymity are also pertinent to protecting the privacy of participants involved (Polit & Beck). Participants were assigned a number that was referenced in relation to data they provided. Their name and assigned

number were indicated only on the Informed Consent and master list. The electronic copy of the informed consents and master list were kept in a password protected file accessible only to me as the researcher and my academic advisor.

Confidentiality of virtual interviews were maintained utilizing security features of the UM Zoom platform. Zoom offers the ability to provide live encryption of recordings and storage onto local drives without distribution to third party software (Archibald et al., 2019). Utilizing these features, recordings and audio transcripts were observable only to me and my academic advisor. Handheld recorders used for backup audio recordings were stored in a locked cabinet accessible only to me, the researcher. All video and audio recordings were deleted within a year of completing the transcripts. Transcripts, notes, and memos will be maintained in the password protected files for up to 7 years (April 2032), after which they will be permanently deleted.

An honorarium of a \$50.00 Amazon Gift Card was provided to participants immediately following receipt of their Informed Consent as a token of appreciation for the participant's time. Interviews were scheduled for an hour, and this honorarium was comparable or close to an hour of salary for participating registered nurses. Participants were informed the honorarium would not be revoked should they withdraw from the study.

As part of the Informed Consent, participants were asked if they would be willing to participate in a 20 minute follow up interview to review themes that emerged from the study to ensure they were an accurate reflection on their perspectives. The first 3 participants that indicated their interest in completing the follow up interview were contacted via email within 3 months of their initial interview for the follow up zoom meeting. No additional honorarium was provided for the follow up review.

Study Participants

For this study, 10 registered nurse participants that were redeployed during the COVID-19 pandemic were asked to participate in the study. The criterion for redeployment was defined as a directive to a registered nurse to redeploy from their home unit to an unfamiliar clinical setting for a minimum of 6 weeks in Manitoba, between 2020 – 2023, as a result of the COVID-19 pandemic. A minimum of 6 weeks was chosen as this reflects a standard rotation. Participants needed to be English speaking and willing to be interviewed in a virtual setting.

To ensure participants reflected the phenomenon under study, purposeful sampling was used. Purposeful sampling ensured participants selected were those that would provide the greatest benefit for the study (Polit & Beck, 2021). Snowball sampling was also used since many participants had colleagues who also met the criteria. This is a common recruitment strategy in which early identified participants assist in identifying others who may be interested in participating in the study (Polit & Beck). These recruitment methods facilitated data specific to redeployed nurses' experiences to enhance rich study data to understand the unique perspectives of this group (Polit & Beck; Sandelowski, 2000). Lastly, in qualitative research, it is important that data saturation, the point at which data becomes redundant with no new themes emerging, is obtained (Polit & Beck). The 10 nurses who met the study criteria provided data until saturation was met to meet the goals of the study.

Access

To gain access to Shared Health (SH), Winnipeg Regional Health Authority (WRHA), Prairie Mountain Health (PMH), Interlake-Eastern Regional Health Authority (IERHA), and Southern Health-Santé Sud (SHSS) health care facilities, a request for contact with the regional Chief Nursing Officers (CNO's) was submitted via each region's inquiry platform. Once CNO contact information was obtained, an access letter outlining the purpose and details of the

proposed study (Appendix G) was sent to the CNO and access requested. A request, containing an access letter specific to nurse graduate students (Appendix H), was sent to the University of Manitoba College of Nursing via the Manitoba Centre for Nursing and Health Research (MCNHR), requesting access to eligible nurse graduate students admitted into the program September 2022 or later. The admittance date of September 2022 or later was chosen to prevent accessing students potentially known to the primary researcher from prior graduate course work. Access was granted from Shared Health (SH), Winnipeg Regional Health Authority (WRHA), Interlake-Eastern Regional Health Authority (IERHA), and the College of Nursing.

Recruitment

Following ethics and access approval from the Chief Nursing Officers (CNO's) contacts of Shared Health (SH), Winnipeg Regional Health Authority (WRHA), and Interlake-Eastern Regional Health Authority (IERHA), a letter of invitation was sent to registered nurses employed in their organizations during the pandemic (See Appendix I). Site administrative assistants were requested to blind carbon copy registered nurses on a communication containing the letter of invitation outlining the study. Following ethics and access approval to the College of Nursing, a letter of invitation was sent to nurse graduate students admitted into the program September 2022 or later (See Appendix I). A request was made to all accessed areas to send a follow up email 2 weeks or more following the initial correspondence as a reminder to prospective participants, until the required sample was obtained.

When interested participants made contact, whether they met the inclusion criteria was confirmed. Once it was confirmed the inclusion criteria was met, the prospective participants were sent the consent form to review and sign if interested in participating. Once informed consent was obtained, the participants were sent the \$50 honorarium electronically, and a UM

Zoom meeting link was sent for an interview time that fit the participants' schedule. Additional potential participants who indicated interest in the study after the sample size was reached were thanked for their interest and informed that the study was at capacity.

Data Collection

One on one interviews were conducted virtually via UM Zoom. Zoom offered many advantages as an interview platform, including increased accessibility and convenience for the researcher and participant, while still allowing a visual interface to build rapport (Archibald et al., 2019). This user-friendly platform also allowed for secure recording of interviews and the ability to store data (Archibald et al.). A handheld recorder was utilized as a back-up recording of the interviews. Further information on privacy and data management was discussed in the ethical considerations section.

Demographic Data

At the beginning of the scheduled one on one virtual interview prior to recording, study participants completed a demographic questionnaire developed for the study (Appendix J) to gather data on characteristics present in the sample and how they may relate to the data retrieved. Once the demographic questionnaire was complete, participants were provided a brief overview of the purpose of the study and asked if they had any questions prior to beginning the semi-structured interview.

Semi-Structured Interviews

Following the demographic questionnaire, once readiness was confirmed, permission was requested to commence the semi-structured interview and begin transcription and recording. Semi-structured interview questions developed on the basis of the Conditions for Work Effectiveness Questionnaire (CWEQ) and Kanter's theory were utilized to gather data on the

phenomenon of nurses' perceptions of redeployment during the COVID-19 pandemic. Designed for the purpose of quantitative measurement of structural empowerment in the nursing population, the CWEQ is comprised of subscales measuring empowerment structures, inclusive of opportunity, resources, information, and support (Laschinger, 2012). Bolstered by the tenets of Kanter's original theory, adaptation of CWEQ questions to open ended interview questions led to rich data of nurses' perceptions of the empowerment structures of opportunity, resources, information, and support as they related to experiences with redeployment over the COVID-19 pandemic. The semi-structured interview guide is provided in Appendix K, and a graphic representation of how each question relates to the theory of structural empowerment, and the research questions is presented in Appendix L. In case participants found themselves upset or distressed following recounting their experience of redeployment, a debriefing form was sent by email after conclusion of the semi-structured interview that included accessible resources for support (Appendix M).

Data Analysis

Audio recordings of the interviews were transcribed by Transcript Heroes, a University of Manitoba approved transcription service. To ensure accuracy of the transcripts, the student principal investigator listened to the recordings while reviewing the written transcripts to correct any inaccuracies. UM Zoom recordings were reviewed to understand tone, body language, and emotion as they related to the transcripts to provide better depth of understanding participants experiences.

Content analysis was used for data analysis. Content analysis is a method of identifying themes and their prevalence in narrative data (Polit & Beck, 2021). Constant comparison was utilized for cross comparison of data from the 10 participants to identify parallels, branching

themes, and contextual differences allowing a deeper understanding of the phenomenon (Kim et al., 2017). Further, constant comparison was utilized to infer how emerging concepts fit with the existing theory (Polit & Beck), making this method a relevant approach to assessing how participants experiences with leadership and redeployment during the COVID-19 pandemic related to the theory of structural empowerment.

Trustworthiness

Accurate and honest representation of data is paramount to research (Polit & Beck, 2021). In accordance with positionality, I was reflexive during the development and throughout the study and analysis using a reflective journal initiated with the first interview and throughout the process of data analysis. Reflexivity in qualitative research is an important activity to prevent bias of findings; critical reflection of myself as the researcher and how the data could be affected by my values, experiences, and beliefs was addressed through reflective journaling (Polit & Beck, 2021). The reflective journal served as a repository for observations of emerging themes and how participants emoted their experience during the initial interview. To ensure findings were accurate to participant perspectives, personal experiences that could impact the findings were noted in the journal. To ensure personal experiences and assumptions were not skewing the data, transcripts and audio-video recordings were reviewed multiple times, to ensure initial insights from the reflective journal were accurate and expansion on themes were the participants own perceptions. Evolving the data through this reflective journaling and repetitive review of transcripts and recordings contributed to trustworthiness.

In qualitative research, trustworthiness, comprised of credibility, dependability, transferability, and confirmability are used to authenticate data (Lincoln & Guba, 1985 as cited in Polit & Beck, 2021). To ensure credibility of data, following data analysis, the data

interpretations were shared with 3 participants of the research study as a confirmatory activity to verify their findings were reflective of their experiences (Polit & Beck, 2021). Dependability of findings pertains to whether, if the study were replicated, would the findings be consistent (Lincoln & Guba, 1985 as cited in Polit & Beck, 2021). Repetitive themes and data saturation observed in this study support dependability should the same or similar study be completed. The thesis chair analyzed two transcripts to corroborate emerging themes to facilitate confirmability. Congruence was established between my advisor and I and internal committee member on the evolving analysis and findings (Lincoln & Guba, 1985 as cited in Polit & Beck, 2021). Robust description of the phenomena from participants contributed to transferability of the findings. As the study is grounded in the theory of structural empowerment, further research in varying contexts can be developed based on the findings of this study (Lincoln & Guba, 1985 as cited in Polit & Beck, 2021).

Summary

This chapter described the study design and methods that were used to garner the experiences and perceptions of redeployed nurses during the COVID-19 pandemic. A description of positionality and ethical considerations for the purpose of safeguarding participants were provided. Detail on recruitment of study participants, data collection, and analysis were described. Processes to establish trustworthiness of the data that emerged were explained.

Chapter 4 - Findings

The purpose of this study was to understand nurse perceptions of redeployment during the COVID-19 pandemic. Understanding nurse experiences of redeployment will provide valuable information to nurse leaders in future nurse redeployment efforts to improve outcomes and nurse wellbeing. Nurse experiences of redeployment are underrepresented in the literature. One to one virtual interviews were conducted with the 10 registered nurse participants that agreed to participate in the study. A short, 20 minute, follow up interview was conducted with 3 of the 10 participants to confirm emerging themes were accurately reflective of their experiences. Sample characteristics and study findings are described in this chapter.

Sample Characteristics:

Through purposive and snowball sampling, 10 registered nurse participants were obtained over 3 months. Interviews were recorded and transcribed via UM Zoom, and a handheld recorder for backup purposes.

The following questions were explored in this study:

1. What were nurse's overall perceptions of their redeployment experiences?
2. How were redeployed nurses informed of their redeployment by their nurse leader?
3. How did the nurses frame the redeployment experience?
4. What resources supported the nurse's transition to the redeployed unit?
5. What were their experiences with communication and dissemination of information from nurse leaders during their redeployment?

Description of Participants

The 10 participants all identified as female with an age range of 31-60. Highest education degree held by all participants was a Baccalaureate of Nursing. Of the 10 participants, only one

was working part-time at the time of redeployment, the rest were in a full-time position. Years of nursing experience ranged from 11 to over 31 years of experience. Participants in this sample came from a variety of backgrounds, including non-acute care, outpatient, public health, and educator roles. Years of the pandemic participants were redeployed ranged from 2020-2022, with length of redeployment ranging from 6 weeks to more than 49 weeks. Redeployment settings included critical care, medicine, long term care, contact tracing, COVID-19 testing sites, and vaccination sites. Demographic data of the sample are represented in Table 1.

Table 1

Participant Demographic Data

Demographic Category	Parameter	Number of Participants
Age Category	31-40	4
	41-50	3
	51-60	3
Gender	Female	10
Highest Education Degree Held	Baccalaureate of Nursing	10
EFT at Time of Redeployment	Part Time	1
	Full Time	9
Calendar Year(s) Redeployed	2020	6
	2021	10
	2022	2
Years Employed as a Nurse	11-15	3
	16-20	3
	21-25	1
	26-30	1
	≥31	2
Home Unit at Time of Redeployment	Outpatient	4
	Educator	4
	Non-Acute Care	1
	Public Health	1

Redeployment Setting(s)	Critical Care	3
	Medicine	1
	Long Term Care	2
	Contact Tracing	4
	COVID-19 Test Site	3
	COVID-19 Vaccination Site	2
Length of Redeployment	6-12 Weeks	2
	13-24 Weeks	4
	≥49 Weeks	4

Characteristics of the Interviews and Transcripts

To provide anonymity and confidentiality of the 10 participants that completed the one-to-one interviews, participants were coded as Redeployed Nurse 1-10. All participants provided in-depth responses regarding their redeployment experiences. Data saturation was achieved with the sample of 10 nurses as emerging themes and categories became consistent and repetitive across the interviews.

The primary investigator utilized the Transcript Heroes transcription service, and cross reviewed the transcripts and interviews to ensure accuracy of text and nuances from participants. Content analysis was used to identify themes and their prevalence in the data. Additionally, constant comparison was used as a method of cross comparison of data from the participants to identify parallels, branching themes, and contextual differences for a deeper understanding of participants experiences with leadership and redeployment during the COVID-19 pandemic. Transcripts were then reread to consolidate emerging themes and categories. Themes and subthemes that emerged from the data are listed in Table 2.

Table 2

Findings Themes and Subthemes

Theme	Subthemes
1. Redeployment: The Ask	Is There a Choice? Ambivalence Ambiguity in the Ask
2. Managing Redeployment	Preparation Importance of Relationships Leaders Engagement Visibility Compassion Nurses and Healthcare Professionals Coping Ambiguity Managing Redeployment What is Happening? Who is in Charge? Why am I Here? When Will This End?
3. Consequences of Redeployment	Impact on Wellbeing Overwhelmed Burnout Moral Distress Retention Feeling Devalued Professional Role Personal Factors Respect Ambiguity of Consequences Patient Outcomes Quality of Care Not Feeling Safe Do Leaders Care?

Redeployment during COVID-19 was not static, but a progressive phenomenon. Redeployment began, not with the first day at the redeployment area, but with the ask. Further, impacts of redeployment did not simply end with return to the home unit. Upon thematic analysis, it became apparent that themes existed in a somewhat chronological order, but interacted with each other, and to understand perceptions of redeployment, I needed to understand the before, during, and after redeployment experiences of the participants.

Perceptions of redeployment initiated with the ask to redeploy, followed by how redeployment was managed and lastly, the consequences of redeployment.

Through data analysis, it became clear that throughout all themes, there was an overlying context of ambiguity. This context existed simultaneously and continuously throughout all three themes: redeployment: the ask, managing redeployment, and consequences of redeployment. Therefore, it was important to highlight this context to better understand how ambiguity impacted all aspects of redeployment across the participants and the identified themes. Many unknowns existed with the emergence of the COVID-19 pandemic and were threaded through the phenomena of redeployment in many ways. As themes are individually explored, ambiguity will be discussed to highlight how this context underpins all themes.

Theme 1 – Redeployment: ‘The Ask’

In this study, a redeployed nurse was considered any registered nurse who was redeployed from their home unit to an unfamiliar clinical setting for a minimum of 6 weeks in Manitoba between 2020 – 2023 as a result of the demands of COVID-19. During the COVID-19 pandemic, many nurses were asked to be redeployed. For participants, perceptions of redeployment initiated with the ask to be redeployed. The following sub concepts emerged in this theme: i) is there a choice and ii) ambivalence.

For some participants, after the call for nurses to be redeployed went out, they volunteered to be redeployed. For others, the ‘ask’ to redeploy was more a mandate. Thus, the degree of choice participants had regarding the decision to redeploy varied. The ask to redeploy invoked ambivalence for many participants, whether they volunteered or were mandated to redeploy. Many participants had doubts with respect to their capacity to manage certain tasks and

practice settings, since working in different practice settings require different responsibilities.

Lastly, the context of ambiguity was foundational to the ask to redeploy.

Is there a Choice?

The choice to be redeployed was variable among the participants. For some participants, a high degree of choice existed, while for others, there was minimal to no choice in the decision to be redeployed. Choice for participants was influenced by several factors that included: a desire to help, perceived competence, level of seniority, and mandate.

Two participants agreed to a request to be redeployed. There was a desire to help and support the pandemic efforts.

Mine was actually volunteer. [My care unit] put out an email saying you could contact Human Resources if you were willing to be redeployed. I said that I was. (Redeployed Nurse 9)

It was apparent that self-determination of the redeployment setting and fit with skillset and competence were important to participants. This allowed them flexibility in selecting a more favorable placement and autonomy to refuse a setting where they did not feel confident.

I was clear that I used to work in [a critical care area] but I was like, “I can’t go back to [critical care]” because it had been too long. I didn’t want to be – so they sort of said you could kind of indicate where you were willing to go. I already kind of, I recused myself, or whatever, from certain situations. (Redeployed Nurse 9)

Reflection on competence, skill, and confidence had bearing on the decision of other participants to redeploy as well. For some participants, choosing to redeploy at the initial ask was the lesser of two evils. These participants had the option to refuse, but they recognized that refusal would lead to a less favorable outcome of a mandate to redeploy later to a less desirable

setting. Though constrained, these participants could reflect on their skillset and where they would be most comfortable and confident to inform their choice.

We were never formally redeployed. We never got the letter of, like, "Surprise, your job doesn't exist and now you're doing something else."... it was very much like, "We know you're there." And yeah, in my past life, I have an ICU background, so I was always like, "Oh shit. Like, they're going to find me." My name's on a list somewhere, so I better go do everything else that I could possibly do, so I don't have to drive to the city and work 12 hour night shifts... The thought was kind of like, "Well... I mean, obviously I'm capable of going back to my acute care roots, but it's been a long time." Primary care was in charge of our testing sites out here, so it was the same leadership team and the same people that I would normally work with. It was just sort of like, "Yeah, I'll come with you and we'll do that." (Redeployed Nurse 5)

Among participants, the expression "voluntold" perpetuated. In addition to describing their redeployment as the lesser of two evils, one participant described their redeployment conversation as being "voluntold." Although a degree of choice regarding redeployment existed, participants believed it was not truly an option to refuse. They could either redeploy now or could expect to do so later. Importantly, this participant expressed a desire to help. Notably however, the undertone that redeployment was inevitable persisted concurrently with the desire to help; therefore, the pressure remained to redeploy.

We or I should say, at least, I was never officially redeployed in the formal sense. It was more of a voluntold type situation and, I don't want to say, a threat, because it didn't feel scary or anything. It was very much, like, "Primary care is basically closing down. Physicians are not seeing patients in person. Your workload is going to be very low. You

might want to help out with some of these things before we find you and make you, you know, go work in the Emergency Room” or something. we were like, “Yikes.” ... wanted to help as well in some ways. Being a nurse for a long time and this crazy pandemic happening, you want to be able to do something. (Redeployed Nurse 5)

For others, being “voluntold” was a sense that they were volunteered by their leaders with no form of choice in the situation. Unlike where choice was an option, the organization determined participant competence and whether they would be redeployed. In these instances, there was no ability to discuss the situation with the leader and no option to refuse reassignment. As a nurse, there was an assumption that participants would adapt to the redeployment setting and skills to support these areas.

Well, we were voluntold, where we had a meeting with our manager, the director... and [they] said, “You’re being redeployed.” ... It was more like you’re going to go. You have the education. It wasn’t one of those things where you can refuse ... you will be going. (Redeployed Nurse 2)

Choice was also impacted by seniority; those with less seniority were often targeted initially for redeployment in the absence of volunteers. Similar to the participants “voluntold” to redeploy, there was no choice for less senior nurses regarding their redeployment.

It was based on seniority, so I had the lowest seniority, and because there was no volunteers I was it and I didn’t have a choice.... and at that time we were it, like public health nurses were it, we didn’t have a choice, we were all – it was all hands on deck. (Redeployed Nurse 8)

Ambivalence

Ambivalence related to the emotions and internal feelings of participants corresponding to ‘the ask’ to redeploy. Ambivalence manifested in numerous ways with ‘the ask’. Ambivalent feelings often correlated with participants wondering how and if they could manage care in a redeployed practice setting that was different than their current practice. Many participants had a desire to help and make a difference, but the chaos of the pandemic added another layer of stress. Conversely, others had no desire to leave their role, and ambivalence related to disparity between where they were going and where they wanted to be. Further, ambivalence was not limited to participants but also perceived in leaders who asked them to redeploy.

A high degree of emotion was inherent with the ask to redeploy, with redeployment conversations often leading to a maelstrom of feelings. Many participants found their home unit leaders supportive during their initial redeployment conversations, expressing they felt they were compassionate. Regardless, ‘the ask’ was still difficult for participants and brought forth a level of distress.

I really like our director, she was very empathetic... very understanding about it. I think she was very compassionate when she kind of told me the news. It was tough, because I was at the end of the workday, right? I was still at work, and I did cry, right? Because it's nothing that people want to be hearing, that they're also redeployed to an area.

(Redeployed Nurse 3)

Ambivalence and mixed feelings were not limited to the participants but extended to the leader who had the redeployment conversation. Participants perceived that ‘the ask’ was also difficult for leaders and placed them in uncomfortable positions broaching redeployment with staff. A participant explained that the leader relaying the redeployment message was a temporary

leader that had only worked on the unit a couple of days before having to redeploy staff. They expressed:

"It was kind of a shitty thing for her too... My boss was an interim boss who felt very bad to have to do that, I did feel that she didn't want to redeploy us, and that she felt that. I did feel some support from her. (Redeployed Nurse 1)

Despite the stress inherent with the pandemic and redeployment, participants often expressed a desire to help aid in pandemic efforts. There was a feeling of being 'called to duty' and a desire to support as a nurse however they were able; there was a sense of pride and fulfillment in making a difference.

I think it was a stressful time... It did feel good to try and do something for our communities... I remember feeling at the time glad to be able to do something, especially not working in acute care anymore... being a nurse in the community or in the outpatient setting is; sometimes you don't feel very "nursey", if that makes sense. Especially with a lot of my past friends and colleagues, really in the thick of things, it felt kind of like I should be doing more... Especially rurally and all the challenges of our population out here, it was good to be able to help. (Redeployed Nurse 5)

Ambivalence was also related to the redeployment setting. Participants often expressed concern over inherent difficulty in shifting from their area of expertise to patient care areas they had not worked in for years or had no prior work experience in, indicating uncertainty in their ability to work effectively in those care areas.

Honestly, I think I was just like, "Oh my God, oh my God, oh my God. What am I going to do?" trying to get information from people to start preparing... because it was so [out] of my wheelhouse. I worked at Adult Emergency [up

north] for 5 years when I first started nursing, but when I went into [my current unit], that became my prime, my full focus, because it's like, this is the area I love. I got so immersed in it that it's like I don't remember that anymore, right. It's having to relearn and be like, "Where are all my notes? What can I Google search?... How can I prepare for this?" (Redeployed Nurse 2)

Although some participants had a desire to help and go to different settings to assist in pandemic efforts, other participants had no desire to leave their positions. Ambivalence for them related to being forced into another department, whereas their passion was related to their current role. Redeployment was sometimes promoted as a great 'opportunity' and valuable practice experience as part of 'the ask.' However, these sentiments were not always shared by the participants, particularly when they had no desire to redeploy from their role.

There were a few people who [chose] to be redeployed because they saw it as an opportunity to try something new, but... I'm firmly established where I am, [I] wasn't looking for a change... I wasn't looking for a new opportunity. I'm still trying to grow where I'm at... I wouldn't have chosen this opportunity... [the critical care unit] ... they're highly promoting themselves, which is awesome, "By the time you're done this, you're going to be taking care of your own patient..." It's like, I don't want to. I want to keep everyone safe. I will help out, but I'm not here for a new job... I don't want to move here... I'm going back [to my original role]. I'm here for my time, but I'm going back... (Redeployed Nurse 2)

Ambiguity in the Ask

Ambiguity was related to external factors and gaps in knowledge associated with 'the ask' to redeploy. Ambiguity in the ask was diverse and widespread for participants. Ambiguity

refers to whether participants would be redeployed, the information regarding their redeployment, forms of communication, and turnaround time.

Even though some participants volunteered for redeployment, there was still ambiguity in whether they would be redeployed. The formal request to redeploy did not always immediately follow the volunteer date. There was sometimes a lag between volunteering and notice of redeployment.

Nothing came of it [volunteering to redeploy]. Many months later, that must have been sometime in 2020... I was contacted, and they said, "Do you still agree to do it?" I said, "Yes." It was made very clear that I could have turned it down. (Redeployed Nurse 9)

The ambiguity of 'the ask' was also linked to information and communication. The level of information provided about redeployment was linked to preparedness and predictability. For some participants, they indicated that information about roles and responsibilities at the redeployment setting were clear. This clarity facilitated managing participant expectations and forming a full picture of what redeployment would be like.

When I met with the CNO or the director of [the redeployment unit] at that time... She went through in quite a bit of detail what I would be doing... no major issues about communication. I just would have liked to [have] known a timeline, if possible... which I don't think they could have actually given me. (Redeployed Nurse 4)

Unfortunately, many participants specified they were provided with minimal information regarding their upcoming redeployment. Information was often vague and limited to when and where they were redeploying, leaving participants to guess what redeployment meant. This ambiguity led to concerns regarding competency to redeploy and provide quality care.

We were just told that we were being redeployed, we worked days or nights, and there wasn't a lot of notice of shifts or anything like that. I knew I was coming, I knew where it was, that I was going, but my communication with redeployment would be exactly what I said. I didn't feel there was enough communication to make sure I was competent and [giving] the best care that I could give. (Redeployed Nurse 1)

Vague information regarding roles and responsibilities in the redeployment setting extended to participants redeployed to alternate facilities as well. Those initiating 'the ask' were not from the redeployment facility, so information was focused on details of pay and location, whereas information regarding the practices and care standards was less.

I received quite a bit of info, which, at that point mostly involved... info about the pay, because [there] was all this extra pay you could get. They kind of outlined that. No one really knew how long – they knew where – who was asking me to come... I got the info about the financial stuff, but then there was not much more they could say because they didn't know... The people from the [personal care home] contacted me, which I knew they were going to. They kind of just set that up that they would then be telling me how it would go from then, that point forward. (Redeployed Nurse 9)

Participants also perceived requests for redeployment as creating a sense of ambiguity for leaders. Some participants highlighted that leaders themselves were likely unaware of details; noting information was not limited intentionally, but rather the leaders had no further clarity to offer. Therefore, gaps in information permeated the health care hierarchy, suggesting systemic ambiguity.

I don't think [my director] even had much information at that time about it... besides the dates, "You'll have some orientation," ... very to the point about it. [She] probably wasn't

very aware, just basically, “Here’s the date you need to start for, your job pretty much no one else is covering,” right, so the job that I was in... that’s put on hold, you need to go be redeployed pretty much, I think it was two days’ notice. then I would have some sort of orientation. (Redeployed Nurse 3)

How participants would be informed of redeployment was also ambiguous. Participants reported notices in the form of emails, phone calls, and in person. The form of communicating ‘the ask’ was often important, with in-person communication preferable as opposed to a telephone conversation or via email.

I was called into my manager’s office at the [program] Institute, which is much better when you’re told in-person, I think, than via email... most of the communication was verbal, and that would be my preference, considering all what was going on. (Redeployed Nurse 4)

Not all participants were told of their redeployment in person. The absence of this face-to-face interaction was notable, suggesting the importance of leaders prioritizing human interaction when delivering difficult news.

It was with our director; it was a phone call... I think it was, [in] a way, I guess the best way. I mean, maybe ideally, whether she came here in person to talk to me about it. Sometimes it’s a little bit nicer [than] on the phone. I don’t know the details when she found out, when she had to let me know, because it was at the end of the day, which at least was nice that it was at the end of the day, so I could kind of have the rest of the evening to decompress. (Redeployed Nurse 3)

Ambiguity also existed about COVID-19. At the onset of the pandemic, knowledge of the virus and transmission was evolving. Participants were faced with concerns about protecting not

only themselves, but their families. As a result, many emotions were tied to redeployment and COVID-19, particularly unease and fear.

I think there was all of the unknown, the fear of bringing it home to my own family and getting my own kids sick... Just being more diligent on taking your clothes off at a certain spot, and then go right to the shower before you have contact with anybody, When I try to think back to how I probably felt at that time, I was probably a little overwhelmed... especially with lack of knowledge, lack of experience, and the unknown. I think I probably was a little bit more anxious at those times. "Did you wash your hands enough? Did I touch this? Did I cross contaminate that?" (Redeployed Nurse 7)

The COVID-19 pandemic led to the implementation of new clinical programs and roles, such as COVID-19 testing sites. Due to the novelty of these programs, there was also ambiguity among participants at the onset of establishing them.

At the start of [redeployment] with the testing sites, we all were very, like, "What the heck is going on?" There was a sense of unity in that... We were all very like, "I don't know, but we're trying our best." (Redeployed Nurse 5)

A high degree of ambiguity existed in turnaround time from the ask to redeploy to the date of redeployment. In reports of turnaround time, a sense of chaos was apparent. Whether through short notice of redeployment, or rapid notices of changes to the redeployment setting/service, it was clear participants felt redeployment was happening at a fast pace. Concurrently with a shift in environment and practice, this rapidity of changes was fueled by the chaos and disorder consistent with the COVID-19 pandemic as it evolved. The amount of notice of impending redeployment varied across participants from a single day to weeks, with one participant stating they had a colleague who received only 12 hours' notice before being

redeployed. Despite varying intervals of notice, the majority of participants stated that turnaround time to being redeployed to a new setting was quick and often came as a shock, especially for those that received less than a week's notice.

It was a bit of a shock. I believe I was called into the office of the manager of [my non-acute care program] saying I was going to Medicine the next day at the hospital... at first I'm like, "OK, well, I'm doing a good thing here. They need help," right? It was just the swiftness of it that bothered me a bit; I would have liked a little more, a couple more days, probably, to set up everything before I left. (Redeployed Nurse 4)

One of the participants also noted a sense of haste from the time they volunteered to the time they were redeployed.

It was very fast; a week after I said, "You know what, I'd be agreeable to go for a short amount of time," to actually being pulled from my unit to being put into orientation in the [critical care unit] at [the hospital]. (Redeployed Nurse 10)

Ambiguity regarding turnaround time and redeployment requirements extended into the redeployment period as well, with some participants required to mobilize to different sites or different services quickly. "It was very much from one week to the next" (Redeployed Nurse 5). This sentiment was shared by other participants.

Well, I think when I [first] started... I feel like I got a week and a half notice, maybe, that they were wanting to set up the test site...that was a very short turnaround. With deployment to Public Health, I felt like it was very fast. When I was looking back to kind of see dates... we got the email that they were looking for extra support, and then we had to, right away, do the training before a certain time, under a week, and then we were ready to go and deploy that following week. It seemed like it was less than 2 weeks

notice... If we had clinics booked in my designated role, we had to cancel and change things because those outreach [redeployment role] were priority. (Redeployed Nurse 7)

Theme 2 – Managing Redeployment

Managing redeployment related to the active phase of redeployment following the ask, from the time participants began preparation for redeployment and through the duration of their redeployment away from their home unit. Three sub-themes were associated with managing redeployment: i) preparation, ii) importance of relationships, and iii) coping. Beyond the act of informing nurses they would be redeployed, leaders also determined the level of preparation participants and other redeployed nurses would have ahead of their start date on the redeployment unit or setting. Participants received information, education, and/or orientation prior to their redeployment. Their perceptions of redeployment preparation ranged from no preparation to good experiences with preparation. Factors impacting perceptions of preparation included participant familiarity with colleagues and skills required in the redeployment setting, mentor selection, preparation time and content/materials, chaos related to the pandemic, reactivity of leaders to the pandemic, as well as leaders' flexibility, bias, and assumptions regarding participant background. The second integral aspect of managing redeployment was the importance of relationships throughout the participants' redeployment, particularly with leaders and nurses/healthcare colleagues. Relationships were foundational to the level of support participants perceived during their redeployment. Key indicators for participant-leader relationships were leader engagement, visibility, and compassion. Third, coping related to the ability of the participant to manage redeployment, particularly their feelings regarding redeployment, the associated expectations, and ability to adopt coping mechanisms to adapt during their redeployment. Ambiguity related to managing redeployment will also be discussed.

Preparation

Perceptions of preparation for redeployment varied among the participants, ranging from adequate to inadequate. The adequacy of preparation to manage transition into the redeployment role was related to familiarity with colleagues, knowledge, and skills. Mentors chosen for orientation were also impactful, with participants noting some were better than others.

Participants frequently expressed preparation was inadequate when leaders and/or education administrators failed to provide education/orientation or were inflexible in what education was delivered. Additionally, leaders were described as biased as they made assumptions based on the acuity of the redeployment setting and participant's educational/practice backgrounds. This perception overgeneralized participants and led to shortcomings in redeployment preparation. Time was a factor impacting preparation adequacy, with more time to prepare frequently correlated with better outcomes. The chaos associated with the pandemic put the healthcare system in a reactive state and led to an urgency to redeploy nurses. As a result, preparation efforts were perceived as rushed and/or disorganized. However, participants reflected that even though preparation was often inadequate, leaders and educators were doing the best they could in the context of a global pandemic. Lastly, they highlighted how chaos impacted all levels of the hierarchy, leading to systemic insufficiency.

Familiarity played a role in participant perceptions of adequacy of preparation. Familiarity came in the form of colleagues in the redeployment setting, as well as familiarity with information and skills. Having familiar colleagues buffered comfort and confidence through trust in colleagues and their program(s).

I did have... 2 [to] 3 online days and 2 shadow days with Public Health, to learn how to contact trace... we were stepping in to help the Public Health Department, who was very

well established, and their offices are just down the hall. We know them personally...

(Redeployed Nurse 5)

Participant background impacted familiarity and had a bearing on perceived adequacy of preparation. Participants who had a background and skillset congruent with the redeployment setting demonstrated more self-confidence and trust in their ability to meet practice requirements in the redeployment setting. A participant even opted to shorten their orientation phase as they were familiar with the knowledge and skills being taught.

They had a 2-week orientation program... I could have done the full 2 weeks... We

[shortened] it ourselves, because we thought it kind of overlapped for information that we already knew... we did a condensed version of it... I was always helping some of the other redeployed people to show them the skills, because that was something that I was a bit more familiar with. (Redeployed Nurse 3)

Conversely, lack of familiarity with skills and practice in the redeployment setting was described as an issue. Participants asserted blanket education plans for redeployment were not adequate to address variations in knowledge and practice across all redeployed nurses.

I could see someone coming from... clinics who had not worked inpatient care in 20+ years. Giving them 2 weeks of ICU skills is not enough for them... For me it was as best as you could, but I think I was kind of the exception to that... (Redeployed Nurse 3)

Further, efforts to foster comfort, with the redeployment setting and tasks, were important to participants. Participants were more comfortable when orientation adequately provided the knowledge, skill, and competency to be successful; they felt better supported and prepared.

The vaccine orientation was good... well supported. The people who worked as the clinical leads made sure that everybody knew how to physically do the vaccines, and we

had all the documentation we needed about side effects and questions... (Redeployed Nurse 5)

The efficacy of mentors impacted the suitability of preparation. A participant described how their initial mentors were not as effective in preparing them to manage practice expectations as mentors encountered later in their redeployment. A lack of strategic planning and failure to assign appropriate mentors led to reduced efficacy and confidence in managing a full patient assignment.

Later, after I got more experience there, I wished I had been with a different nurse who was more of a... better [teacher]... The [unit staff] know [what] works... They [had] a lot of experience, and they could do it, and they were pretty quick. They'd show me the ropes... That part was all fine. But... how are you going to manage keeping track of 26 people was a bit beyond me... Later I was working with a nurse... The way she kind of had organized... or just her sort of way of teaching or explaining or approaching things, was more [effective] – I think they could have picked a better person to buddy me with. But... they just put me through. (Redeployed Nurse 9)

The inflexibility of leaders at the redeployment setting, or organizing orientation, led to failures to address education needs identified by participants as necessary for their competency and safety of practice. Inflexibility in education and preparation precluded participants' autonomy and control to meet their unique needs. There was often a disparity between what the facility deemed necessary to orientation versus requirements expressed by participants. Consequently, leaders were perceived as rigid and unreasonable.

I did ask specifically for more time, a couple hours... to go through central lines again and some wound care, etcetera... and was denied that by the director. I actually ended up

contacting the College of Nurses... The director told me I could do it on the unit during the course of the clinical day... I said, "Well, that's not reasonable." She says, "Well, that's the way it is. We need you." She says... really, we don't have central lines on [the redeployed unit]. [Yet], my second orientation day shift, there was one unit that had three central lines. I don't know if I had been assigned that unit what I would have done...

(Redeployed Nurse 4)

Further, leaders who determined education requirements based on participant background, and assumptions of their knowledge and skills, were described as biased. Bias was ascribed to assumptions made about participants' ease of practice expectations in the redeployment setting, as well as participant capability based on their previous education, practice background, and/or years of experience. One participant stated that they were not given the same opportunities for education and preparation prior to redeployment as others. The rationale for this practice was that their background did not require the full orientation period.

I have the critical care course, that's what they said. Even though I took the critical care course many years ago. I was not given the opportunity to have the full orientation... but other people who were redeployed got the full orientation... I think because I'm an older educator, I didn't get as much support, probably because they're ageist, as other newer educators probably. (Redeployed Nurse 1)

Leader bias in required preparation also resulted in over generalization of nurses' abilities from a specific background, particularly critical care. Leader assumptions about knowledge and competency failed to recognize nursing as dynamic and evolving, or that nuances exist even amongst nurses with the same educational and/or practice background. There was a lack of consideration for time away from a critical care role and variation of acuity across critical care

departments in the regions. Therefore, participants cited inadequacy of preparation when leaders assumed readiness based on clinical background.

There was not enough [preparation]... It was very limited as to what they gave us in terms of information and number of days... especially considering how long it had been since I was actually a staff ICU nurse. Yes, I was picking up as a casual, but maybe that was once every 3 weeks at a smaller site than the site that I was redeployed to. I believe it was 1 or 2 days of orientation, and then it was immediately going into buddy shifts, and then it was immediately into you're a nurse extender now [a redeployed nurse assisting a unit nurse with their patient load]. (Redeployed Nurse 10)

Bias also pertained to where the participant was redeployed; one participant perceived their redeployment setting, long term care, was viewed with a bias of being a low acuity setting and less difficult clinically. As a result, the novelty of the setting and role was not taken into consideration when planning preparation and the participant felt overwhelmed.

I think part of [it] is maybe the bias about personal care, 'Well... it's not that hard...' Regardless, [when] you're going to a different situation, you can feel like you don't know anything... even if they're an experienced person... it's like they're brand new, and you should... treat them as a new grad in terms of what they need... then if they're fine, or they can kind of progress really quickly... it's better to ramp [up] rather than throw someone in the deep end. (Redeployed Nurse 9)

Time also played a pivotal role in participants' perceptions of preparation. In one instance, a participant asserted there was a complete absence of preparation prior to their redeployment, nor any structured orientation once they arrived at the redeployment setting. As a result, they were left to figure out their new role as they went.

Nope, nothing... Not at all effective.... Because there was none... we were just told this is our desk, this is what we're doing, this is what you're doing, and we go from there. "If you have any questions, just ask one of your colleagues who's been there a couple months prior to you." (Redeployed Nurse 8)

At the onset of the pandemic, the healthcare system was in a reactive state of rapidly assembling measures to manage rising COVID-19 cases and redeploying staff to facilitate and support them. According to some participants, the resultant haste in redeployment led to shortcomings in education and preparation.

They were just putting together the COVID testing sites as they were kind of pulling staff to run them... everything was just kind of being put together all at once, so there wasn't a lot of information going into it... I don't think I had any time preparation-wise to the testing site. Definitely, no hands-on training of how to do any of that... it would have been nice to maybe have a bit more support just initially with how to do some of the nasal pharyngeal swabs. (Redeployed Nurse 6)

Conversely, participants asserted that when orientation in redeployment areas were not rushed, it resulted in more robust preparation. There was room to provide support, easing transitions to the redeployment setting.

Contact tracing, there was a lot of support and orientation. They actually paired us with some of the Public Health nurses... there was a lot more support and orientation... it was a sufficient amount of time, I felt comfortable to go forward. [We had] access to ask questions and those types of things when more complicated scenarios came up or when we didn't know what to do with something. (Redeployed Nurse 6)

Despite the numerous inadequacies noted with preparation, many participants were empathetic and understanding of those supporting education, asserting they did the best they could considering the circumstances of the pandemic.

I think they did as best as what they could for, kind of a quick crash course into [critical care] for two weeks... they had a variety of skills... [The Educators] also would do a post conference with us too... they'd come around, checking on us. They would pull us aside at the end of our day and kind of talk about how our orientation was going too, I think that was really nice. I know they were extremely overwhelmed with everything too, but I think I did feel supported by their educators, and you could see how tiring it was for them, too. They were doing the best with what they could, and I think they were very appreciative of us being there. (Redeployed Nurse 3)

All levels of the system, from front line staff to executives, were impacted by uncertainty, resulting in systemic insufficiencies, ultimately leading to perceptions of disorganization by participants.

[Preparation] did not work well; it was very disorganized... I guess you could only do so much with it being a pandemic at the time and us dealing with this for the first time ever, but it did not feel organized. It did not feel complete almost. That's the only way I can describe it, it didn't feel like it was complete. (Redeployed Nurse 10)

Systemic insufficiency was also ascribed to pre-existing factors by one participant; observing that the preparation received for their redeployment was likely not impacted by the pandemic and was more a product of an inadequacy in the system, with their training being status quo for any new nurse at the setting.

I felt on the one hand, they were sort of doing the best they could. On the other hand, the best they could was not great. But... anyone who had been hired there, just as a nurse... would have been dealing with exactly the same thing. It wasn't any different because I was redeployed. (Redeployed Nurse 9)

Thus, adequacy of preparation was impacted by participant background and familiarity with expected practice, leader assumptions of participant competency, adequacy of mentors and orientation programs, and systemic factors. These variables often did not exist in isolation but were interrelated across participant experiences and compounded one another impacting overall satisfaction with preparation for redeployment. Participants that faced greater disparity in terms of linearity of background with the redeployment setting and inadequate preparation expressed greater dissatisfaction and less comfort approaching redeployment. Conversely, participants that were familiar with redeployment expectations and perceived previous practice sufficiently prepared them to manage requirements in the redeployment setting had greater confidence.

Importance of Relationships

Over the course of the interviews, the importance of relationships became apparent. For participants, relationships of particular importance were relationships with leaders, at all levels of the hierarchy and in government, and other nurses/healthcare professionals.

Leaders. Participants frequently commented on their relationships with leaders across all levels of the institutions' hierarchy and even discussed government leaders. Relationships with leaders ranged from excellent to poor across the participants. Key determinants of how positively or negatively participants perceived leaders were engagement, visibility, and compassion. Active engagement by leaders promoted positive working relationships with participants that promoted partnership and meaningful outcomes. Leaders who were disengaged failed to be a tangible

resource for the participants they were meant to support. When participants felt disconnected or forgotten by leaders, it led to confusion, dissatisfaction, and even anger. Visible leaders promoted a sense of unity, whereas lack of visibility led to a sense of disconnect with leaders and dissatisfaction. Compassion was important in demonstrating leaders cared about participants and what they were going through during redeployment. Failure to show compassion conversely led to participants feeling disregarded.

Engagement. Participants described engagement as active efforts of leaders to foster, or maintain relationships, work alongside participants as a united front, and provide tangible support. Conversely, disengagement was observed as leaders distancing themselves from participants and failing to maintain or foster a relationship. Levels of engagement demonstrated by leaders, from both the home unit and redeployment setting, impacted relationships with participants. Leader engagement related to involvement of leaders in the participants' redeployment experience. Some leaders were actively involved integrating the participants into the redeployment setting. Participants believed leaders were engaged when they respected participants' capacity, skills, and worked in partnership with them. Engagement from home unit leaders was also impactful to participants; when leaders continued to engage with participants, the result was positive relationships, whereas failure to maintain a relationship after redeployment led to participants feeling forgotten.

When leaders engaged in understanding the feelings of the participants and/or promoting their satisfaction, it demonstrated they cared about the participants' experience and created supportive environments.

The second manager was excellent. She could tell that I was very unsettled. She approached me multiple times, asked if I had set up appointments with EAP as needed... Very approachable and could tell how I was struggling. (Redeployed Nurse 4)

Engaged leaders demonstrated understanding of the participants' capacity and confidence in their autonomy and practice. Thereby participants perceived their leader(s) trusted their decision making and self-efficacy.

Primary Care management then was like, "Go ahead and help [Public Health]. Do what you've got to do, just don't ignore your own job." That was really good. They were very trusting in that I could do my own job but also [balance redeployment part-time] when asked to help. (Redeployed Nurse 5)

Positive engagement was also demonstrated when leaders were flexible and exhibited willingness to work with the participant to better balance redeployment to fit with participant responsibilities outside of work.

They were trying to mandate me frequently, which is a huge stress... "I can't do nights. This is hard on me. I can't be mandated every day because of a personal situation at home." [The director] ended up approving a Day 12 rotation for me with no nights and no questions asked. (Redeployed Nurse 4)

Meaningful engagement was also perceived when leaders made connections with participants by being candid about their opinions on the current state of the healthcare system. Honesty and openness made leaders more relatable.

There was one manager who was a bit more... real... She was quite clear about her own frustrations with the role... I felt kind of mutual. I felt like that was emotionally... nice to hear. (Redeployed Nurse 9)

A major indicator in positive participant-home unit leader relationships occurred when leaders continued to engage with the participant after their redeployment. Frequency of engagement from home unit leaders ranged from daily to a couple of times over the course of participant redeployment. Regardless of the number of touchpoints, maintaining a relationship with the participant, even though they were displaced from the home unit, was appreciated and led to perceptions that the leader cared about the participant and their wellbeing.

I missed [my home unit leader] very much. She was very supportive, she was texting me... almost daily just to see how things were going. My manager was always reaching out to me by email... asking how it's going, giving me updates as to when they thought I would be coming back. The information [they were] being given regarding my redeployment was very limited... but they were always checking up on me... trying to give me updates as to when they thought I was gonna be able to come back home. (Redeployed Nurse 10)

Conversely, other participants found their home unit leaders failed to maintain a relationship with them as soon as they were redeployed. As a result, participants expressed feeling forgotten by their home unit leaders; since they were no longer physically there, they were no longer their concern.

Not one manager checked up on me after I was redeployed. Nor did the manager of the unit... Not one person checked up on me afterwards, how it was going... We got a new boss who ran the redeployment, [and they] never once sent an email, phone call, or popped in to see how we were doing... And my director did not check in afterwards... nobody did. (Redeployed Nurse 1)

A participant also noted that there was a sense they and other redeployed nurses were “falling through the cracks” once displaced from their home unit. There was no engagement or

relationship fostered with the leader managing the redeployed staff. They were treated more as a commodity and seldomly engaged, simply maneuvered to fit scheduling needs.

[After] being redeployed, you're separated from your unit and from your place of work, and there [the redeployment unit], I did not find there was much support... When I was redeployed, the nurse manager who was taking care of all the nurses who were redeployed was a redeployed nurse manager; a lot of people were falling through the cracks... I worked 4 weeks of straight nights because someone had dropped that I was a redeployed nurse and they needed to adjust my schedule. I was getting my schedule in 2-week blocks... Nobody had caught on that 2-week block was nights, and then the next 2-week block that they sent out was also nights, so not stellar communication whatsoever.
(Redeployed Nurse 10)

Disengagement by leaders sometimes predated redeployment. One participant expressed no surprise that their home unit leader did not try to remain engaged and communicate with them once redeployed. Thus, prior relationships transferred to redeployment.

I did have a different manager then that I didn't get along with quite as well. I basically didn't have much communication with her at all. It didn't really feel like she necessarily would have cared if I had concerns about [redeployment] anyway... (Redeployed Nurse 6)

Visibility. The physical presence of leaders was an important factor in participant-leader relationships, with high visibility associated with better participant satisfaction. When leaders were visible in redeployment settings, they were noticeable and tangible; their presence demonstrated a sense of solidarity.

Our manager, and actually the Director of [the program] in the region was working with us at the testing sites... That was nice to see... [They were] excellent. They were at the test sites with us, with their laptop. They were very easy to get a hold of. They came to meetings that were had... I felt very supported... The head leadership was always great during the whole thing. I felt very supported by them and... if I'd had a non-resolvable issue, I would have felt comfortable going up to them... [that] was always a positive.

(Redeployed Nurse 5)

Though some other leaders were physically visible, this alone was insufficient to promote good leader-participant relationships. Superficial interactions and leaving the onus on the participant to reach out for help were inadequate in terms of support.

There were no mechanisms in place... I'm sure I was told, "The manager has an open door" ... "You could always go and talk to the manager." but... No one connected with me, "How are you?" ... No one specifically checked in with me about how it was going... Nothing formal. It was up to me if I felt like I needed more "something". There was no more "something", so I didn't bother asking for it. (Redeployed Nurse 9)

Further, a lack of visibility and failure to provide access to leader support led to a sense of abandonment, with participants feeling adrift with no apparent avenue for leader support.

The other nurse that was there was the only thing I had... to help me basically. I had nothing else... I didn't feel like at that time there was a lot of managerial support from my [home unit] manager, or even if there was an issue while I was there, I don't even know who I would call. My manager wouldn't necessarily answer. I had no idea who the manager even would be for that [redeployment] site. (Redeployed Nurse 6)

The lack of visible executive leaders was often described by participants. Many asserted they heard nothing from or ever saw executive leaders, with the highest point of contact and acknowledgement typically their home unit director. Further, some participants expressed disdain over executive leadership who were quoted in media saying, "we got this" and expressing organizational success in managing the pandemic through redeployment, particularly when executive leaders were not visible on the wards with redeployed staff and failed to personally communicate with or acknowledge redeployed nurses. As a result, participants believed executive leaders were out of touch with reality and did not understand the plight of the redeployed nurse.

When you are quoted in the paper saying, "We got this, because we're training everyone to look after people," ... A few of the executives were quoted like that in the paper. When you don't talk to your bedside staff... It just seemed like they didn't understand... It would have been nice if [executive leaders] would have walked around once in a while and just even said, "Thank you for coming." Just to be visible would actually be a very helpful thing. But I mean... the manager of the units didn't do it either... it was a failure in leadership... I know everyone was tired and burnt out, but not good. (Redeployed Nurse 1)

Compassion. Participants perceived compassion as the presence or absence of partnerships with home or redeployment leaders to improve the redeployment experience. Compassion was also observed when leaders demonstrated empathy for participants' redeployment experience and advocated for their benefit. The level of compassion participants experienced from leaders varied, from high to absent. The more compassionate leaders were, the more positively they were perceived. It was particularly meaningful to participants when leaders

demonstrated compassion through being actionable on their concerns and provided tangible outcomes. This improved participant satisfaction and comfort.

[Our program leaders] would have... check-ins with us to how we were doing, any complaints that we had. One of [the complaints was] we didn't have access to a locker when we were redeployed... "Where can we put our stuff?" ... They actually brought in extra lockers into another area for us to use... You felt that you had their support... especially when they got us the lockers that we wanted... "OK, they have our back. They're trying." (Redeployed Nurse 2)

Compassion was also demonstrated through leader advocacy. When participants felt like they had a voice and were backed by their leaders, it was perceived as support. Listening and following through on participants' concerns exhibited respect for the participants' knowledge and a desire to improve wellbeing.

I think they worked with us. When we started to question, "[Why] are we having to go to the different communities to offer these test sites when they're [in] a [COVID-19] outbreak, and they have their own nursing staff..." They were supportive helping us get [across] the understanding that the [other community] also [needed] to train their own staff, because then we're just exposing others... I feel like they advocated for us and supported us at the time to the best that they could. (Redeployed Nurse 7)

Advocacy for participants also played a role in ending redeployment for some participants, with one participant declaring their return to their usual role was likely a result of support from their home unit leader.

I kept reaching out to my manager towards the end, when I felt like things were kind of slowing down with Public Health, she was a big advocate to get me off deployment so I

could go back to my full-time job... she was able to raise it up and discuss at the other meetings and [say]... basically, I couldn't do it anymore. they deployed me back to my regular position... I think if she didn't voice it, I probably would have been deployed longer. (Redeployed Nurse 7)

Poor quality relationships with home unit and/or redeployment leaders were exacerbated when leaders demonstrated complete lack of compassion for participants. A dispassionate email was sent to one participant when they finally heard from their program leader while redeployed. That led to a perception of isolation and lack of empathy for their plight as a redeployed nurse.

There was no contact with [my home program leader] throughout the majority of the redeployment until [my program] reopened... I actually saved the email because I just found it so cold... The gist of [their email] was, "just wanted to let you know that even though the [programs] Institute is reopening, you are not returning to us because the needs of the hospital are superior, or you're more needed at the hospital than [at] the [program]." It's sort of like, "Sorry, have a nice life." ... It could have been worded nicer. Like, "Sorry, we miss you, right? I'm sorry, you know, you're still there," but no, just again businesslike. I couldn't feel like I could go and approach her and say, "Oh man, I don't like this." I don't think I even answered her. (Redeployed Nurse 4)

Additionally, lack of compassion when seeking support from leaders was expressed by participants, further damaging leader-participant relationships. Participants asserted, in response to concerns, leaders were often perfunctory or displayed a "suck it up" attitude, instead of empathy and compassion. One participant also pointed out that leaders appeared to care more about optics and image than the comfort of their staff.

If we had issues about the workload or the safety at the testing site... it was just like, "Well, suck it up." I remember that summer, it was so hot, and the public complained... "Oh, it's unprofessional to see nurses wearing shorts." And it's like, "Well, we're outside" or inside... without air conditioning, working 10-hour shifts. But management's like, "Well, we have to look good for the public, you have to look professional." That got kind of annoying. (Redeployed Nurse 5)

Other participants felt leaders lacked compassion by failing to understand their situation as a redeployed nurse. The expectations of leaders were discordant with the participants' comfort level and the novelty the redeployment position represented for them.

[That] manager I found kind of pushing me. One day during that 4- or 5-day period of orientation where they were short a nurse she said to me, "Oh, you can take part of the assignment then." I'm like, "No, no, I'm still learning on orientation... I'm not comfortable." I could tell she was quite annoyed that I wouldn't do that. (Redeployed Nurse 4)

Executive leaders and the government were also perceived as not compassionate by participants. Working conditions of participants redeployed were often detrimental to their wellbeing and mental health. Despite these factors, there was no apparent concern perceived on the part of executive leaders or the government.

We didn't get enough support from senior leadership and the government. We were working 12 to 16 hours a day, mostly almost seven days a week. There was no regard for nursing mental health, staff mental health, whether we're getting breaks or not... I think my perception is that [management] might've been torn too, right. Like they're doing the best they can as well to support us, but again, it's really not coming from them. Cause a

lot of our meeting is, 'The province wants this. The province wants that.' (Redeployed Nurse 8)

Nurses and Healthcare Professionals. One of the most prevalent and important relationships for participants were with staff nurses, redeployed nurses, and other healthcare colleagues on the redeployment unit. They expressed these relationships were their primary source of support, particularly nurses. Support came from unit nurses, nurse educators, as well as fellow redeployed nurses. Positive perceptions of support and relationships were attributed to collaboration, teamwork, and positivity.

The nurses and the healthcare aides were wonderful. At one point... I was kind of running around between bedsides, and a nurse came by and asked, "What can I do for you?" And then another nurse came, and instead of taking breaks – unfortunately we are not always gonna be able to take breaks – they elected to stay on the unit to give [me] a hand. And the healthcare aides were wonderful as well, just asking, "What do you need?" ... There was a lot of support when things went haywire... I really appreciated... the camaraderie between the nurses in the ICU and the redeployed nurses... Majority [were] super supportive and super understanding... (Redeployed Nurse 10)

A sense of unity for participants was achieved by forming networks of support within their redeployment environment, creating camaraderie, and finding comfort from others in the same position.

I also had other colleagues who I was redeployed with too. I think it was just nice knowing you're not alone and checking in with them, them checking in with you as well, too. I think it was nice to feel supported; I think the other extenders who were there too. I think we all kind of supported each other as well. (Redeployed Nurse 3)

Participants were appreciative and felt valued when unit staff expressed gratitude for the support of the participants and their assistance with the increased burden and acuity associated with the pandemic. This led to positive work relationships and a better redeployment experience.

I think that it seemed that she was just happy to have help. Was grateful that I was there. Was very receptive to just help me, and didn't seem annoyed or bothered that I was coming to her with so many questions, even when she had her own work to do... It was a decent experience. I still felt in over my head. I wouldn't necessarily have wanted to go back, but it wasn't because of the staff, that's for sure. (Redeployed Nurse 6)

Other members of the healthcare team also provided supportive relationships to participants. Participants often cited high levels of engagement from the physicians on the unit, promoting positive rapport and inclusion into the healthcare team.

The medical team was lovely. They always... because you're with their staff, they would start talking to you... they were lovely to chat with. (Redeployed Nurse 2)

Some participants expressed support from their nurse colleagues was all they had in the redeployment setting, and relationships were formed through shared experience and circumstance:

A lot of us did not agree with [redeployment], but we just did what we were told. We did the best we could at that time. We supported each other 'cause that's all we had. And one by one we lost people... I developed really good relationships with my colleagues, because we were all on the same boat we were each other's support and that we all understood. (Redeployed Nurse 8)

Though predominantly positive, there was variance in relationships with nurse colleagues and perceived support. One participant explained that colleague support depended on who you

were working with. They also indicated that inadequacy of support was a global issue impacting all staff.

Kind of dependent on the personality of the nurses and the healthcare aides. I was a new person they didn't know. Some of them were quite nice... Some of them I felt like I could ask questions of... I would say the feeling of support was not... totally adequate – but I don't know if anyone really felt supported. It was the same as what everyone else was getting. (Redeployed Nurse 9)

Regrettably, negative nurse relationships and interactions also existed. Some participants felt unwelcome in the redeployment setting and experienced negativity from unit staff. This was distressful and led to perceptions of ungratefulness and rudeness.

I had one nurse that I worked with, and I'm like, "Hi, I'm [Name]. I'm going to be your extender today." She didn't tell me her name... It wasn't until halfway through a 12-hour shift that someone else had said her name that I learned what her name was. She barely spoke to me, I'd be like, "OK, I'm going to engage this person." like, "OK, does this need to be done now or should we do this or?" It was just either "Yes, no," or she'd be talking to someone else. I was just like, "Why the hell am I here?" ... "I'm here to help you... and you can't even acknowledge me." (Redeployed Nurse 2)

Coping

Inherent to redeployment was the need to cope with this change among participants. The ability to effectively cope with redeployment was often related to reasonability of the expectations required of the participant and their level of comfort with them. Perceptions of expectations ranged from reasonable to unreasonable. Participants found it easier to cope when their nursing background facilitated redeployment roles and responsibilities and/or when the

participants were in control of whether additional or more difficult responsibilities were undertaken. When participants perceived expectations were unrealistic, they had more difficulty coping. Contributing factors were insufficient education prior to redeployment, failure to consider participant background, and/or inaccurate assumptions based on participant background. In these instances, participants had difficulty coping with redeployment; they needed to adopt coping strategies to manage unrealistic expectations.

Participant background played a role in coping with redeployment. A background congruous with the redeployment setting facilitated comfort with tasks and expectations, since participants were able to utilize their expertise in their redeployment role.

The case investigation and contact tracing... I think my past nursing experience kind of helped with that too, because I was comfortable already calling people to discuss different things... (Redeployed Nurse 7)

Participants were also better able to cope with redeployment by exercising autonomy. When participants recognized practice and skills familiar to them, they opted to take on additional responsibility to further aid in managing patient care. Having self-determination in identifying responsibilities within their scope of practice facilitated being helpful to the redeployment setting while also promoting confidence.

The role was, for extenders, "Don't do anything with a ventilator. Don't write any numbers down." However, I know ventilators; it's a little bit different for how we do it in [my unit versus theirs]... I kind of feel like I modified a little bit saying, "I'm comfortable doing this, I can help a bit more." I think I was someone helping a bit more than [some of] the other [extenders]. (Redeployed Nurse 3)

Conversely, impressing on participants that they would welcome additional responsibilities in the redeployment setting was seldom appreciated and added anxiety. During orientation, some participants were told that following preparation and time on the redeployed unit, they would “want” to take on patient loads. This statement was perceived as presumptuous; that they could cope with this added responsibility.

They had said, like, “By the time you’re done [orientation]... you’re going to want to take a patient assignment.” And it’s just kind of like you’re not being realistic. (Redeployed Nurse 2)

Further, expectations for participants and other redeployed nurses were not always concrete and varied across or within redeployment settings; reasons for this variation were often unclear. For instance, certain nurses were allowed or expected to do a task that other redeployed nurses were not, without obvious rationale as to why these expectations differed, and contributed to further confusion regarding redeployment and expectations.

I can look after a ventilated patient, some of my colleagues weren’t allowed to, and I was allowed to do suction... I don’t know why we were treated differently... but we were. (Redeployed Nurse 1)

Also, while there were clear guidelines related to extender duties in certain facilities, these expectations were not uniformly understood by the unit staff, and varying expectations were dependent on the buddy nurse.

I think even just noticing that in practice, you’ll have different nurses have different expectations. I know there are some nurses who would sit at the desk while I did all the work... which is not what I was there for... Different nurses would have different expectations of the extenders as well. (Redeployed Nurse 3)

Participants asserted that leaders had the expectation that any nurse should be able to cope with the expectations set forth by the facility. Participants perceived there was a belief they came with “universal” nursing knowledge and practice that all nurses should have. This led to expectations that participants redeployed would be independent and able to do practices that were in fact unfamiliar to them. Some of the participants cited the title of the study, “a nurse, is a nurse, is a nurse,” or expressed the feeling of being an interchangeable pawn during the pandemic.

I like your [title of the research project], “A nurse as a nurse is a nurse,” because I think that’s how a lot of us felt. “Oh, it’s a nurse. Let’s look at this nurse, let’s plop them into this position, right?” I don’t think you recognize the challenges with that; I think this disruption is of people’s lives. I think that part was a challenge, it really does make you feel not recognized as being in your role... kind of feels like your role is not important. That, “OK, we can just take you from your role, here you go.” (Redeployed Nurse 3)

Leaders of redeployment settings also failed to fully integrate participants into the team, resulting in a silo between unit staff and the participants and other redeployed staff. One participant described how this lack of integration impacted knowledge transfer and accountability to patient care. Further, these silos led to participants, and fellow redeployed nurses being treated like “bodies” on the redeployed unit versus part of the team.

Not everybody was encouraged, even for transfer of information, I always went to my bedside where I was, and I got the information along with the person I was buddied with. I was told that was unusual, most of the redeployed nurses, I think, because they felt like they were bodies, stood at the desk and weren’t even included in report. That was weird to

me, that's not accountability on our part, but it wasn't expected, because "we weren't there." (Redeployed Nurse 1)

The ability to cope with redeployment for some participants was also strained due to competing demands. Some participants were splitting time between their usual role and redeployed areas, which led to having to balance the two distinct roles and responsibilities.

It could be tricky sometimes. Luckily, my Primary Care role is mostly [outpatient] education, so not a lot of emergency things happen. But there would be times I'd have a voicemail from a patient, and I didn't get back to them for three days because I was doing other stuff, and they'd be a little bit cranky about it. But for the most part, people understood. There was always a little bit of wearing two hats at once and thinking about multiple things at once. But it was overall, OK... (Redeployed Nurse 5)

Difficulty coping was also related to parallels with previous roles. One participant detailed how the redeployment experience mirrored one of their earlier career roles and reawakened feeling a lack of completion in their work due to time constraints. Thus, redeployment put them back in a situation they had chosen to leave.

I was not comfortable. I used to work Medicine in the hospital, and one of the reasons I left it for [my current care area] was that to do the job right I was never given enough time. Or we didn't have time to do the job right, and so I didn't feel like I was doing a full and complete job, or being a good nurse... And I definitely felt like that same way here [at the redeployment setting]. (Redeployed Nurse 9)

Inaccurate leader assumptions about participant capacity further contributed to difficulty coping with redeployment. Participants highlighted many preconceived notions existed about the scope of practice and knowledge they and other redeployed nurses had as a baseline, sometimes

due to a participants' age or number of years in practice, not taking into account individual backgrounds and time away from previous practice.

It was more so being told, "You've been a nurse X amount of years, you know what you're doing, this is what I need you to do." There was a level of support if you had questions, but there was a lot of expectation that you could function as your own unit there. Even though you didn't know where all the supplies were, where you didn't know all the names of the doctors or the rest of the staff. Like there was still a level of independence that was expected of you, especially if you'd had more than, I guess, 5 years of nursing, or more than a year of nursing under your belt. (Redeployed Nurse 10)

Additionally, many participants, though experts in their own fields, were shocked when they went to the redeployment setting. Although they were experienced nurses, their expertise did not always transfer to the redeployment setting. They expressed feeling as though they were going from being an expert to a novice, yet they were still treated as an expert when they felt they should have been supported and/or educated as though they were a novice nurse.

You think you know everything, but you don't. The ventilators we use in our unit are different than the ventilators they use in theirs. In the [redeployment settings] world, you have to give 100% oxygen before you suction the patient. In my world, you're never allowed to do that. Remember – I'm an expert at what I do. I'm going into a place where now I'm a novice, but they want to treat me like I should know everything, but it's the opposite of everything that I know what to do and how to do it... You're second-guessing everything that you're doing, because what comes naturally for me... they're like, "No, no you can't do it that way, that's wrong." But it's not wrong. It's right in my world, wrong in yours. (Redeployed Nurse 2)

Participants who had taken a critical care course were also generalized, and differences in patient population were not considered, despite key differences in treatment of their patient population versus that on the redeployment unit.

I've been working with the medications that we use in our area. I don't know the [other units] medications... What they think as their... "common medications..." They're not common to me... I don't give these medications... Can I please have the list of all the common medications so I could be going back to nursing school and reviewing my medications, what are they for? How often do you give them? What's the reaction you should expect when you give that medication? It's kind of that part that you're doing on your own to be prepared to work. (Redeployed Nurse 2)

Participants came into redeployment with nursing knowledge but also understood what knowledge they were lacking due to time and distance from certain practices/care areas. To facilitate coping with redeployment, participants often identified their learning needs to those delivering the education. These participants were sometimes met with statements that this was “basic” knowledge they should know, regardless of background and time away from certain clinical settings and skills. Participants were often frustrated by this generalization and lack of understanding for their unique learning needs.

Where I need the help, is how to use your GT tubes, how to mix up adult meds and the volume of fluid you use... I was not offered that; I was told that's very basic orientation. I said, "Yes, it is. If I was a brand-new grad, I would know this." I wasn't offered anything specific to meet the needs that I had; not taking into account the last time certain nurses had done "basic nursing" was decades ago. (Redeployed Nurse 1)

Further, practices in scope on participant units were not always congruent with scope of practice on the redeployed unit. These differences in common practice led to confusion, greater difficulty assimilating to the redeployment setting, and concern over missing something.

[My unit], we can adjust oxygen on the ventilator, [the redeployment unit], you can't. It's taking a nurse out of their environment they know [and] putting them in a different environment. "Well, what if I don't know this?" I think it's a lot of, "This is what I do, this is what we do in practice." But how different is this in [their] world? "Am I missing something? Is my nurse too busy to realize something's being missed?" I think there's a challenge with that. (Redeployed Nurse 3)

Some participants asserted that during redeployment you either “*sink or swim.*” They expressed minimal support was available to support them to effectively cope and integrate into the unit. It was the responsibility of the participants to be successful.

I hate to say, it was kind of like a sink or swim... It wasn't something that I think they could spend too much time supporting us... they were just basically bringing in, extenders that they just didn't have much time. They kind of did at the beginning when you're in orientation over the couple weeks, but besides that, it was kind of like, "You're on your own, here you go." (Redeployed Nurse 3)

Despite feeling more consideration should be given to differences in practice and gaps in knowledge, it was understood that desperation and chaos associated with the pandemic played a role in elevated expectations of redeployed nurses.

I understood it almost... especially as somebody who is ICU background for the most part, you probably have some surgical or medical background before going into ICU. I understood some of that, but I also would've wished that there would've been some

consideration that the unit is new to you, and that you don't know the staff, and it's all unfamiliar. I also understand though that, trying times, and sometimes you just don't have a choice, and you have to let people fly on their own because otherwise we're all gonna drown. (Redeployed Nurse 10)

Some participants openly expressed discord between expectations and their scope of practice. To cope with unreasonable redeployment expectations, self-advocacy was employed by some participants to stay in scope of their practice when faced with unreasonable expectations.

They wanted me to analyze cardiac rhythms, and I said, "No, I'm never going to be looking after the patient myself, so actually, that's not where I need the help, my buddy nurse will do that..." it was unreasonable to think that I would be able to read arrhythmias after a one hour course, when I absolutely know the course, of how many hours it is... I just said I wasn't going to... [And] when you're in your 50s and you say no to new educators that are in their 20s... they were shocked, but they were like, "Oh, OK." (Redeployed Nurse 1)

Positive coping was also accomplished through making the most of redeployment by furthering nursing skills and building relationships. For some participants, while redeployment may have begun as a negative ordeal, they were able to reframe the situation.

I ended up having a good time, because I like to learn, and nurses are great people to spend time with. I got over being mad and frustrated, and actually it was a very pleasant experience overall, because I like to learn. (Redeployed Nurse 1)

Time was a more subtle mechanism of coping; participants asserted that time and experience in the redeployment setting improved their confidence.

By the end of it, I was pretty comfortable. The initial testing site was very, “I hope we’re not screwing this up, I hope it’s OK.” ... After a couple days of like, “Oh my God,” it was kind of like, “All right, I can handle this. It’s not terrible.” (Redeployed Nurse 5)

Similarly, although one participant felt capable of managing their redeployment role, they did not like it.

It’s hard work working on Medicine. I was worried physically; I wasn’t sure [I was] going to be able to do it, but at the end of the day, I was able to manage. It was a lot of unknowns that quickly became known, and I was able to function better than I thought I would. I just didn’t like it. (Redeployed Nurse 4)

Ambiguity Managing Redeployment:

Participants experienced a high degree of ambiguity related to the management of redeployment. Ambiguity related to four key questions: What is happening? Who is in Charge? Why am I Here? When Will This End?

What is Happening? Much uncertainty existed regarding what was happening and the management of redeployment, particularly due to the novelty of COVID-19 and chaos of the pandemic. Many questions existed regarding the virus initially because of limited information and there was uncertainty of the impact it would have on the healthcare system.

I think [redeployment] was very fast with limited information... I think it was kind of like a call for [all] hands-on-deck, and then we kind of just learned as we went. (Redeployed Nurse 7)

As the pandemic progressed, what was known about COVID-19 and best practices constantly evolved and changed, often making it difficult for participants to keep up with the most current information.

For the information, I feel like it changed... The testing sites [changed] from how they were initially set up... Same with the case and contact tracing, it also changed almost week to week, sometimes-even days... It kind of felt like you were constantly learning but also having to be on guard to make sure that you were doing the right thing at the right time... and especially when I was doing it only part-time... trying to do that in-between your regular work... by the time I would kind of get to it, maybe it could have changed within those two days... I felt like I had to be... a quick learner. (Redeployed Nurse 7)

Despite constant change and confusion regarding the pandemic, many participants believed there was transparency in communications provided and that leaders were open to questions and answering where they could.

I feel like I got the information when it was available to management. I don't think they were hiding anything, or trying to minimize things... It was just like, "Well, we're kicked out of the gym, so next week, you're going to this trailer..." Or whatever the case was. (Redeployed Nurse 5)

However, others stated that not all information regarding what was known was related to the front lines or was slow to arrive.

I did not have any issues per se, I think they handled it... as well as you could have in a global pandemic. There wasn't much communication 'cause I know there were a lot of meetings between higher ups that didn't really trickle down to the ward staff until later on when policies were created or when updates were sent out. (Redeployed Nurse 10)

Who is in Charge? It was often unclear which leader was in charge. Pandemic redeployment also directly impacted leaders, with many redeployed in the organization to aid in

pandemic efforts as well. This shuffling of leaders added confusion and challenges for both the leader and participants.

I think it was also challenging because the director who was in the role was covering for two different other people who... had been redeployed... They were in that same position, I was now in the same position... [It] was just challenging because that actually wasn't my director; it was somebody acting as the director... (Redeployed Nurse 3)

High turnover of leader positions also led to a revolving door. The constant changeover of leaders in some instances led to stress and added another layer of confusion for some participants.

We had lots of management changes. I've been in my role since 2018, and my seventh manager just started this week... there's always lots and lots of change... During that window of the testing sites, there was a lot of change. There was a lot of, "Well, who am I answering [to?]" I don't even really remember the cascade of who was here when, but there's always stress with leader change, especially when your job is different from week to week, as well as in terms of what you expect of me... they were... sometimes good, sometimes not so good. (Redeployed Nurse 5)

Why am I Here? Several participants often stated feeling, 'why am I here' at some point during redeployment. Participants frequently did not understand the reasoning behind who leaders chose to redeploy, and redeployment decisions were referred to as disorganized. One participant expressed difficulty understanding the structure of how colleagues were redeployed:

I know we had a couple other educators that I work with, they kind of rotated turns [being redeployed]. I think it was just a bit confusing for how the [leaders] chose, for who's doing what and for how long, I think that was just not clear... Felt a bit left out of

all the communications for what was happening and just being told kind of last minute what you're doing. (Redeployed Nurse 3)

Another participant highlighted that mechanisms of redeployment often did not optimize utilization of redeployed nurses. There was a lack of clarity of why leaders did not structure redeployment to better suit growth and comfort with practice expectations in the redeployment setting.

One of the things that I didn't like was that I was rotated through units... they were using me as a float, which makes sense from their point of view. But from my point of view, it made it really, really hard, because I couldn't get to know my patients... It would have been much better if they had just stuck me on the lowest acuity spot and in the same spot... I would have gotten much better at what I was doing. (Redeployed Nurse 9)

There came a time during redeployment where some participants believed they were no longer needed, and their continued redeployment was detrimental to their home unit. Despite talking with leaders, and trying to work out solutions to be flexible and lend their support where it was needed, leaders were rigid and did not collaborate with each other to optimize human resources. As a result, participants began wondering 'why am I still here?'

I'd be like, "You don't need me." My own home unit put out an SOS asking for staff, and I was like, "Could I go back to my staff ward? if you get overwhelmed, you could pull me back?" The answer was no... [That] night staff went "1-2, 1-2," ... That means every hour, either me or another nurse was on break. Six hours of [the shift], you're on break, and you're redeployed, it doesn't make you feel like you're needed... When I told the supervisor that, "Why am I here when my home unit is so short and yet I know I'm not needed here." I was told that would have been my responsibility to contact the supervisor

and do all this extra work to go back to my unit. It seemed like nobody was coordinating, [making the] best use of resources. (Redeployed Nurse 1)

Further, participants asserted they found leaders disregarded inquiries about their continued redeployment. Consequently, participants felt ignored and without options to return to their role.

There was no communication as to, “Why am I still here? How many more weeks are you trying to keep me here?” ... I’d be damned if I could get anyone on the phone to talk to me... Even if I left voicemails nobody would call back. It got to the point where I would have to cc my manager or my charge nurse in the email to ensure that someone would respond to me because I’d cc’d somebody higher up than me. It was almost always, “We don’t have that answer right now, but when we get it, we will come back to you.” [They] almost never got back to [me]. (Redeployed Nurse 10)

When Will This End? It was one of the biggest sources of ambiguity for participants. Participants in the study frequently expressed a high degree of uncertainty regarding the length of redeployment or when their redeployment would end. The participants seldom knew specific timelines, and even those that did, did not trust the legitimacy of an end date.

I always had a date... that I was going back. But lots of people I was working with kept telling me they had dates and were extended... I did have a date, it just didn’t seem like that would be a real date. Because I worked side-by-side with other people saying, “Oh, I was supposed to be back in my unit a month ago...” My date came, and I did come back when I was supposed to, but... we would wonder... (Redeployed Nurse 1)

Some also entered redeployment knowing there was a high degree of ambiguity related to unknowns surrounding the pandemic.

It was just sort of like, 'Do this until they don't need you anymore...' There wasn't an abrupt end to anything... I was vaccinating three days a week, and then a month or 2 later, it was twice a week, and then by that fall of 2021 it looks like I maybe worked the seasonal vaccine sites and then stopped vaccinating at that point... But there was no formal end to being [redeployed], it just sort of petered off. And that must have been around when... the clinics opened back up normally again, and we were expected to be back in clinic and back to doing our normal roles. (Redeployed Nurse 5)

One participant discussed that there was no true way to know when redeployment would end, due to the uncertainty of when the pandemic would end. They indicated that, although leaders could not provide concrete answers, it was likely an outcome of leaders not having answers themselves.

I think it was maybe just that nobody really knew much... I think, as people realized, "This isn't going away anytime soon, like we're in it for the long haul," things changed pretty quickly... And I guess, how would anybody know, right? At the time, I'm sure I was frustrated of, like, "How long is this going on for?" But nobody knew. There was no way to know... (Redeployed Nurse 5)

Theme 3 - Consequences of Redeployment

Many consequences were associated with redeployment, and ranged from impacting the participant directly, to impacting fellow redeployed nurses or colleagues, as well as impacting patients and families. Participants indicated that the quality of patient care was an issue. Personal consequences included participant satisfaction, as well as physical and mental wellbeing. Participants identified consequences to the healthcare system pertaining to participant and nurse retention, such as early retirement and turnover. Participants felt devalued, particularly related to

their professional role, impact on their personal life, and lack of respect demonstrated by leaders. Further, there was ambiguity whether redeployment was safe and whether leaders cared about the consequences and safety implications of redeployment for the participants and patients. The following three themes of consequences of redeployment will be discussed: i) impact on wellbeing, ii) retention, and iii) feeling devalued. Ending this theme will be discussion on the ambiguity of consequences to patient outcomes and do leaders care?

Impact on Wellbeing

A concerning theme that emerged from many of the participants was a negative impact on their physical and emotional wellbeing. Participants reported feeling overwhelmed prior to, during, and after redeployment. Related to being overwhelmed by redeployment and the pandemic, participants reported burnout, at a personal level and amongst colleagues. Lastly, participants experienced moral distress related to barriers to patient care and aftershocks of the pandemic.

Overwhelmed. Participants felt overwhelmed due to loss of control, excessive expectations/care burdens, and fear. Participants had no control over redeployment; this lack of autonomy contributed to participants being overwhelmed in the new practice environment.

You're out of your zone; you're out of the area you want to work in, where you desire to be. And you feel like a piece of furniture being moved around at will, yet at the same time understanding you're part of a bigger picture, that the system is struggling and they do need help right now. But yeah, loss of control is basically how I felt, right. (Redeployed Nurse 4)

Participants commonly expressed feeling overwhelmed at the onset of redeployment during the education/orientation phase. The volume of knowledge and breadth of practice

requirements exceeded participant capacity and left them drowning in the expectations.

Importantly, participants perceived educators providing orientation were also overwhelmed and alluded to this impacting the overall quality of orientation.

[You] got as good an orientation, I think you could give in that time... But you can't remember it all, it's overwhelming... And they were overwhelmed, I think I got as good a tour as [what] the educators there could have done. (Redeployed Nurse 1)

The chaos and severity of the pandemic resulted in increased patient volumes and higher acuity patients. Participants felt overwhelming anxiety and fear over what they would encounter at the redeployment setting on any given day.

You'd go in for the shift and it was nerve wracking because you didn't know what you were going to experience, you didn't know what kind of surge there'd be from emergency or from the wards having patients admitted with COVID, who was gonna get sick, and if we had beds, and if we had the nurses to staff the beds. (Redeployed Nurse 10)

Although many programs were put on hold to prioritize the elevated acute care needs at the height of the pandemic, the patient care needs of the less acute care programs did not cease during the pandemic. As a result, some participants were also overwhelmed when they returned to their normal practice responsibilities. Many had to face patient backlogs that resulted from program closures during the pandemic.

We do [outpatient] testing and screening. Those things weren't happening [at the peak of the pandemic] because we weren't allowed to do inpatient work during that time. When we started that up again, we had two years worth of referrals that had been sitting in a binder somewhere to go through... It was like, "Oh, you guys are doing [this outpatient]

testing again. Here's 200 referrals that we've collected for you over the last two years. Get on it." (Redeployed Nurse 5)

Burnout. The overwhelming experience of redeployment frequently led to participants reporting poor wellbeing and mental health to the point participants expressed feeling burnout. Half of the participants in the study expressed burnout as a result of redeployment. Burnout was described by participants as severe mental health deficits, hopelessness, and negative work cultures. Personal accounts of burnout in participants described negative mental health outcomes and stress.

I volunteered to be redeployed for four weeks, and they kept extending it and extending it. It got to the point where I was burned right out... It took my doctor writing a very strongly worded note and having to apply for a – I believe it was an exemption against my redeployment, saying it was severely adverse to my mental health. [My doctor] actually put me on antidepressants during my redeployment because it was so significantly bad. (Redeployed Nurse 10)

Participants also perceived burnout impacted all nurses where they were redeployed, regardless of redeployment status. The burden of the pandemic led to unsustainable workloads and exhaustion in healthcare workers.

Everybody was burned out and tired, and I know some people were doing six shifts in a row. [Some unit staff] before you started... you could just tell they were burned out. And they were tired, and you just did exactly what they wanted, because it just was easier. Nursing wasn't unpleasant, but we weren't at our best (Redeployed Nurse 1)

There was a sense of hopelessness associated with burnout; participants felt isolated and were doing what they could to survive.

It was just that state you recognize; there's no one there to support you... It's who you're [buddied] with for your nurse. It's really horrible to fill that position; everyone feels like this; everyone's burned out. You [are] kind of just survival mode during it. (Redeployed Nurse 3)

An unsettling point was raised by a participant regarding how redeploying high volumes of young/new nurses was leading to them becoming burned out. They struggled to handle the workload, high patient acuity, and mortality rates associated with the redeployment setting. Leaders also redeployed more experienced nurses, but as described by this participant, seniority was a key indicator in decision making.

They were burning out the young girls who had never seen horrific things [severely ill and dying patients], that's why they wanted a more mature group to be redeployed. [Redeployment goes] by seniority, my co-worker and I chose to split it, the redeployment. But if I really wanted to be a "bitch" I didn't have to get redeployed, because that's not how it works. (Redeployed Nurse 1)

Nurse burnout also gave rise to anger and a culture of negativity. Some of the nurses were so distressed that they left their position and potentially the profession.

I did [see] some pretty harsh situations happen, particularly on night shifts with nurses who were burned out. I watched one nurse extender end up just leaving the unit, and never came back, in the middle of the night. She didn't have a patient load, and she told the charge nurse, "I'm done." She'd been screamed at, ripped a new one by one of the nurses on the unit, and she never came back. I'm pretty sure she was freshly, freshly graduated. I saw the best and I saw the worst in people in this redeployment both from a unit standpoint and from the public standpoint. (Redeployed Nurse 10)

Impacts of the negative cultures created by burnout also impacted behaviors towards patients and their families.

I saw the staff so angry and burned out, complaining about people who didn't believe in COVID very openly in rounds... I'm like, "Wow, you guys are really negative," that's really judging. Yes, it's frustrating as hell. Yes, the mom wants you to put the person up in the sunlight, but it is what it is." (Redeployed Nurse 1)

Burnout was also not limited to the redeployment setting; one participant described how burnout also extended past the end of their redeployment period and as they transitioned back to their previous full-time role.

It really was the after effects of it all that have sort of not been as good, I guess. I was full-time when it started. I went down to my point 0.8 [EFT] in 2021... I remember I was just super burned out at that point. All the driving, all the change. I do have an underlying autoimmune disease that flared really badly during all of this, probably because of the stress. I basically went to my leadership and was like, "Listen, I'm going to quit my job if you don't let me go down to a 0.8." I wasn't. Where was I going to go? But they let me, so that was good. (Redeployed Nurse 5)

Moral Distress. Moral distress was described by participants as a disparity between their care standards versus the level of care they were able to provide during their redeployment. Many barriers to optimal patient care were perceived by participants. One participant noted barriers to end of life care were particularly distressing. Workloads in high acuity settings required participants to triage care and prioritize patients that could be saved over being present for people dying. This led to internal struggles as they were incongruent with typical nursing moral codes and standards, as well as personal values.

You would see people die by themselves; this is more kind of an expectation that they were going to die from COVID and kind of withdrawal of care. That was also really morally distressing to see they died or having them on a Zoom call with their loved ones bawling and knowing how busy it is, and me feeling like I need to be there with their loved ones. But realizing it's so busy that I am also trying to help other patients... It is important to have someone there with them, when their family couldn't be. To have someone help in whatever way a family member would do. But you also have the other patients who are alive and their blood pressures are falling, or your buddy nurse needs help with repositioning. Or whatever is happening, they need to have this done. It's just challenging. (Redeployed Nurse 3)

Participants also experienced moral distress related to nursing ratios of the redeployment setting that differed from their experience in their usual role. Baseline human resources for staffing on their redeployment unit were not conducive to staff wellbeing and optimal patient care.

The director and I ended up having an argument one day... I told her, "I was shocked at the staff to patient ratio that I encountered on this unit... it was unbelievable to me that the quality of care was suffering because of the ratio." She got upset because she said, "I would think that the staff, if they heard you talking about the care that they're giving, would be very upset." I'm like, "No [director]," I said, "I think they would support what I'm saying, that they're working themselves to the bone to try and give exceptional care, and can't." I kept asking my manager, "Did the Executive know about this [the excessive patient loads]? Do they know how the staff struggle to provide care?" She said, "Yeah... They know." That was the biggest reason I couldn't stay there. I couldn't morally feel

good about the job that I was doing on a daily basis. That's still ongoing, and it still upsets me. (Redeployed Nurse 4)

Moral distress over quality of patient care was not limited to the time participants were actively redeployed. Aftershocks of the pandemic and the impact on patients and their families burdened some participants long after redeployment ended.

Right now [2 years after the COVID-19 Pandemic]... It's almost like people have a little bit of trauma related to the events that happened. And I get it, because there was lots of loss that happened, and people weren't able to be at people's bedsides – people are noticing changes now and health-wise, that they're saying is linked to what happened when we had the COVID virus. I feel there's lots of unknowns that are still causing people to be skeptical... I still have people question... why and what we were doing at that time. "Well, during a pandemic, this is what we do," right? I find I still have to kind of go back and justify why or what we were doing at the time, because things are so different now. (Redeployed Nurse 7)

Retention

A consequence of redeployment was retention of nurses. Healthcare at the time of the pandemic was experiencing nursing shortages; participants described the negative impact of redeployment on retention. Some participants moved to different nursing positions and opted to retire early. Further, a negative redeployment experience impacted organizational commitment and willingness to engage in facility initiatives. One participant volunteered for redeployment thinking it was a positive opportunity only to find out it was not. The experience negatively impacted their future willingness to support the region.

I hope we never have to do that ever again... I would never do it again. I have never volunteered for anything ever again since that. I have to be told that something is going to be coming my way, I don't volunteer for anything. I would not wish redeployment on my worst enemy. It was horrible. I feel for all the nurses who were there for longer... than I was. I was only 12 weeks, and it honestly felt like an eternity. I thought I was never gonna get out of the ICU. I thought I was gonna have to go on stress leave to be able to leave the unit. (Redeployed Nurse 10)

Redeployment spurred some participants to move to different positions. Frequently, there was no end date to redeployment; some participants expressed the only way to get out of redeployment was to leave their position.

Moving onto another role, moving onto another job. Moving on... I had to take another job because it was not good for my mental health anymore. The exit [from redeployment] is leaving. (Redeployed Nurse 8)

In an extreme case, the negative experiences of redeployment and failure of leaders to provide a timeline ultimately led to one participant retiring.

This all led to my retirement... I struggled the whole amount of time I was on that unit. I just hated going into work every day knowing I couldn't provide great care... I sent [my manager] an email and I don't even think she responded to me... I said, "Because there was no timeframe," I said, "I have submitted my retirement. My retirement date is [this]. I'll be putting in my notice shortly to the [program]." (Redeployed Nurse 4)

When asked if knowing a timeline to return to their usual position would have altered their decision to retire, they stated:

I do, because then there would have been an end in sight, a goal I could reach, think about, right, knowing when it was going to be potentially over. (Redeployed Nurse 4)

Occasionally redeployment led to a positive outcome for participants. Even though redeployment led to their early retirement, a positive career change resulted when they decided to return to work as a nurse.

I have to say, though, this is the best thing that happened to me, because I ended up changing what I was doing. I'm still working in nursing, but as a nursing clinical instructor for [a couple nursing programs], and I am loving it... Went right back to work, I wasn't ready, I was only 52, but just not happy with what I was doing on a regular basis, and again, no end line, no timeline in sight... I never would have retired if this hadn't happened, and unfortunately, fortunately, it worked out for me in the end... it kind of came full circle... it ended up being an awesome thing because of the career change and I'm just thrilled with what I'm doing now. (Redeployed Nurse 4)

Feeling Devalued

A consequence of redeployment was participants feeling devalued by their leaders, executives, and the healthcare system as a whole. Feeling devalued related to failure to acknowledge and appreciate the participants' professional contributions and personal sacrifices. Participants indicated three key areas they felt devalued: professional role, personal factors, and respect.

Professional Role. Participants placed a high value on their role as a nurse and took pride in the positions they attained over the course of their career. Consequently, some participants expressed that being redeployed from a specialized role to performing basic skills often and/or

previously carried out by non-nurses felt demeaning. Prior to redeployment, they were working at their full scope of practice and now they were not.

Some of the tasks I did were Nurse Assistant (NA) tasks... I was like, "You're paying me 50 bucks an hour and I'm emptying your Foleys. NAs could be doing that..." Some of those tasks weren't [up] to my knowledge level... my overall thought is, it's a negative thing to do. It's terrible to feel like you're not being used to your full potential. Because you are an educated person that has spent years specializing in something. Then [to feel] that [it isn't valued]... It's hard when you've been nursing for over 30 years, and all of a sudden, I'm a task nurse?... It's insulting and it's not as rewarding. (Redeployed Nurse 1)

Further, little consideration was given to participants' current positions and associated responsibilities. Participants' perceived leaders placed minimal value on their current role and its importance. Redeployment from their role led to them feeling their position was unimportant.

That was also tough for me to be in this brand new[educator] role, and then all of a sudden it [was] pulled out from me for any sort of momentum that I was getting... it was also really challenging then going back into [my educator] role, because then not long after that, I was redeployed again a few more times... It's a lot of that not feeling valued where you are, your role isn't that important. It's tough going back to your position where you think, well, it wasn't valued before. (Redeployed Nurse 3)

Leaders also failed to value participant limitations. Little consideration was given to feasibility and capacity to complete expectations. Participants described expectations were unreasonable and/or not realistic within the limitations of time and human resources, yet the expectation remained that the work would be completed.

There were just things that were unfolding that, we're like, "That doesn't make any sense. We can't stay past seven, but you want us to finish the work by X amount of time. How do you expect us to do that?" The expectation wasn't [matching] what they're saying or what they're telling us to do... [Because] the government had said [we] have 24 hours to notify the individual. If we have 50 contact cases between 10 nurses, and one of them becomes a school... we helped each other as best as we could, but... we all have our own load. Expectations from the government was just unrealistic, but we had to do it, that's why we had to stay. (Redeployed Nurse 8)

Additionally, participants highlighted that redeployment without backfilling their position at their site was to the detriment of home units, failing to understand and value the gap left in the home unit, *"home units were 'gutted' and could never get staff back"* (Redeployed Nurse 1).

Participants also felt devalued in their usual role. When they remained on their home unit, they were expected to take on their colleagues' responsibilities and utilize their own personal time to meet these expectations.

When [my colleague] was redeployed, I had to do the work that she had to do, because orientation and teaching still goes on. That was not allowed for in my work, I had to do... unpaid time at home, and when I [was redeployed], they had to teach my stuff too. It's different than just being a bedside nurse, because you do your shift, you leave. I still had to teach other people's things that I'd never taught before. We weren't allowed to come back... "Can they just come back for one day and teach their part and I'll teach my part?" The answer was, "No." It was 'dance puppet, dance.' (Redeployed Nurse 1)

Further, participants identified a gap in leaders prioritizing accountability to debrief colleagues carrying out their pre-redeployment role and responsibilities to maintain continuity of care.

It wasn't completely unexpected, but just saying that "You're going tomorrow." [My role in the non-acute care program], you have multiple balls in the air... I'm not going to be able to wrap up with all these people. I bargained; I was able to get an extra day back in [my program] to tidy up and pass over to my peer... I'm kind of a type A person that does everything 110%, I don't like leaving loose ends. (Redeployed Nurse 4)

Some participants were redeployed part-time, meaning they worked a portion of their EFT in their usual role, and the other EFT redeployed in various capacities to support the pandemic. Leaders often failed to value the complexity these participants experienced balancing their redeployment responsibilities while also maintaining aspects of their usual position leading to extra burden on participants who felt stretched beyond their capacity.

There were periods of time where we certainly felt pulled in many different directions at once and some unreasonable expectations as well. If you want me here, then I'm here, but then I'm also not there. Especially as Primary Care started to open up again... "OK, do you want me back in the clinic? If that's the case, then I can no longer be vaccinating four days a week or testing or driving all over the place." (Redeployed Nurse 5)

Devaluation of nurses in the redeployment settings occurred with staff nurses on the redeployed units who did not receive certain benefits provided to those redeployed. One participant expressed discomfort and a sense of guilt regarding pay differences between themselves, as a redeployed nurse, and LPN's generally staffed at the long-term care facility:

I felt kind of bad because I was working with a lot of LPNs, and I was getting extra money to do this work, which they knew... I was also working with lots of [agency nurses]... Who were also getting shitloads of money. No one... I don't think, overtly resented about the money, but it was just sort of like... I was making more per hour already, plus I was making extra COVID money, and I was not doing as good of a job as them. (Redeployed Nurse 9)

Personal Factors. Many participants expressed a disconnect from their leaders, perceiving that leaders did not fully consider or value the impact that schedule changes and travel requirements had on redeployed staff. Though the pandemic required rapid change and introduced chaos to the healthcare system, the leaders' devaluation for participants' work life balance highlighted the importance of leaders seeing the nurse as a person.

Participants expressed concern regarding how they were going to manage redeployment while still balancing personal requirements and responsibilities outside of work. A particular concern was childcare, with many participants expressing difficulties associated with their redeployment.

It was stressful, on a personal side of things, very difficult with my family... to change hours and have to travel more, especially during the times of the lockdowns where we couldn't have daycare and we couldn't have grandma and grandpa's help. I think that was often overlooked sometimes by leaders and everybody... I had a young child and a self-employed husband, and it was very much like, "Oh my God, what are we going to do? I have to go to [this rural site] every day now; it's an hour away from home. What am I supposed to do?" (Redeployed Nurse 5)

Further, this participant also stressed how chosen career roles were often linked to life outside of work. Many choose their current nursing role based on harmonization with their personal life. Different shift patterns and/or travel requirements destabilized this balance and resulted in a misalignment between work and personal routine. Participants were required to adjust to these transitions, which were difficult in many instances.

We went from my cushy 8-4 job that's 5 minutes away from my house, which I know is such a privilege to have, but I've also scheduled my life around it, to having to sort of drive an hour each way and work weekends and all of that. It was a crazy busy, busy, busy time. (Redeployed Nurse 5)

Participants asserted that shifts and schedules were prone to frequent, short notice changes, further exacerbating the imbalance between work and home life. Leaders did not appear to recognize or value the challenges associated with managing these rapid changes and the disruptions they caused in participants' lives.

Weekends, your unpredictable schedule, because also [it's] kind of last minute, "Hey, by the way, your schedule is changing in 2 days from what you expected this to be. Everything's kind of changed again." (Redeployed Nurse 3)

It was common for participants redeployed to stay past the end of their shift, making the workday less certain and further disrupting family responsibility. One participant had issues balancing the frequent mandates in their redeployment schedule and responsibilities outside of work; they needed to work with leaders to find a solution that better balanced their work and home life.

There was a lot of pressure to stay, and I was mandated a couple times, and I just said, "I can't do this every day and think, "Am I going to be mandated?" I had a little secondary

business outside of the hospital. My husband has Parkinson's. He had a couple falls during all this, right? I needed more control over my life. I said, "Put me on the 12s, as long as you're not going to put me on night." ... and they did. (Redeployed Nurse 4)

Respect. Participants sensed a lack of appreciation and value related to disregarding verbal agreements and disrupting planned vacations. One participant underscored how their verbal redeployment agreement with their leaders was not respected. Despite agreeing to a finite timeline when asked to redeploy, this predetermined time was not honored; participants' redeployment was repeatedly extended.

When I had agreed... to being redeployed... When I had spoken to... my manager, there was somebody else involved who I unfortunately do not remember what their role was, but the agreement was it was going to be for a short term, 2 to 4 weeks, and this was also on me, I should have gotten it in writing. It just kept getting extended, because once I got to that unit they would not let [me] go. (Redeployed Nurse 10)

Further, lack of respect impacted vacation time. Participants were uncertain whether vacation time would be honored. Experiences varied, with some participants citing instances of vacation being rescinded, whereas others planned vacation time was honored. Failure to honor planned time away was perceived by participants as disrespect.

I know a lot of my colleagues who were redeployed also talked about the inability to plan their lives, right. Your [vacation time planned] before you redeployed was not honored. They just said, "Oh, no, we will schedule you wherever we want." That doesn't feel very respectful. (Redeployed Nurse 1)

Actions by leaders were also described as blatantly disrespectful. Participants expressed that leaders often ignored them and failed to show appreciation. One of the participants described how redeployed nurses were treated as if they were invisible by unit leaders.

The managers of the unit would come and talk to the staff I was buddied with, and never once asked me how [I was] doing. That was a pretty common theme [for] all of us, that we felt like we were invisible. They would come and talk to the bedside nurse that you were assigned to, and not even say, 'Hello, thank you for coming.' Nothing, it was like I wasn't there, we were shadows. And I get everyone's redeployed, and I honestly get that they were burned out and just probably done. But it doesn't make you feel very good. It was like you're phantoms in the night... (Redeployed Nurse 1)

Leaders are not the only members of the healthcare system participants perceived as disrespectful for their situation as a redeployed nurse. Participants seldom felt the reality of redeployment was understood by unit staff. As a result, participants frequently felt isolated and alone as a redeployed nurse.

There was nobody you could really speak to because the nurses who were working the [critical care unit], they did care, but they were also glad that you were there, nobody really understood your plight when you were talking about how awful it was or how hard it was to be redeployed. (Redeployed Nurse 10)

Leaders failed to value participants, which resulted in dissatisfaction and poor perceptions of leader support. Participants felt isolated and invisible; they perceived that leaders had minimal regard for the roles they played in supporting the pandemic through their redeployment. This failure in leaders extended to devaluation of the participants' usual role as

well, furthering perceptions of disrespect for their role as a nurse in and out of the context of the pandemic.

Ambiguity of Consequences

Ambiguity of consequences of redeployment existed in two key areas, patient outcomes and whether leaders cared about the participants' experience of redeployment. Chaos as a consequence of the pandemic and redeployment raised many safety questions among the participants. Participants questioned how much patients benefited from redeployed nurses in terms of quality of care and not feeling safe. Leaders' actions regarding how they responded to concerns of the participants during their redeployment and treatment upon their return to their home unit/position raised questions about leader empathy.

Patient Outcomes. The question of patient outcomes related to redeployment during the pandemic was common among participants and frequently garnered much uncertainty. Two key areas were identified related to patient outcomes; quality of care, and not feeling safe. Quality of care was impacted by methods of participant assignment, exclusion from communications of practice updates, rapidness and breadth of redeployment, novelty of COVID-19, and variance between standards and practice. Participant concerns regarding not feeling safe pertained to nurse/patient ratios, redeployment burden on unit staff as well as participant capacity, competency, and/or background. Safety concerns were also raised for participants themselves, particularly failure to prioritize staff safeguards and fear of their nursing license being at risk.

Quality of Care. Impacts to the quality of patient care were raised by many participants as a consequence of redeployment. One participant highlighted how utilization of redeployed nurses failed to prioritize patients and their unique care needs.

I had one poor man that I had to figure out how to communicate with him, he could only communicate by pointing his foot at a board, because he couldn't talk. You spend all night trying to figure out how to provide the best communication with him. Then the next day, they [assigned] a brand new person [with that patient], and I was gone. There was no consistency, you couldn't even build a good relationship, give the best care that you can. It took me all night to figure out this man's communication style, because I'm not used to that, and then somebody else has to figure it out. (Redeployed Nurse 1)

Further, failing to consistently assign participants to the same patients hindered professional growth and practice. Bed assignments failed to prioritize nurse-patient relationships.

We were redeployed like bodies... or numbers, no plan to make sure that I got better.

Because if I'm [with the same patients] 2 or 3 days in a row, I'm going to get to know the patients. I'm going to be better at what I do for my own safety, but also for the patient's comfort and safety. I don't really feel that patients got, felt, or were treated as they were important. (Redeployed Nurse 1)

Other barriers to quality care related to communication and incorporation of participants into the unit's team. Participants were often excluded from email updates regarding practice information sent to the unit employees where they were redeployed. As a result, they were unaware of identified practice problems or updates regarding appropriate care practices. This oversight left a gap in maintaining practice standards and promoting optimal patient care and safety by all staff on the unit.

Nobody asked if you knew what you're doing, and no one sent you the information... that the regular staff members were getting so you could stay up to date... I'm looking over [the staff nurses] shoulder and I'm like, "I should be looking at that. I'm actually

suctioning the trachs, maybe I'm the one that's causing this practice problem."

(Redeployed Nurse 1)

The pandemic and the need to enforce mass redeployment had a large systemic impact on healthcare facilities and programs, leading to a widespread weakening of the organizations infrastructure. One participant highlighted how the chaos of COVID-19 deteriorated critical care areas that were previously renowned and celebrated.

One of the extenders I was talking to had tons of experience... and was redeployed because she had Critical Care experience. She said... Winnipeg was known for their Critical Care [Program]. They created their own courses; they were world renowned for what they were doing. And the [critical care] staff... are heartbroken of how they have to bring people in and to do all this... "People would be spitting in their graves of how – what had come" because everything had collapsed. It's like [the critical care staff] are dealing with the grief of not being able to handle the crisis. (Redeployed Nurse 2)

Novelty of the pandemic introduced uncertainty regarding care protocols. Care interventions were introduced that would not typically be standard to the program. Consequently, participants were left to wonder if the care they were providing was appropriate and consistent with advance care directives.

One thing that did come up [at the personal care home] is one of the patients who had COVID, her oxygen saturation level was quite low when I did her vitals, and it seemed to be a bit of a process for us to track down an oxygen tank, for us to be able to put her on some oxygen. I didn't even know either, what would be the procedure here? This person probably is not a code, do we put her on oxygen? I don't know. It was complicated. I was

just going to the other staff with all these questions, I don't even know what we should be doing in that situation. (Redeployed Nurse 6)

In efforts to support contact tracing, non-nursing professionals were hired to address workload volumes. A participant expressed that hiring non-nurses resulted in further burden on redeployed nurses and decline in care standards instead of a benefit.

[Us redeployed Nurses] were to tackle all the COVID cases. When it got to the point where the cases blew up, we had to mentor and train secondary case investigators that weren't even nurses. They were like probably high school graduates or... call center people. That was very concerning, we brought that up to the College [College of Registered Nurses of Manitoba] as well. We did a lot of cleaning up their work [documentation] because some of them [we] were finding inappropriate or incorrect. (Redeployed Nurse 8)

There were also concerns related to practice standards; participants described facing instances where unit practice differed from best practice guidelines, leading to distress with the task. Participants were new to redeployment environments, the tasks, and medications; to support their transition, they accessed regional standards to support and guide their practice for safe patient care. Participants did not feel comfortable with the assertion from unit nurses that the requested practice was acceptable when it deviated from written standards.

How they give the medications [differed from the best practice guide], because reading [the guide] on how you're supposed to give a medication, [it says] one at a time through a [Naso Gastric Tube]. The [unit nurses are] putting all the medications in one cup, crushing them all up and giving it and [I'm] just like, "That's not how they say they do it in the book... I'm not going to do that." they're like... "But that's not how we do it. Then

you can do it, right?” Looking at nursing skills online, you’re told how to do it properly...

“That’s not how it says to do it, so I’ll let you do it then the way that you [and the other unit staff] feel comfortable doing it.” (Redeployed Nurse 2)

The ask to redeploy also directly impacted patient care in the programs from which participants were redeployed. As a result of how quickly participants redeployed, they had to cancel scheduled patients in their normal practice unit impeding patient access to care.

[The time to when I was redeployed]... I want to say it was for sure within the same week.

I actually had patients booked in my job. The [redeployment] shift that [my manager] wanted me to do, I had to cancel patients for that.... which is an inconvenience to them.

(Redeployed Nurse 6)

It is important to highlight that strength in quality of care was also described. A participant described the compassionate, robust efforts made during the pandemic to safeguard the emotional needs of those dying, despite visitor restrictions during the pandemic. Valiant and meaningful efforts were made to safely allow connections between patients and loved ones.

You actually got to see what they were trying to do for the patients, which was incredible.

Having the volunteers that were coming in to do FaceTime with families so they can see their loved ones that are ventilated, and so that they could talk to them and they can give them that support. (Redeployed Nurse 2)

Despite the heroic efforts observed and undertaken to provide high quality of care, participants perceived many barriers to quality patient care during their redeployment. Failure to consistently assign participants to the same patients was detrimental to care. In addition, the number of nurses staffed on the unit was insufficient to meet care demands. Further, uncertainty

regarding care protocols and observed deviation from standard practice guidelines led to participant confusion and concern.

Not Feeling Safe. Some participants were thrust into new care environments with short notice and minimal or no preparation. Some had never worked in these settings, whereas others had not provided acute patient care for many years, exacerbating a difficult transition. Regardless of practice background, the participants were expected to report and function as a staff nurse on the new units. One participant was sent to carry a full patient load at a personal care home despite having no experience in long term care. Not only did this put the nurse in an uncomfortable position, it also led to them noting patient safety concerns:

I had no comfort with any of [it]... I've never worked in a personal care home... It had been] at least eight years or so since I had been in any kind of Acute Care setting where I was giving medications of any kind... I feel like that's all I did, was give meds... I also found in that environment it's really difficult, they're not wearing ID bracelets like they would in a hospital... They have a picture on the chart, but a lot of these residents, their picture is not the same as when they first came into the PCH, compared to maybe how they looked at the time... I was often going to that other nurse to be like, "Who is who?" I felt really concerned that I was going to give the wrong person the wrong medication, because I wasn't even able to identify them properly. (Redeployed Nurse 6)

In other instances, participants thought they were being used haphazardly to patch holes in care environments, with minimal regard for comfort or capacity of them as a redeployed nurse nor patient care and safety. In one participant's case, shuffling them to another assignment mid-shift resulted in a medication error.

The employees of [this personal care home] needed time to do this extra sort of charting on a computer. So sometimes [it] was sort of like, "Oh, you're here, you can take over." One day... I had one group [of patients] for the morning, and then they switched me to a different group of patients for the afternoon, which was completely unfair, in my opinion... because I was now with a whole brand new group... my a.m. meds were done, and now I had to start over... with a new group [of patients]. I made a med error that day... because I was switched in the middle... I felt terrible about it... They didn't go out of their way to make me feel terrible, [but] they did not do a lot of reassuring. (Redeployed Nurse 9)

In critical care environments, participants often faced increased patient ratios where they cared for more than two critical care patients. In addition to increased ratios, patients were often higher acuity, adding further burden to the already overworked staff. There were many instances where this caused anxiety and fear for the participants and sparked patient safety concerns. Similar to participant experiences of moral distress triaging the dying, care demands were so high participants also triaged their patients' acuity to prioritize care, with an underlying fear of missing something or inadvertently making a mistake in the chaos.

There were a lot of times I would come home, and I would tell my husband like, "I think this went wrong, and I don't know what the repercussions are gonna be." I remember there was one night where I had three vented patients (which were stable vents of course). At the same time, things were going wrong. I had a patient who was desaturating, so had to deal with that vent, then I had a patient who was on vasopressors and their blood pressure was labile, so I had to go and deal with that. Then I had another patient who went tachycardic on me, and this was all in the same probably hour that they all started

having these events. You get into this mind frame where you have to pick. How do you pick? I came home a lot and there were a lot of tears and anxiety, and it was not conducive to my mental health. It just got to a point where I was consistently coming home after a shift going, 'Did I kill somebody? Did I make a mistake? Did I miss something that I shouldn't have missed?' because I was so busy that it negatively impacted somebody's care or adversely affected them. (Redeployed Nurse 10)

Participants also asserted that staffing ratios and patient acuity were a safety concern for staff and patients when they took scheduled breaks.

Even going for breaks... my nurse and I would go opposite for breaks. There would be, maybe one other nurse and I in the area we're in; I couldn't see all the patients who are intubated. I said, "I'm not safe here for breaks." they said, "Neither are we, but we don't get breaks if we don't [take them]." I did vocalize too, how I felt unsafe often. But they said, "This is years, they had been going through this for at least a year..." You're kind of in that unsafe position that you feel all the time.... You leave patients unsafe or don't take a break, but you need that break, especially when you are burned out, there is no other option and no one else around. (Redeployed Nurse 3)

Fear was so palpable that multiple participants expressed concern for their nursing license.

It's going into work feeling, "This is unsafe, this is my license... Is something going to happen where, once again, I don't know what I don't know." (Redeployed Nurse 3)

Other instances highlighted how scope of practice between redeployed nurses varied, and happenstance in certain care situations could result in adverse events had the participant not happened to have more experience and a higher skill level.

I remember there was one time we had very, very busy sick patients, and my [buddy] nurse was pretty much the whole time with this other patient who is kind of on the verge of going to an arrest state. I was looking after the other patient who is also on the verge of going to arrest state. I would be titrating their blood pressure medications. They weren't around to even help me, I felt like, "This is probably not very safe for a typical extender. However, I felt OK... I know what to do. I can recognize that this patient's deteriorating, and I can start caring for them..." But if that were any other extender, they would have no idea... I thought, "What if I wasn't here? What would have happened to this other patient?" It was scary. It was really scary. (Redeployed Nurse 3)

Participants asserted that the burden redeployed nurses placed on unit staff also represented a safety concern, as the energy needed to orientate and support redeployed nurses was often an extra task that took away time from patient care. One participant commented that it was sometimes necessary for a staff nurse to seek out a redeployed nurse with higher competency rather than trying to support a redeployed nurse with less expertise.

[A staff nurse] having a nurse... from clinic for 20 years, who hasn't worked on the bedside. It's more work for them to also now try to orientate the extender; support the extender... It was tough for everyone... One [unit] nurse with a couple sick patients... she had another extender, and she said, "I'm pulling you to come with me, because I need your help over here." It's just so much work for the [unit nurses] every way... Looking after heavier assignments and then now trying to orientate extenders who... most of them are not choosing to be there. (Redeployed Nurse 3)

Importantly, the direct safety of participants was also raised. Logistically, some decisions were made by leaders that led to questionable staff safety, but concerns raised by staff were not acknowledged.

From the start, the testing site, the preparation was minimal. There was always challenges with the testing sites, of being moved to a new location. In [one rural setting], we were literally stopping traffic in the middle of the road and directing people to our site.... Not a lot of safety practices in place. By that time, management had changed and was perhaps not as supportive of our concerns. It was kind of like, “This is what’s happening and deal with it.” (Redeployed Nurse 5)

Safety concerns impacted both patients and nurses. Participants highlighted how redeployment represented possible safety risks through unit staff burden and participant capacity/competency. Further, the elevated burdens of patient care related to high acuity and insufficient staffing were described as a safety risk. Lastly, participants asserted their safety was not prioritized, and redeployment placed them in a situation that risked their professional nursing license.

Do Leaders Care? There was also ambiguity from participants regarding whether leaders cared about them and their redeployment experiences. Leaders were often described as apathetic towards participants and other redeployed nurses. According to one participant:

I think they were just happy to have bodies. Didn’t matter what background you had, didn’t matter how burned out you were, didn’t matter as long as you came in and did what they needed you to do. (Redeployed Nurse 10)

Leaders were also autocratic and failed to value participants’ backgrounds and practices, with participants slotted into redeployment roles despite lack of experience and no option to

refuse. On two separate instances, one participant was instructed to redeploy to a long-term care home despite having no experience in this area or formal preparation. In the first instance, they were also required to manage a full patient load, despite not working in a multi-patient setting for several years. They believed their leaders' only priority was to fill the gap in care with little to no concern for the participant or their current role.

Those two situations... I had a different manager at that time, and she basically was like, "If you don't agree to this, I will make you," I was told I was going to be mandated. Whether or not she would actually mandate me I don't know, but she said that, so I felt like I had no choice... I was upset, angry, frustrated... I didn't want to do it... I didn't feel comfortable, because I had no idea what to expect... She didn't seem to care about any of that. There was this gap at that site, and that was kind of her only priority. "Either you agreed to go or I make you." That was basically our only conversation. In one of the shifts, it was just staffed by two nurses, and I was one of the nurses... I had a full patient load, and... it was an evening shift. So that's different for me, too, I normally am days... Then the [second time], it was a different personal care home. In that situation... I was just an extra nurse, and my only role there was to do vitals on all these people.

(Redeployed Nurse 6)

Participants often perceived leaders seldom prioritized their wellbeing. One participant was forced to miss a scheduled EAP appointment they had booked to support their mental health; instead of being understood, they were told by one leader *"it doesn't matter."* Importantly, participants cared about other nurses. When a nurse replacement was chosen for the participants mandate, the participant accepted the mandate at the cost of their EAP appointment in order to support the other nurse who was also struggling.

I actually had to cancel an EAP appointment to stay at work. The manager told me I was mandated. I said, "Well, I have an EAP appointment because I'm struggling with my redeployment;" she said, "It doesn't matter." Then I talked to [the director], and I said, "Oh my goodness, you know this is what's going on, and I'm, you know, struggling." The director, [close to the time I was off] brought another nurse to relieve me, but I knew the nurse. I could see on her face how upset she was, she was even in worse shape than I was, so I ended up staying so that that other nurse could go home... I just did not appreciate [the managers] lack of sensitivity to what was going on with me that day in particular. That was a huge thing that still sticks with me. I would like them to know... that you cannot do that to people. That's a sign I was struggling... that I needed support. I get patient care needs were important, but maybe there was some other options that day.

(Redeployed Nurse 4)

Disregard for participant mental health and wellbeing by leaders was often described. There was a continued sense that the health of the nurse was unimportant, and only the role they were sent to fulfill mattered.

They had a nurse who was ICU trained and was taking on vented patients, and they held on for dear life despite me losing weight because I was so anxious. Despite working four weeks of straight nights and nobody addressing that. Despite me reaching out to the charge nurse in the ICU, and to my manager, and to my home unit saying, "I need to get out of this, I'm losing my mind." (Redeployed Nurse 10)

Failure to follow-up by leaders was also perceived by participants as a lack of caring. Leaders did not follow up to ask about or understand participants' experiences, whether they

could provide support, or develop strategies to improve redeployment. In rare instances when follow-up efforts were provided to participants, they were too late to be impactful.

I wish they would have surveyed every person when they came back [from redeployment], so that you could actually do quality improvement... Survey you, how can we make this better? We did get a survey done... well over a year after I was back, and it was like, it's too late. If you really want to change and you want to give the best care to Manitobans, and you want to have your nurses have the best, safest, most rewarding experience, you have to do surveys. With Teams and all the things that we do now, I don't see how that should have been a problem, [it could] have been voluntary, just to say, "What could we have done to make this experience better?" (Redeployed Nurse 1)

Further, many participants expressed appreciation for this research study as an opportunity to express their feelings and share their experiences, and thankful that someone wanted to talk with them about what they had experienced.

[They] never said even really, thank you. It was just the expectation you go... They didn't talk to us after the fact. Honestly, I think this [research interview] has been helpful for closure of it. To talk about it... because even preparing for [this interview]... it was just kind of like, "Oh yeah, I haven't dealt with things." It's just like I buried it, put it in the past, and it's like, "Now I can actually – someone wants to hear what happened." Thank you, I really appreciate it. (Redeployed Nurse 2)

When leaders expressed appreciation for participants' redeployment, it was often perceived as superficial and impersonal. One participant highlighted how the method to thank them for their redeployment felt like a recycled effort by executive leaders.

When I finally got out of my redeployment – [I received] a thank you letter for being a hero. It was a photocopy, black and white, “Thank you,” that they didn’t mail to me... they couldn’t even have printed it in colour... There was no signature... It just said, “Thank you for doing what you did.” I laughed, I actually framed it... I received the letter at [my home unit] when I just got back to the unit. There was an administrative assistant who was walking around asking for [me]... I said, “Can I help you?” She goes, “I just have something for you,” and she hands me this brown envelope. I’m like, “You’ve gotta be joking me...” It’s ridiculous. (Redeployed Nurse 10)

Lastly, early in the pandemic, nurses were heralded as heroes. They were granted autonomy, the ability to have independent control and decision making in their practice, as well as flexibility to work at home. However, following the pandemic as work returned to normal, some participants indicated the appreciation and grace garnered during the pandemic ceased, and they went from “*hero to zero*”. Despite all the participants’ efforts to support healthcare through the unprecedented chaos of the pandemic, once things returned to the status quo, autonomy and flexibility previously offered were rescinded and participants found themselves reeling from the sudden constraints and seeming thanklessness for all the extremes and lengths they provided to support the pandemic efforts.

During [redeployment]... it was very much the “healthcare hero” time of COVID... There was a lot of praise for Primary Care in that we maintained our normal jobs, our normal patients... praise for our flexibility and our ability to do our job from home. Then the pandemic ended, and [the leaders] were like, “Well, you’re never allowed to work from home again,” and you’re tied back to your office, and “I better see you here from eight to four”... I understand, obviously I can’t work from home every day because I’m a nurse in

a clinic. But there's no flexibility with leadership or management anymore at all... In a way I felt a little bit used and abused by the end of it. We were very flexible for [the healthcare system], we worked really hard and took on quite a bit of extra responsibility, even though we weren't officially told we had to. I was at the end of the day still a volunteer. I could have just tried to sit at home and do nothing for as long as possible... but I didn't. You don't really feel super thanked afterwards or very respected. (Redeployed Nurse 5)

Redeployment had a major impact on participant satisfaction. Participants perceived leaders failed to demonstrate adequate empathy and understanding of their experience. Insufficient effort by leaders was observed during redeployment, as well as after, through failure to follow-up and adequately express or demonstrate gratitude for the sacrifices they made.

Summary of Findings

This chapter summarizes the 3 themes identified in the data on nurse perceptions of redeployment: i) redeployment: the ask, ii) managing redeployment, and iii) consequences of redeployment. These 3 themes follow along a chronological order, beginning with the ask to redeploy then continuing the duration of redeployment and after redeployment ended. Consistent across all 3 themes, there was an overlying context of ambiguity. The first theme, the ask to redeploy explored the degree of choice participants had in being redeployed and ambivalence related to the pending redeployment. Ambiguity in the ask pertained to whether redeployment would occur, redeployment information, communication, and turnaround time. Managing redeployment, the second theme, pertained largely to the active phase of redeployment. Within this theme, preparation and relationships with leaders, as well as other nurses and healthcare professionals, greatly impacted participant redeployment experiences. Participants' ability to

cope with redeployment and coping mechanisms some participants utilized also had bearing on how they perceived their redeployment. Ambiguity managing redeployment related to four key questions: What is happening? Who is in Charge? Why am I Here? When Will This End? Lastly, consequences of redeployment highlighted the breadth of impact redeployment had on participants' wellbeing, retention, and feeling devalued. It also raised ambiguity over redeployment and patient outcomes, particularly quality of care and not feeling safe. Ambiguity also existed for participants around whether leaders cared about them and their experiences with redeployment.

Chapter 5 – Discussion of the Findings

The purpose of this study was to understand nurse perceptions of redeployment during the COVID-19 pandemic. Unprecedented levels of redeployment during the pandemic represented a mass change for the many nurses impacted. The literature regarding nurse perceptions of redeployment is limited. This gap in literature has implications for nurse satisfaction, wellbeing, and retention in future instances of redeployment. It is imperative that nurse leaders understand the perspective of the redeployed nurse to improve nurse redeployment strategies and outcomes in future.

Rosabeth Kanter's (1977; 1993) theory of structural empowerment was used as a framework to guide this study. Structural empowerment posits access to structural components of resources, information, support, and opportunity leads to satisfaction in the workplace, not inherent characteristics of the worker (Kanter, 1977; 1993). Utilization of this theoretical framework aided in obtaining rich data and valuable insight into participants' perceptions of redeployment during the COVID-19 pandemic. Framing the interview guide using the proponents of Kanter's theory elicited in depth detail to how information was communicated and shared in the context of redeployment during the pandemic, as well as how participants perceived redeployment in terms of opportunity. Further, this framework led to important insights to availability and utilization of resources in preparing and supporting participants through redeployment. Lastly, investigating access to the proponent of support provided significant insight to participant perceptions of leaders throughout the healthcare system hierarchy, and how they handled the redeployment of nurses. Instances of empowerment and disempowerment were apparent in the findings. Some participants were empowered by a desire to help, the choice to volunteer, flexibility in managing their work, as well as advocacy and

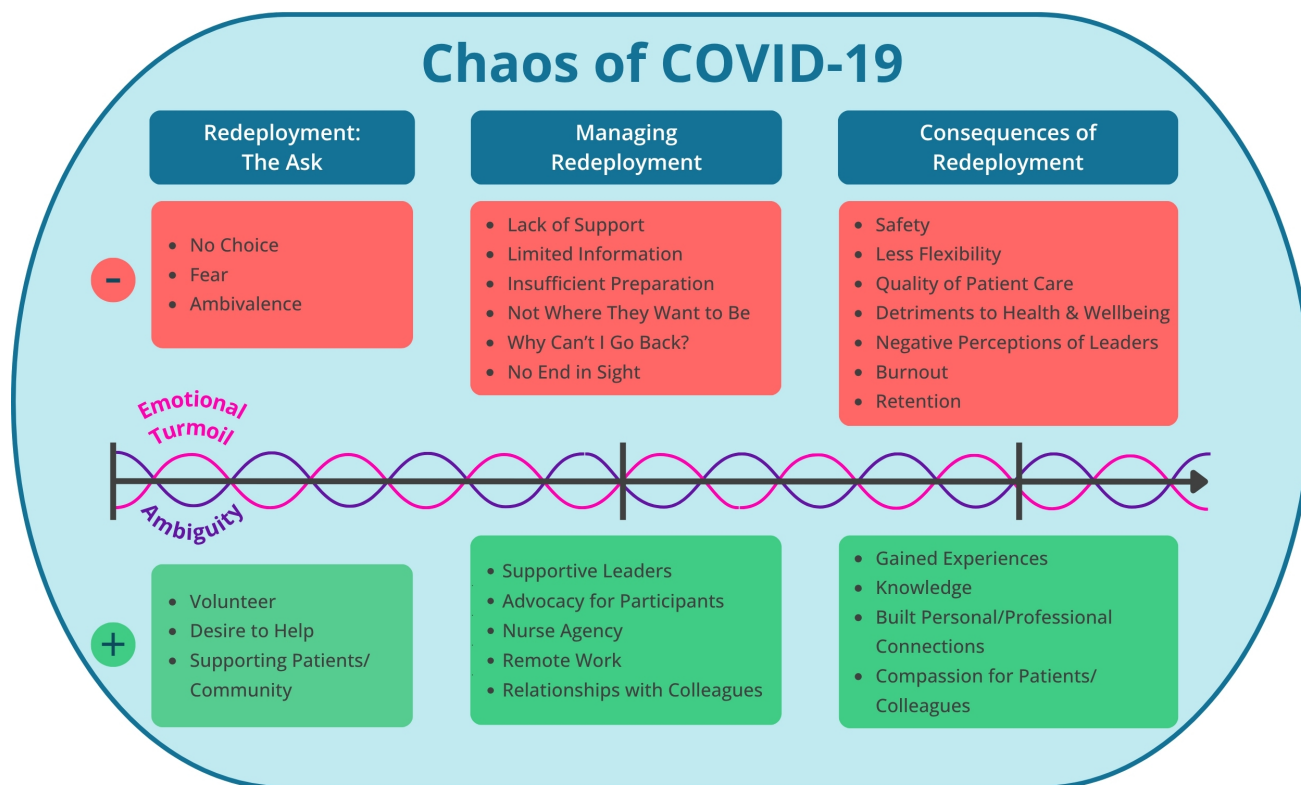
support by leaders. However, despite occurrences of empowerment, the disempowerment of participants was predominant in this study. Participants frequently felt unsupported, overburdened by workloads and/or insufficient human resources, ill-informed, and an absence of control over the course of their redeployment. Clearly, structural factors of redeployment impacted participant experiences and satisfaction. It is argued that structural empowerment is a leadership strategy, unit contexts are shaped by nurse leaders; how leaders mobilize resources and provide support determines the degree of empowerment experienced by staff (Laschinger et al., 2013). The outcomes from this study addresses gaps in the current literature and provides valuable insight regarding nurse redeployment to assist nurse leaders in approaching redeployment efforts in future to better support nurse satisfaction, wellbeing, and retention.

This chapter will discuss key findings related to participant perceptions of redeployment during the pandemic. The three themes of this study, 1) redeployment: the ask, 2) managing redeployment, and 3) consequences of redeployment followed a chronological theme. However, despite this orderly fashion of themes, a context of ambiguity overlayed all themes, warranting discussion. Additionally, it was apparent emotional turmoil was experienced by participants throughout their redeployment. An array of emotions was apparent throughout the three themes and the emotional turmoil of redeployment had a profound impact on participant wellbeing in many instances. Emotional turmoil was impacted by nurse agency throughout the themes, relative to autonomy, flexibility, and control. Emotional turmoil also tended to predominantly have a negative impact, especially regarding fear, moral distress, and burnout. Emotional turmoil was also reflected in how relationships functioned as lifelines for participants, and failure to follow up by leaders. Lastly, the ambiguity and emotional turmoil experienced by participants

raised important concerns for nurse retention (see Figure 1). How these findings relate to current literature on nurse perspectives of redeployment will also be discussed.

Figure 1

Thematic Map of Participant Perceptions of Redeployment



Ambiguity

Across all three themes, there was a context of ambiguity. This ambiguity was inherently related to the novelty of COVID-19 and lack of knowledge surrounding the virus. Information regarding the virus was sparse, leading to fear of the virus and uncertainty among participants over what to expect during their redeployment. Constantly changing information and the chaos of redeployment to meet surging healthcare demands was overwhelming. Global pandemics are a form of disaster and cause severe systemic disruption to healthcare organizations (Aqtam et al., 2024). This was apparent in participants' accounts of disorganization across many of the

redeployment settings. There was a common perspective that the system was in a constant reactive state. Integral to disaster management is proactive preparation in advance of a disaster event (Aqtam et al., 2024). This study's findings highlight the importance of better planning and readiness to support redeployment and ease nurse transitions to different care environments.

Ambiguity also existed because no one knew how long the pandemic would last. Consequently, participants were frequently uncertain and had no idea how long their redeployment would last and therefore was one of the most distressing factors for participants in this study. Uncertainty led to frustration with leaders, the turnover of nurses, and even early retirement. Participants frequently wondered why they were still redeployed, particularly when they observed a lack of apparent need for them in the redeployment setting. The literature is scarce regarding redeployed nurses believing the redeployment unit was 'overstaffed,' yet they remained redeployed without an apparent rationale. In one study, Darchen et al. (2023) found redeployed nurses noticed apparent staffing excess and were unclear as to why they were not sent back to their unit when their assistance seemed unnecessary. This raises an interesting question as to the origin of redeployment decisions and monitoring of care demands. A disconnect was expressed by participants, where they perceived there was an evident lack of communication among leaders within the system. Participants described responsibility for redeployment decisions was not apparent, bringing to question the chain of command and ownership of staff management.

Most concerning was a sense of ambiguity in patient care and safety standards. The importance of access to education, resources, and support for those redeployed to a new setting and perceptions of safety is represented in the literature (Darchen et al., 2023; Denning et al., 2020; Maben et al., 2022). In this study, inconsistency in preparation, generalization of education

requirements, and assumptions based on participant background often failed to address gaps in knowledge, resulting in lowering confidence and comfort in redeployment roles. Further lack of clarity on expectations, incongruence of written standards with unit practice, and excessive patient loads raised questions on safety for patients and participants. This led to querying the benefit of redeployment without appropriate preparation and safeguards in place. The fact many participants feared for their nursing license raises strong concerns about appropriateness of responsibilities placed on redeployed nurses and patient care ratios. Consistent with Kanter's (1977; 1993) theory of structural empowerment, impact of environmental factors on nurse job experiences was apparent, the disorganized environments in which participants worked resulted in disorientation and ambiguity.

Emotional Turmoil

Redeployment had a significant emotional impact on the participants throughout the three themes. Emotional turmoil encompassed both positive and negative emotions and was frequently in flux. Nurse agency is a prime example of highs and lows relative to turmoil, as choice was not always available nor autonomy static. Unfortunately, the majority of emotional turmoil experienced by participants were negative emotional experiences and outcomes, particularly fear, moral distress, and burnout. However, even amidst the emotionally tumultuous experience of redeployment, participants demonstrated their value and care for colleagues, exemplifying how these relationships served as lifelines. Lastly, failure of leaders to follow up with participants left them to manage their feelings of redeployment alone and with the perception leaders had no interest in improving redeployment practices or outcomes.

Nurse Agency

Nurse agency was the degree of autonomy, choice, flexibility and control participants had regarding their redeployment, as well as their roles and responsibilities throughout all three themes. Throughout participant accounts of their redeployment experience, it was apparent that nurse agency varied across participants and the various themes. From the onset of “redeployment: the ask,” agency of nurses ranged from having the autonomy to volunteer to redeploy to an absence of choice. Positive emotions were felt, such as feeling satisfaction when they were able to help patients and their communities, and a sense of pride over their efforts in the pandemic. Notably, if choice was present when asked to redeploy, autonomy did not always extend into the active redeployment phase. Once redeployed, many participants expressed a lack of control. There was no end to their redeployment by choice. Redeployment decisions were made by leaders. Without advocacy from leaders for their return, the only recourse for participants was leaving their role, retiring, or getting a medical exemption. It was important that leaders needed to redeploy nurses to meet the demand of rising patient volumes and acuity during the pandemic (Kennedy et al., 2022). However, leaders often failed to consistently provide resources and support for those redeployed, as a result, participants felt a lack of autonomy and safety during their redeployment.

Interestingly, some participants expressed greater agency during their redeployment. These participants were granted greater flexibility through the capability to work from home and coordinate their usual role activities with their redeployment responsibilities. Participants who worked from home provided patient support and education virtually. Working from home enabled participants to deal with personal and/or family issues, for example, an illness that previously would have resulted in missed work. Participants conveyed a sense of appreciation for this control over their work life. However, despite the efficacy of working from home and the

extra efforts provided by participants during the pandemic, the freedom to work remotely was rescinded at the end of the pandemic; this shift to rigid control left participants feeling unappreciated. Participants were confused as to why leaders were suddenly so inflexible, refusing remote work on occasions that would otherwise require sick time. Accommodation appeared to be one sided, with participants expected to have flexibility to benefit the system, but the system failed to provide reciprocal accommodation to benefit participants. Consequently, in the post pandemic period there were times when participants could not work in the office, but would have been able to work from home, instead they needed to call in sick. Limoges et al. (2021) argued leaders engaging redeployed nurses in making decisions and promoting even small amounts of choice or control is empowering and important to nurse wellbeing. Empowerment of nurses through promoting autonomy and wellbeing is paramount to satisfaction, this empowerment should be continued or improved, not rescinded.

Although the literature on redeployment discusses lack of autonomy and control related to being redeployed, the participants in this study experiencing greater control over their work through remote work and coordinating their standard work with redeployment expectations is a gap in the literature (Abrams et al., 2023; Ballantyne & Achour, 2023; Taylor et al., 2023; White et al., 2025; Womack et al., 2024). The literature that indicated nurses had control and autonomy primarily related to agency over volunteering to redeploy, choosing where to redeploy to, and in one instance, the ability to choose to end their redeployment if they were unable to cope (Kelly et al., 2025; Lukewich et al., 2024; Rollison et al., 2021).

Fear

Fear was a key contributor to the emotional turmoil experienced by participants. Fear was common among participants and related to fear over the virus and the impact it could have on

them and/or their families. They also often feared redeployment itself and what would be expected of them. Unmanageable workloads, lack of familiarity with practices, and chaos of the pandemic also led to fear for patient safety as well as fear redeployment put them in danger of losing their nursing licenses. These findings are reflective of other studies in the literature on redeployment that reported fear among redeployed nurses related to the virus, redeployment expectations, safety, and their professional license (Agyekum, 2022; Darchen et al., 2023; Li et al., 2022b; Maben et al., 2022; Montgomery et al., 2021; Wheeler et al., 2021; Woodford et al., 2020).

Moral Distress

Participants also experienced an emotional toll caring for patients in the redeployment setting. Romero-García et al. (2022) highlighted the impact of barriers to ethical care on mental health and experiences of moral distress in redeployed nurses. Consistent with this, participants in this study frequently experienced personal and professional conflict when triaging patient care. As a result of high patient volumes and acuity, participants faced morally complex situations. Human resource constraints have been linked to increased risk of moral distress in redeployed nurses (Miljeteig et al., 2021). Participants expressed facing a moral dilemma over the need to sacrifice standard end of life care due to limited human resources and the need to prioritize patients that might be saved. This placed intense moral distress on participants, particularly since patients were commonly isolated from their families due to isolation restrictions. As a result, some patients passed with only a screen as connection to their families, or completely alone. Participants also internalized the chaos of the redeployment setting and their care decisions, expressing being followed by thoughts of whether they did enough or the right

thing after their shift ended. Emotional burden was intense; participants wanted to care but at the same time were feeling burned out.

Burnout

Relative to emotional turmoil was burnout as a result of redeployment. Participants of this study described burnout as serious, deleterious mental health effects, cultures of negativity, and hopelessness. Participants' experiences of burnout are consistent with literature on burnout. Maslach & Leiter (2016) defined burnout as an outcome of chronic stress related to work environments, resulting in negative impacts on psychological wellbeing. Burnout characteristically manifests as exhaustion, depersonalization, and inefficacy. Exhaustion relates to both physical and emotional exhaustion, eventually resulting in workers distancing themselves from stressors as a defense mechanism (Maslach et al., 2001). This detachment ultimately results in depersonalization, characterized by a lack of emotion and insensitivity. Ultimately, this leads to inefficacy; feeling a lack of accomplishment and failure to provide adequate care (Bentley, 2010; Maslach & Jackson, 1981). Detrimental mental health impacts experienced by participants are consistent with negative impacts on psychological wellbeing. Further, cultures of negativity experienced by participants are indicative of depersonalization. Participants described excessive workloads and lack of support as contributing factors to burnout, both of which have been linked to burnout in the literature (Maslach & Leiter, 2016). Burnout can have severe consequences for healthcare systems, particularly higher nurse absences, turnover rates, and even leaving the nursing profession entirely (Bentley, 2010; Hayes et al., 2014; Meng et al., 2016). Studies show leadership that empowers nurses through structural empowerment strategies can help prevent nurse burnout (Greco et al., 2006; Orgambidez-Ramos et al., 2017). Thus, structural

empowerment offers relevant strategies to both understanding nurse redeployment and addressing redeployment consequences such as nurse burnout.

Relationships as Lifelines

Importantly, despite immense emotional turmoil, distress, and burnout, the findings of this study exemplify the compassion and empathy nurses had for each other during their redeployment. This was exhibited through the unity of forgoing breaks to aid a fellow nurse, through the relationships and emotional support built on shared experience, and most apparently through prioritizing the health of a colleague in the face of personal struggles. One participant sacrificed a personal EAP appointment to support a colleague they knew was struggling, despite their own personal distress. It was evident that participants and the nurses they encountered on their redeployment journey resoundingly cared for each other. This care and camaraderie in the end are what flowed through as a positive lining for the majority of participants.

Failure to Follow Up

Failure of leaders to follow up with participants during and/or after their redeployment was frequently described and was a barrier to participants unburdening themselves of the emotional impacts of redeployment. Participants seldom received any form of debrief with leaders on their redeployment experience. No one asked them or tried to understand what they went through. Frontline nursing perspectives provide valuable insight for leaders on frontline processes and provide better understanding of what support and resources are necessary for work efficiency (Boamah et al., 2017). Many participants were appreciative of this study and glad someone finally wanted to talk to them and listen to their story, with many expressing the study provided a sense of closure. This highlights the importance of thorough and timely follow up by leaders with nurses following redeployment. Participants felt there was a lack of care to

understand their experience or invest effort into improving redeployment through meaningful follow up.

Summary of Emotional Turmoil

Redeployment was an overall emotional experience for nurses, both positive and negative. Findings of this study highlight the importance of accounting for these emotions and approaching redeployment with care and empathy. Emotions extend past the ask and beyond the end of redeployment. Leaders play an important role in redeployment experiences and need to prioritize safeguarding emotional wellbeing of nurses that face the mass change event redeployment represents to improve nurse satisfaction with the experience.

Retention

Nurse retention is an ongoing concern for the healthcare system. This study provided evidence on the impact nurse redeployment has on nurse turnover and retention. Lack of transparency and/or ambiguity of redeployment timelines caused frustration and distress in many participants. There was no way out of redeployment through choice, return to the home unit was out of participant control. One participant experiencing negative physical and mental health affects required obtaining a medical note to ultimately exempt them from redeployment. Lengthy redeployment, unclear timelines, and stress of redeployment settings resulted in participants leaving for different positions and even early retirement. Intent to leave positions and/or nursing are also present in the literature on redeployment (Bogdán et al., 2024; Hartley et al., 2025; Robinson & Madge, 2024; Romero-García et al., 2022; Womack et al., 2024). Thus, it is imperative that leaders adopt strategies to better manage nurse redeployment to improve retention and reduce turnover.

Redeployments' impact on younger nurses and/or nurses newer to the profession was also apparent in this study. Consequences of the pandemic were so great for new nurses that it was noted that one left the redeployment setting, never to return, potentially leaving the profession entirely. Further, the assertion of participants that young nurses, or those newer to the profession, were becoming burned out through redeployment is concerning when considering nurse retention. Participants expressed that lower seniority was frequently a determinant for redeployment. Though there is minimal literature on redeployment of young/new nurses, it corroborates that young/new nurses were most frequently redeployed, leading to a sense of unfairness (Foster, 2022). Redeployment based on seniority does not account for the vulnerability of new nurses, who have not yet built up their skills and resilience as a healthcare professional, raising questions of safeguards for new nurses and retention. The evident gap in the literature on redeployments' impact on the vulnerable population of young/new nurses is concerning since retention of new nurses is paramount to addressing nursing shortages.

Limitations of the Study

There were several limitations of this study. First, this study was limited to a smaller sample size of 10 participants. Participants of the study may not be representative of all redeployed nurse experiences in Manitoba. Further, snowball sampling may have led to recruitment of nurses with similar redeployment experiences. Not all Manitoba healthcare regions and facilities were represented in the study. Experiences of redeployed nurses across the other regions and facilities may vary from those in this sample. Nurse redeployment is a phenomenon that occurred globally during the COVID-19 pandemic. Perceptions of nurse redeployment may vary on the global scale dependent on the redeployment practices and procedures utilized internationally.

Moreover, this study only explored the perspectives of nurses redeployed during the pandemic. Perspectives of leaders on redeployment were not explored. Leaders were also impacted by nurse redeployment. Leaders were required to redeploy nurses from their home units, the feelings and experiences of leaders who had these conversations are absent from this study but are important to understanding the perspectives of redeployed nurses and leaders regarding redeployment.

Implications for Nurse Leaders

There are several implications for nurse leaders identified by this study. The findings of this study emphasize the need for leaders to understand how important their relationships are with nurses in times of crisis, such as redeployment. Participants described how throughout their redeployment experience some leaders cared for their wellbeing while others seemingly did not. The amount of care leaders demonstrated for participants impacted their satisfaction and wellbeing. It was meaningful to participants when their home unit leaders stayed connected with them after they were redeployed. Similar to nurse colleagues, this continued relationship acted as a lifeline and demonstrated leaders cared, leading to participants feeling less isolated. Conversely, when leaders failed to maintain a relationship with participants post redeployment, they felt abandoned and forgotten. This is reflected by a study by Darchen et al. (2023) that found redeployed nurses perceived their leaders as indifferent when they failed to maintain contact. How leaders of the redeployment unit treated participants was also important. When leaders failed to welcome and acknowledge participants, they were viewed as rude and unwelcoming, leading to participants feeling a lack of gratitude and ignored. Nurses harbor greater trust of the organization when they have access to support through guidance and emotional support (De Almeida & Orgambidez, 2019). Fostering a supportive culture through

meaningful, active engagement and demonstrating empathy were important to participant satisfaction in this study. When leaders are perceived as supportive and encourage involvement of staff, the likelihood of nurses remaining with the organization increases (Laschinger et al., 2003).

Should a future need for nurse redeployment occur, follow up with redeployed nurses, both during and after their redeployment, is imperative to demonstrate empathy and a commitment to addressing concerns and affecting change. Asking redeployed nurses about their feelings and experiences with redeployment also fosters retention through meaningful engagement with the redeployed nurse and identification of areas for improvement. Though there is minimal literature on efficacy of follow up with nurse's post redeployment, Clements et al. (2021) found open communication forums post redeployment allowed nurses to reflect on their experiences and provided validation of their experiences, offering a sense of closure.

Unfortunately, leaders were reported as directly contributing to emotional distress by some participants. These leaders were described as apathetic, with minimal to no empathy for the participants. There was an evident *'go or I will make you'* attitude by some leaders, brooking no room for the participants feelings on the matter. Further, some leaders were distant or unresponsive, resulting in participants feeling they had no voice. Redeployed nurses feeling silenced arose in the literature, where nurses felt an inability or inherent consequence to speak up regarding their redeployment (Abrams et al., 2023; Ballantyne & Achour, 2023). This exemplifies the importance of leaders aiding redeployed nurses by being an approachable and compassionate source of support. It is important to consider that the chaos of the pandemic might also have impacted leaders negatively, without leader perspectives, it is unclear what barriers and emotional toll they were experiencing.

Relationships with leaders are foundational to redeployment experiences; failure to develop meaningful relationships led to participants feeling deserted by their leaders. Findings of this study indicated participants felt appreciated and supported by leaders, from their home and receiving unit, when they communicated with them and invested time building a rapport and relationship. Moving forward, in future crises that impact the healthcare system, it is important leaders do not lose their connection to frontline staff in the chaos, particularly with those redeployed.

Recommendations for Future Research

There is inadequate literature on nurse perceptions of redeployment. First, replications of this study using larger sample sizes and/or other nursing populations would provide further depth and understanding of nurse perceptions of redeployment and how structural empowerment can be leveraged by nurse leaders to improve satisfaction and retention.

Second, participants in this study had a minimum of 11 years of nursing experience. The vulnerability of young nurses and/or nurses newer to the profession was raised in this study. Future studies focusing on nurse redeployment experiences of Gen Z nurses are recommended to understand the impact of redeployment on nurses newer to the profession and unique considerations for supporting new generations of nurses.

Third, research on the impact of redeployment on retention would provide insight into the impact on the provincial health system. Investigating whether nurse redeployment directly impacted turnover, nurse retirement, and/or nurse leaving the profession could provide valuable insights to how redeployment relates to retention.

Fourth, redeployment was also impactful to nurse leaders. Participants in this study noted some leaders felt remorseful about having to redeploy nurses. Further, the ambiguity and chaos

of the pandemic led to variability in leader approaches to redeployment as leaders also faced uncertainty during the pandemic. Hartley et al. (2024) described managers felt trapped in the middle and insufficiently supported regarding redeployment of nurses, ultimately leading to difficulty managing redeployment and struggling emotionally. Further, though managers may be seen as a source of control, they often lack sufficient power and autonomy to affect change (Udod, 2017). Studies of leader experiences with redeployment are important to understand the perspective and emotional burden on leaders required to redeploy nurses.

Conclusion

There are limited studies on nurse experiences of redeployment during the COVID-19 pandemic. This study used Kanter's theoretical framework of structural empowerment to gather and analyze data on nurse perceptions of redeployment. Leader implications from this study will help inform strategies for future nurse redeployment. Strategies should focus on improving transparency and communication with redeployed nurses to reduce ambiguity. Redeployment is emotionally taxing. Leaders should focus on improving support through active engagement, visibility, compassion, and frequent follow up with redeployed nurses. Strong, positive relations between redeployed nurses and leaders are essential to improving redeployment experiences. Leaders should also safeguard nurse agency by prioritizing voluntary redeployment and nurse autonomy where possible. Lastly, generalization of nurses by leaders was a shortcoming in the findings. This study further demonstrates how the concept "a nurse, is a nurse, is a nurse" is outdated, derogatory, and diminishes the robust profession nursing has evolved to be. Leaders need to appreciate the unique knowledge, and skills nurses have cultivated over their career and avoid assumptions about transferability of nurses to different practice settings. Improved collaboration and understanding of redeployment experiences will mitigate the perceived

disconnect between leaders and nurses, fostering improved relationships, satisfaction, wellbeing, and retention.

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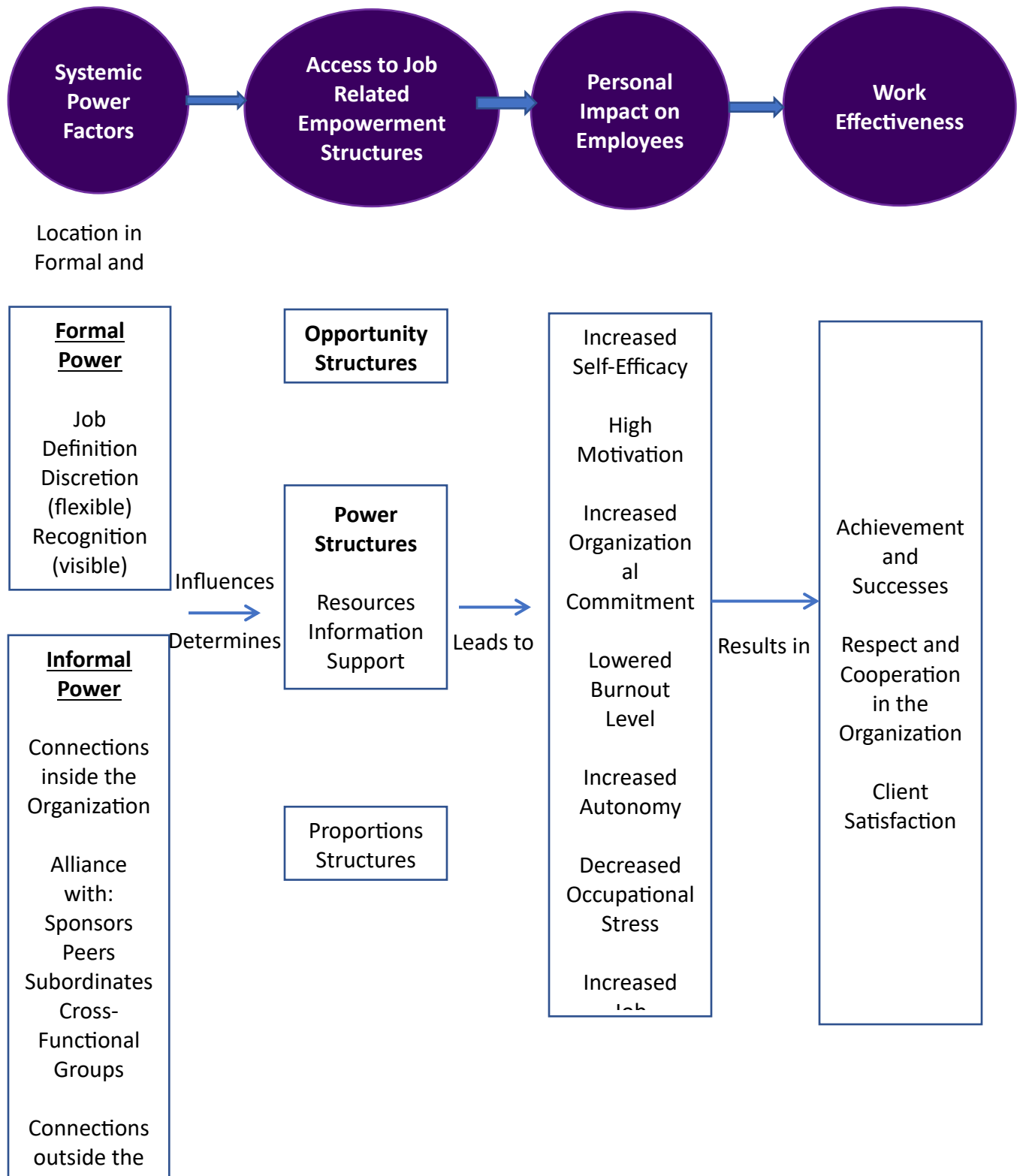
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Appendix A

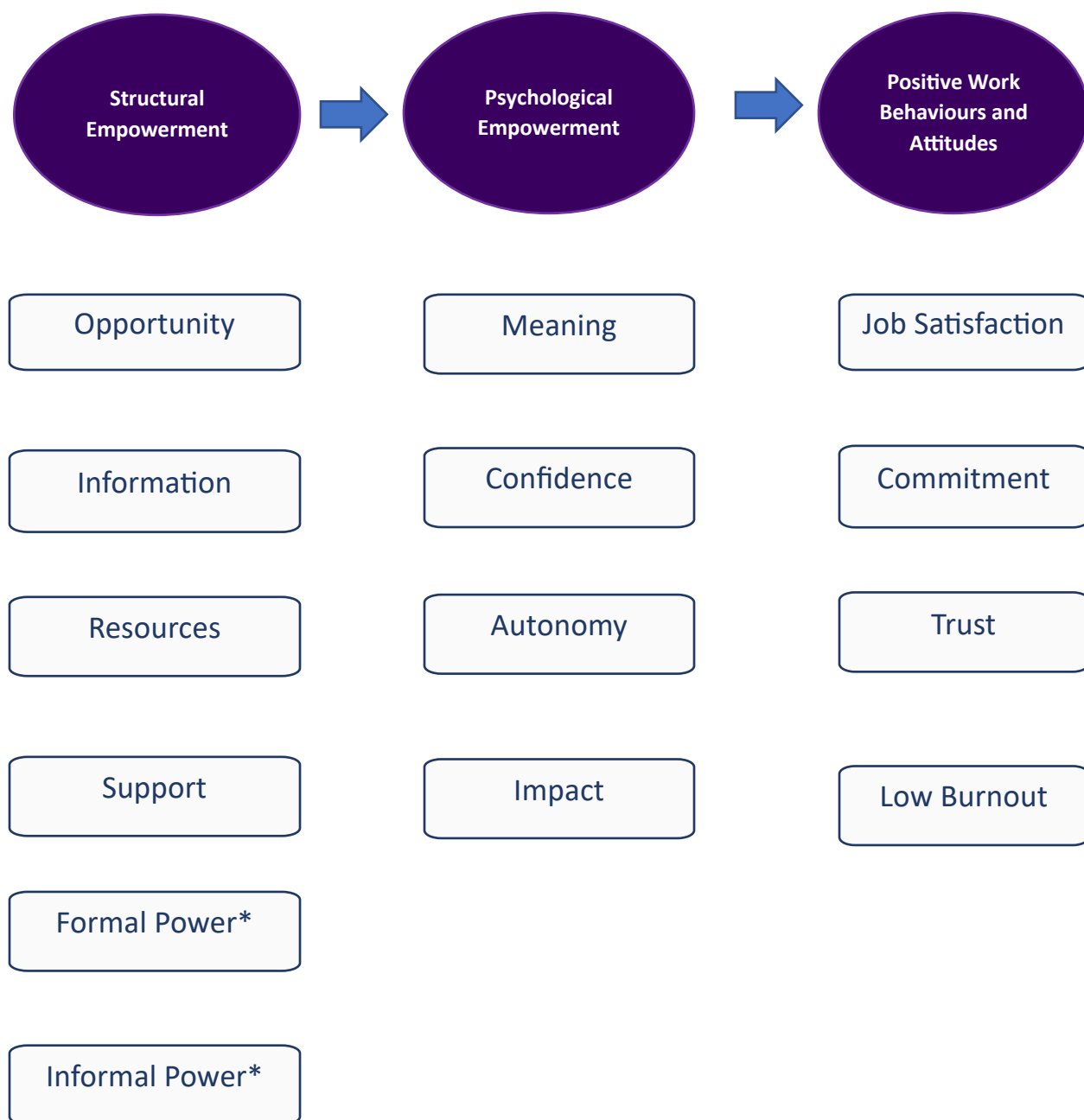
Relationship of Concepts in Rosabeth Kanter's (1979) Structural Theory of Power in Organizations (Laschinger, 2012)



Appendix B

THEORETICAL FRAMEWORK

Expanded Workplace Empowerment Model (Laschinger, Finegan, Shamian, & Wilk, 2001)
Retrieved from Laschinger (2012)



*Can be omitted

Appendix C

Personal Assumptions

1. Redeployment was a dramatic change for many nurses.
2. Many nurses did not have a background in the care area to which they were redeployed.
3. Access to resources for education and support were often inconsistent or varied.
4. Approaches by leaders for redeployment conversations with nurses varied and may not have always been perceived positively by nurses about to be redeployed.
5. Leaders' supports for redeployed nurses were often inconsistent and sometimes inadequate.
6. Timeliness and transparency of information before and during redeployment often fell short of nurses' expectations. Communication often occurred last minute and/or inquiries about redeployment went unanswered.
7. The perception of redeployment as a "good opportunity" to advance knowledge and skills was not a universal perspective for all nurses who were redeployed.

Appendix D

TCPS 2: CORE Certificate

PANEL ON RESEARCH ETHICS Navigating the ethics of human research		TCPS 2: CORE	
<i>Certificate of Completion</i> <i>This document certifies that</i> Charlene Ibbetson <i>has completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE)</i> Date of Issue: 21 November, 2020			

Appendix E

Privacy Training for Researchers Certificate

CERTIFICATE *of* COMPLETION

THIS ACKNOWLEDGES THAT

Charlene Braun

HAS SUCCESSFULLY COMPLETED THE

Privacy Training for Researchers

AND HAS BEEN AWARDED THE

UM Privacy Certificate of Completion

The person named on this certificate has successfully completed the UM Privacy Training for Researchers course.



Date Issued: Sunday, September 8, 2024

Expiry Date: Saturday, September 8, 2029

Issued by the Access and Privacy Office – February 2020



Appendix F

Participant Informed Consent Form

Study Title: A Nurse, is a Nurse, is a Nurse: A Qualitative Descriptive Study of Nurse Redeployment During the COVID-19 Pandemic

Student Principal Investigator: Charlene Braun, RN, BN, Master of Nursing student, College of Nursing, University of Manitoba, [REDACTED]

Student Advisor: Dr. Judith Scanlan, RN, PhD, FCNEI, Associate Professor, College of Nursing, Faculty of Health Sciences, University of Manitoba, [REDACTED]

Funder: Manitoba Centre for Nursing and Health Research (MCNHR)

Conflicts of Interest and Undue Influence: Charlene Braun does not have any conflicts of interest in this study.

You are being invited to participate in a research study. This consent form, a copy of which has been provided to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, feel free to ask any of the people named above. Please take the time to read this document and any accompanying information carefully. It is very important that you understand:

- what is being asked of you,
- what the risks and benefits of participation are, and
- how the information you provide will be used and stored.

Purpose of the Study:

I am doing this research study for a Master of Nursing thesis under the supervision of Dr. Judith Scanlan, RN, PhD. The purpose of this study is to understand redeployed Manitoba nurses' perspectives regarding redeployment, who were redeployed between 2020 and 2023 because of the COVID-19 pandemic. We believe that nurses' perspectives regarding redeployment will help inform nurse leaders about strategies to support redeployed nurses to promote nurse wellbeing and retention.

Study Procedures:

If you decide to take part in the study, you will be asked to perform the following activities:

1. Sign a copy of the Participant Informed Consent Form. A copy of your consent form will be stored in a secure location accessible only to the researcher. A copy of your consent form will be provided to you for your records.

2. Complete a demographic questionnaire that collects general information such as your age, gender, education, EFT, years employed as a nurse, and redeployment information. This questionnaire will be conducted as part of the 60-90 minute virtual interview.
3. Virtual Interview: We will meet for an interview through UM Zoom, where you will be asked about your experience with redeployment. The interview will be approximately 60 to 90 minutes long. The audio and video of our meeting will be recorded. This video recording will be backed up with a handheld recorder from MCNHR. The student principal investigator will be conducting the interview, an interview guide will be used to facilitate and structure the interview.
4. You have the option to consent to participate in a review of the study's findings, which will take approximately 20 minutes. This follow up interview will occur approximately within 3 months of the initial interview. Only 3 participants will be asked to participate in this review. If more than 3 participants provide consent for this follow up interview, the student principal investigator will contact you via email to set up a Zoom meeting for the review if you are one of the 3 selected, or to thank you for your interest in participating if you are not one of the 3 selected. These reviews will be recorded via UM Zoom. A summary of themes that emerged from the study will be shared with you to provide you the opportunity to ensure the themes are an accurate reflection of your perspectives.

Study Risks:

Minimal risk is posed to participants in this study. You will encounter no greater risks than in your daily life. Participation in this study is strictly voluntary with participants reserving the right to refuse to answer any question and/or voluntarily withdraw from the study at any time without penalty. Data from participants that voluntarily withdraw within 2 weeks after completing their interview will be destroyed and not appear in findings. This study will strictly maintain anonymity and confidentiality of all participants.

Study Benefits:

There are no direct benefits to you by participating in this study, but we will learn more about nurses' perspectives on redeployment so that we can better understand the impact redeployment has had on nurses and inform effective leader strategies for redeployment in future.

Compensation:

A \$50 Amazon gift card will be provided as a token of appreciation for your time and participation in the initial interview. An additional honorarium will not be provided for participation in the 20 minute follow up interview to review findings.

Use and Storage of Information:

All the information you provide as a participant in this study is confidential which means we as the research team must keep it safe. We will do our best, however, it is not possible to guarantee absolute confidentiality. We will only share your personal information if required (court order or law).

A code will be linked to your name. The only place your name and code will appear together are on the Consent Form and a file linking your name, code and contact information. This information will be kept in a password protected file separate from the research data you share with us. This file will be accessible only to the me as the principal investigator and my academic advisor Dr. Scanlan. Your name will not appear in report of the findings. When results of this study are shared, responses will be combined and presented in aggregate to remove potential identifying information. Direct quotes may be used to illustrate findings, identifiable features will not be included in quotes, participants will be referred to as a redeployed nurse (ex. Redeployed Nurse 1, Redeployed Nurse 2). No participant names will be used.

A UM-approved transcription service will be used to transcribe interviews and they will be required to sign an oath of confidentiality. Zoom recordings, transcripts, notes, and memos will be stored on a password protected file on UM One Drive, separate from the file containing identifying information. This file will be accessible only to me as the principal investigator and my academic advisor. The handheld recorder from MCNHR will be kept in a locked cabinet, accessible only to me as the principal investigator and my academic advisor, until the audiorecordings can be deleted. Audio-video and handheld recorder recordings will be destroyed within 1 year of completing the transcripts. Transcripts, notes, and memos will be maintained in the password protected files for up to 7 years (April 2032), after which it will be permanently deleted from the computer.

We may collect additional personal information from you to record giving you an honorarium. The researchers will keep this personal information separate from any research information. This personal information will be kept in a secure location for 7 years in case the University of Manitoba has to account for the money during a financial audit. Only I as the principal investigator and my academic advisor will see your personal information and/or responses. We will destroy any information that identifies you (name, contact information) by April 30, 2032. The rest of the information may be kept indefinitely.

Your research information may be shared outside of the University of Manitoba with researchers, other organizations, and/or made publicly available. The information is being shared for further analysis or testing, as part of the research study, and/or because it is required by a funder or journal. It will not include your name or any information that could identify you.

All the information you provide as part of this study is confidential. This means that only members of the research team will see your data. For safety, your information will be kept on a UM-approved secure platform.

Dissemination:

The study results will be shared through 1) the publication of a master's thesis; 2) journal publications and presentations in relevant academic fields; and/or 3) a summarized report of the study results to be sent to interested participants.

Withdrawing:

Your participation in this research study is voluntary. You can choose to answer only the activities and/or answer only the questions that you are comfortable with. You may withdraw from the study at any time for any reason. You do not have to explain why. You will not be penalized in any way. You will keep your honorarium. Should you withdraw partway through the study, all of your information will be destroyed if you withdraw within 2 weeks after completing your interview. After 2 weeks, the data provided will have been integrated into the study findings and will no longer be able to be removed from the study. To withdraw, please contact Charlene Braun at the following email

**Questions or Concerns:**

Designated University of Manitoba personnel may check that this study is being done safely and properly. To do this, they may visit the study site or review the research records. We will tell you if someone outside the research team will be there while you are participating. If this makes you uncomfortable, please tell a member of the research team, who will ask the personnel to return at another time.

This study has been reviewed and approved by a Research Ethics Board at the University of Manitoba. However, this does not mean that participation is risk-free. If you have questions about your rights as a research participant, you may contact the Office of Human Research Ethics at humanethics@umanitoba.ca or (204) 474-7122.

If you have any questions, concerns, or complaints about this study, you may contact any members of the research team listed on the first page or the Office of Human Research Ethics.

Consent:

By signing this document, I agree that:

- I have read the above information or had it read to me.
- I have had the opportunity to ask and have answered all of my questions.
- I understand what is being asked of me.
- I will be taking part in a research study.
- I may freely stop or leave the research study activities at any time.
- My information may be shared outside the University of Manitoba.

- I do not waive my legal rights by participating in the study.

Notice Regarding Collection, Use, and Disclosure of Personal Information

Your personal information is being collected under the authority of The University of Manitoba Act. The University of Manitoba is committed to preserving your right to privacy. The information you provide will be used by the University to support our research. Your personal information will not be used or disclosed for other purposes, unless permitted by The Freedom of Information and Protection of Privacy Act or The Personal Health Information Act. If you have any questions about the collection of personal information: Ph: 204-474-9462 or Email:

fippa@umanitoba.ca

I agree to participate in this study. ☐ YES ☐ NO

I agree to be audio-recorded in this study. ☐ YES ☐ NO

I agree to be video recorded in this study. ☐ YES ☐ NO

Do you consent to participating in a 20 minute follow up virtual interview for review of findings? ☐ YES ☐ NO

(If yes, please provide your Email Address: _____)

Name of Participant	Participant's Signature	Date
---------------------	-------------------------	------

Participant Code

Summary of Results:

Please provide an email address below if you would like to be sent a summary of the study results.

Email address: _____



Appendix G

Access Letter

Dear XXXX

I am a graduate student in the Master of Nursing program at the University of Manitoba. I am writing to request access to your organization to engage nursing participants in my research study "A Nurse, is a Nurse, is a Nurse: A qualitative descriptive study of nurse redeployment during the COVID-19 pandemic." The purpose of this exploratory descriptive study is to understand redeployed nurses' perspectives regarding the phenomenon of redeployment during the COVID-19 pandemic. Manitoba nurses' who were redeployed between 2020 and 2023 because of the COVID-19 pandemic will be invited to share their perceptions and experiences with redeployment. The goal of this study will be to develop strategies for nurse leaders to support redeployed nurses to optimize nurse wellbeing and retention based on study results.

I am seeking permission for a letter of invitation for participation in this study to be sent to registered nurses employed in your organization during the pandemic.

Participants will be asked to participate in a 60-90 minute interview, involving a demographic questionnaire and semi-structured interview, via the virtual platform, ZOOM. These sessions will be recorded and transcribed. Up to three participants will be invited to review summary of the findings for the purpose of validation. This review will be through a one-on-one virtual interview on ZOOM and will take approximately 20 minutes. Information collected during the interviews will be kept confidential and anonymous, and used for the sole purpose of research at the University of Manitoba, College of Nursing. Only the researcher will know the participants identity.

Minimal risk is posed to participants in this study and approval from the Research Ethics Board 1 (REB 1) was obtained prior to study engagement. This study is supervised by a thesis committee consisting of Dr. Judith Scanlan, College of Nursing, University of Manitoba (Thesis Chair and Advisor), Dr. Sonia Udod, College of Nursing, University of Manitoba (Internal Member), Sean MacDonald, Asper School of Business, University of Manitoba (External Member).

Thank you for your consideration of this research request. Please contact me if you have any further questions regarding this study. I look forward to your reply.

Charlene Braun, RN, BN
Graduate Nursing Student, Master of
Nursing Program
College of Nursing
University of Manitoba
Winnipeg, Manitoba
[Redacted]

Judith M. Scanlan , RN, PhD, FCNEI
Associate Professor
College of Nursing
Faculty of Health Sciences
[Redacted]



Appendix H

Access Letter MCNHR

Dear Donna Martin, RN, PhD (Nursing), FCAN
Associate Dean Graduate Programs
College of Nursing
89 Curry Place
Winnipeg, MB
R3T 2N2

I am a graduate student in the Master of Nursing program at the University of Manitoba. I am writing to request access to your organization to engage nursing participants in my research study “A Nurse, is a Nurse, is a Nurse: A qualitative descriptive study of nurse redeployment during the COVID-19 pandemic.” The purpose of this exploratory descriptive study is to understand redeployed nurses’ perspectives regarding the phenomenon of redeployment during the COVID-19 pandemic. Manitoba nurses’ who were redeployed between 2020 and 2023 because of the COVID-19 pandemic will be invited to share their perceptions and experiences with redeployment. The goal of this study will be to develop strategies for nurse leaders to support redeployed nurses to optimize nurse wellbeing and retention based on study results.

I am seeking permission for a letter of invitation for participation in this study to be sent to registered nurses admitted into the Master’s in Nursing program September 2022 or later.

Participants will be asked to participate in a 60-90 minute interview, involving a demographic questionnaire and semi-structured interview, via the virtual platform, ZOOM. These sessions will be recorded and transcribed. Up to three participants will be invited to review summary of the findings for the purpose of validation. This review will be through a one-on-one virtual interview on ZOOM and will take approximately 20 minutes. Information collected during the interviews will be kept confidential and anonymous, and used for the sole purpose of research at the University of Manitoba, College of Nursing. Only the researcher will know the participants identity.

Minimal risk is posed to participants in this study and approval from the Research Ethics Board 1 (REB 1) was obtained prior to study engagement. This study is supervised by a thesis committee consisting of Dr. Judith Scanlan, College of Nursing, University of Manitoba (Thesis Chair and Advisor), Dr. Sonia Udod, College of Nursing, University of Manitoba (Internal Member), Sean MacDonald, Asper School of Business, University of Manitoba (External Member).

Thank you for your consideration of this research request. Please contact me if you have any further questions regarding this study. I look forward to your reply.

Charlene Braun, RN, BN
Graduate Nursing Student, Master of Nursing Program
College of Nursing

University of Manitoba
Winnipeg, Manitoba


Judith M. Scanlan , RN, PhD, FCNEI
Associate Professor
College of Nursing
Faculty of Health Sciences




Appendix I

Letter of Invitation

Dear Nurse,

I am a graduate nursing student at the University of Manitoba. I would like to invite you to participate in my thesis study “A Nurse, is a Nurse, is a Nurse: A Qualitative Descriptive Study of Nurse Redeployment During the COVID-19 Pandemic.” The purpose of this exploratory descriptive study is to understand redeployed nurses’ perspectives regarding the phenomenon of redeployment during the COVID-19 pandemic as they are underreported in the literature. This study will gather information to better understand experiences of Manitoba nurses who were redeployed between 2020 and 2023 as a result of the COVID-19 pandemic to inform leaders’ strategies to support redeployed nurses to optimize nurse wellbeing and retention.

If you decide to participate in this study, you will be invited to participate in a 60-90 minute one-on-one interview via Zoom at a time convenient to you. This meeting will be recorded and transcribed. All information collected will be kept confidential, used only for the purpose of this research study at the University of Manitoba. You may be invited to a short review of findings, which will take approximately 20 minutes. If you consent to this review, the researcher will contact you via email.

Findings of this study will be used for completion of the Master of Nursing’s thesis requirements and will be further shared through peer reviewed publication or presentations at academic or professional platforms. This study may benefit nurses who are redeployed in future, and support satisfaction and confidence with the reality of redeployment.

Participants reserve the right to withdraw from the study at any time and/or refrain from answering any question they prefer not to answer with no negative repercussions. There are no monetary costs attributed to you for participating in this study. As a token of appreciation, you will receive a \$50 Amazon Gift Card for participating in this study.

This study has received approval from the Research Ethics Board 1 (REB 1) at the University of Manitoba.

If you are interested in participating in this study, please contact me at the email address below.

Charlene Braun, RN, BN
Graduate Nursing Student, Master of
Nursing Program
College of Nursing
University of Manitoba
Winnipeg, Manitoba
[Redacted]

Judith M. Scanlan , RN, PhD, FCNEI
Associate Professor
College of Nursing
Faculty of Health Sciences
[Redacted]

Appendix J

Demographic Questionnaire

Please fill in the fields for the following questions:

1. Please select your age category:

- ☐ 18-25
- ☐ 26-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ ≥ 61

2. Gender:

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Non Binary
- ☐ Prefer Not to Disclose

3. Highest education degree currently held.

- ☐ Registered Nurse, RN
- ☐ Baccalaureate of Nursing
- ☐ Master of Nursing
- ☐ Doctoral Degree – please specify
- ☐ _____ Other:

4. What was your EFT when you were redeployed?

- ☐ Part Time
- ☐ Full Time

5. During what year(s) were you redeployed? (Select all that apply)

- ☐ 2020
- ☐ 2021
- ☐ 2022
- ☐ 2023

6. How many years have you been employed as a nurse.

- ☐ 0-5
- ☐ 6-10
- ☐ 11-15
- ☐ 15-20
- ☐ 21-25
- ☐ 26-30
- ☐ ≥ 31

7. At the time of your redeployment, what care area were you working in?

- ☐ Surgery
- ☐ Operating Room
- ☐ PACU
- ☐ Day Surgery
- ☐ Medicine
- ☐ Emergency
- ☐ Outpatient
- ☐ Educator
- ☐ Advanced Practice Nurse (APN)
- ☐ _____ Other:

8. What Type of Clinical Setting were you Redeployed to?

- ☐ Critical Care
- ☐ Medicine
- ☐ COVID Unit
- ☐ _____ Other:

9. For how Long were you Redeployed?

- ☐ 6-12 weeks
- ☐ 13-24 weeks
- ☐ 25-36 weeks
- ☐ 37-48 weeks
- ☐ ≥ 49 weeks

Appendix K

Semi-Structured Interview Guide

Introduction: I want to explore nurse's perceptions of leadership throughout their redeployment experiences during the COVID-19 pandemic. The goal of this research study is to understand nurse's experiences of redeployment utilizing structural empowerment as a framework.

1. How would you describe your experience with your redeployment notification and/or conversation?
 - a. What was your perception of support during your initial redeployment conversation?
 - b. What was your perception of the level of information you received regarding your upcoming redeployment?
2. What was your experience with preparation and/or education for expected nurse duties prior to your redeployment?
 - a. How much time was devoted to redeployment preparation?
 - b. How do you feel about the time and strategies implemented for preparing nurses?
 - c. Can you describe how effective you found the preparation provided?
3. How would you describe your orientation to the unit at the beginning of your redeployment?
 - a. What was your perception of support?
 - b. What expectations were placed on you?
 - i. Can you describe your overall comfort with these expectations?
 - ii. What mechanisms were in place to support you to achieve these expectations?
4. How would you describe your experiences with your home unit leader while you were redeployed?
5. How would you describe your experiences with the leader of the unit to which you were redeployed?
6. What were your perceptions of executive leadership at the facility you were redeployed at with respect to redeployment?
7. Can you describe your experiences with communication regarding redeployment?
 - a. What forms of communication were used to discuss your redeployment status?
 - b. Describe your experiences with asking leaders questions regarding redeployment.
8. How would you describe your overall thoughts and feelings about your redeployed experiences?
9. Is there anything else about your redeployment experiences you would like to share with me?

Appendix L

Interview Question and Structural Empowerment Concept Cross Reference Chart Relation of Research Questions to Theoretical Framework

Questions ↓	Resources	Information	Support	Opportunity
1.		X	X	
2.	X	X	X	
3.	X		X	
4.			X	
5.			X	
6.			X	
7.		X		
8.				X
9.				X

Appendix M

Debriefing Form

Thank you for your participation in my thesis study, A Nurse, is a Nurse, is a Nurse: A Qualitative Descriptive Study of Nurse Redeployment During the COVID-19 Pandemic. Your participation has contributed to a better understanding of nurses' perceptions of redeployment. This can help inform leadership strategies to support nurses through future redeployments to improve nurse satisfaction and retention.

Should you find yourself upset or distressed after recounting your experience of redeployment, please see below for available support services.

Manitoba Blue Cross, Employee Assistance Program (EAP)

Manitoba Blue Cross Employee Assistance Program Page:

<https://www2.mb.bluecross.ca/plans/group-plans/employee-assistance-program>

Manitoba Blue Cross Wellness Platform:

<https://wellness.mb.bluecross.ca/>

EAP Contact Page:

<https://wellness.mb.bluecross.ca/contact-us>

Manitoba Blue Cross EAP Phone Number: (204)786-8880

Klinik Community Health

167 Sherbrook Street

Winnipeg, MB R3C 2B7

(204)784-4090

<https://klinik.mb.ca/>