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Høgskulen på Vestlandet

MASTEROPPGAVE

En kvalitativ studie som undersøker underliggende faktorer for turnoverintensjon blant sykepleiere (TIAN) under Covid- 19 pandemien

A qualitative study investigating the underlying factors for turnover intention among nurses (TIAN) during the COVID-19 pandemic

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Jeg bekrefter at arbeidet er selvstendig utarbeidet, og at referanser/kildehenvisninger til alle kilder som er brukt i arbeidet er oppgitt, *jf. Forskrift om studium og eksamen ved Høgskulen på Vestlandet, § 12-1.*

En kvalitativ studie som undersøker underliggende faktorer for turnoverintensjon blant sykepleiere (TIAN) under Covid- 19 pandemien

Forord

Bakgrunnen for denne masteroppgaven er studien Skiftarbeid, søvn og helse, SUrvey of Shift work, Sleep and Health (SUSSH), som startet i 2008/2009. Studien har årlig sendt ut spørreskjema til tilfeldig utvalgte sykepleiere med medlemskap i Norsk Sykepleierforbund (NSF). I spørreskjemaet for 2020 ble det implementert et kvalitativt spørsmål som omhandlet sykepleiernes underliggende faktorer til turnoverintensjon i forbindelse med Koronapandemien. Turnoverintensjon reflekterer en medarbeiders planer om å se seg om etter jobb et annet sted og har vist seg å være prediktor for faktisk turnover (Alfonso & Fred, 2004). Jeg synes dette er et svært interessant og spennende tema som jeg ønsket å utforske.

Koronapandemien brøt ut under min intensivsykepleierutdannelse, jeg fikk dermed kjenne på usikkerheten som var i sykehusets intensivavdelinger. Avdelingene fikk stadig informasjon om økte smittetall-, dødsfall og de ekstreme forholdene blant annet i Italia. Usikkerhet rundt hvor stort omfanget av pandemien kom til å bli her i Norge var til å føle på. Etter innføringen av strenge restriksjoner rådet det stor usikkerhet rundt tilgangen på- og bruken av smittevernutstyr. Det var mye frykt blant helsepersonell, noe jeg blant annet tror bunnet i manglende informasjon fra myndighetene, samt stadige endringer i gjeldende retningslinjer. Jeg syntes det har vært lærerikt og spennende å få gå i dybden på sykepleiernes egne opplevelser og erfaringer ved å stå i frontlinjeforsvaret under koronapandemien, og hvordan dette har ført til turnoverintensjon blant sykepleierne (TIAN).

Jeg vil gi en spesielt stor takk til veilederen min Kjersti Marie Blytt for god veiledning og konstruktive tilbakemeldinger gjennom hele prosessen. Jeg vil også benytte anledningen til å takke min mann Roger for muligheten og støtten du har gitt meg.

Bergen, mai 2021. Jeanette G. Edvardsen

Introduksjon til masteroppgaven

Masteroppgaven består av to deler; 1. del: kappe og 2. del: artikkelmanuskript. Kappen vil legge vekt på teoretiske og metodiske aspekter ved studien som jeg ikke har fått plass til å presentere eller diskutere i artikkelmanuskriptet. Kappen har fulgt den den opprinnelige emneplanen/vurderingsformen til MKS591 som lå ute når jeg startet på oppgaven. Altså med antall ord inntil 8500. Artikkelen har fulgt BMC Nursing sin forfatterveieledning.

Sammendrag

Bakgrunn: Covid- 19 har ført til økt arbeidsbelastning for flere sykepleiere. Denne studien ønsker å finne de underliggende faktorene for hva sykepleiere oppgir som mulige faktorer til at de vurderer å slutte i jobben sin når pandemien er over. **Metode:** Dette er en kvalitativ studie med en hermeneutisk tilnærming. Studien er en del av den pågående logitudinelle kohort-studien «Søvn Skiftarbeid og Helse (SUSSH)". Dataene er samlet inn i 2020 og inkluderer 98 deltagere. Analyseprosessen er utført med grunnlag i Braun og Clarkes' tematiske analyse. Dataprogrammet NVivo 1.3. er brukt i koding og analysering. **Resultat:** To hovedkategorier ble identifisert: psykologiske faktorer, og statlige og organisatoriske faktorer med åtte underliggende tema: (1) frykt i arbeidshverdagen, (2) en underliggende følelse av å være lite verdsatt, (3) inadekvat smittevern, (4) misnøye med lønnen, (5) arbeidsbelastning, (6) underbemanning, (7) upassende arbeidstid-, turnus- og arbeidssted, (8) misnøye med ledelsen. **Konklusjon:** Resultatet av studien viser at sykepleiere vurderer å slutte i yrket når Covid- 19 pandemien er over. Dette som følge av fysisk og psykisk påkjenning i tillegg til redusert jobbtilfredshet under pandemien. Vi ser at de underliggende faktorene til turnoverintensjon blant sykepleiere (TIAN) under Covid- 19 har høy grad av sammenheng til studier som ikke inkluderer Covid- 19 som en faktor. De underliggende faktorene som skiller seg ut fra tidligere studier uten Covid- 19 som faktor er frykt i arbeidshverdagen og inadekvat- og manglende trening i praktisk håndtering av personlig smittevernutstyr.

Nøkkelord: Tunoverintensjon, sykepleiere, Covid- 19

Abstract

Background: In light of the increased workload Covid- 19 has led to, this study seeks to find what are the underlying factors for turnover intention among nurses (TIAN) during the Corona virus outbreak. **Methods:** This is a qualitative study with a hermeneutic approach. Data were retrieved from the 2020 annual round from the ongoing longitudinal cohort-study "Survey of Shift work, Sleep and Health (SUSSH)" among Norwegian nurses. 98 participants were included. The analysis work was done on the basis of Braun and Clarkes' thematic analysis model. NVivo 1.3. was used to encode and analyze the data. **Results:** This study identified two main categories: Psychological factors, and governmental and organizational

factors, with eight underlying themes: (1) fear in everyday work, (2) an underlying feeling of being underappreciated, (3) inadequate protective equipment, (4) dissatisfaction with salary, (5) workload, (6) lack of staff, (7) inappropriate working time-, schedule- and workplace and (8) dissatisfaction with management. Conclusion: The result of this study showed that nurses consider leaving the profession when Covid- 19 is over as a result of physical and mental strain, as well as reduced job satisfaction during the Corona virus pandemic. We can see that underlying factors for turnover intention among nurses during Covid- 19 has a large degree of connection to other studies that not include Covid- 19 as a factor. The underlying factors that stand out from previous studies is fear in everyday work and inadequate- and lack of training in handling personal protective equipment.

Key words: Turnover intention, nurses, Covid- 19.

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1.0. Innledning

1.1 Bakgrunn for tema

Sykepleiere spiller en viktig rolle i helsesystemet da de utgjør så mye som 59% av verdens helsearbeidere (World Health Organization, 2020). I slutten av 2019 ble Covid- 19 påvist hos mennesker i Wuhan, Kina. Viruset spredte seg raskt og 11. mars 2020 erklærte WHO's leder utbruddet for en pandemi. Viruset smitter ved dråpe- og kontaktsmitte (Pascarella et al., 2020). Covid- 19 gir varierende symptomer som hodepine, tretthet, sår hals, hoste, svak dyspnoe, feber, konjunktivitt og gastrointestinale plager. Personer som blir alvorlig rammet kan få uttalte symptomer med komplikasjoner og multiorgansvikt som kan ende med dødelig utfall (Pascarella et al., 2020). Det finnes per nå kun symptomatisk behandling for viruset (Pascarella et al., 2020).

Under koronapandemien ble sykepleiernes vitale rolle tydeliggjort. World Health Organizations' (WHOs') ukentlige epidemiologiske oppdatering fra 19. januar 2021 hadde registrert 93 217 278 smittede- og 2 014 957 døde som følge av Covid- 19 (World Health Organization, 2021). Disse høye tallene førte til ekstrem mobilisering av sykepleierresurser, økt arbeidsbelastning og arbeidspress, både fysisk og psykisk. Sykepleierne var og er utsatt for mange yrkesmessige farer som bekymring for å bli smittet selv eller å smitte andre (Muller et al., 2020), (Qian et al., 2020).

Dagens mangel på sykepleiere vil gjøre det utfordrende å balansere fremtidig etterspørsel da andelen eldre over 80 år er økende, samt en generell høyere forventet levetid. På verdensbasis er det estimert en sykepleiermangel på omtrent 5,7 millioner innen år 2030 (World Health Organization, 2020). I Norge er det estimert en mangel på 26 000 sykepleiere i den kommunale helse- og omsorgssektoren innen 2035 (SSB, 2012 i Theie et al., 2018).

Turnoverintensjon kan beskrives som den ansattes intensjon om å finne ny jobb med en annen arbeidsgiver (Søbstad et al., 2020). Turnoverintensjon har negativ effekt på helsevesenet, personalet og pasientutfall (Labrague et al., 2020). Mangel på sykepleiere kan føre til redusert kvalitet i profesjonen (Theie et al., 2018), samt økt arbeidsbelastning for de

som er på jobb, hvilket igjen øker faren for tunoverintensjon. Et studie fra 2007 som inkluderte 3266 colombianske sykepleiere fant at omkring 13% av nyutdannede sykepleiere endret hovedjobb etter 1 år, og 37% hadde turnoverintensjon (Kovner et al., 2007). I 2016 hadde 10% av norske sykepleiere intensjon om å slutte i jobben og 18,3% vurderte å forlate arbeidsplassen (Leineweber et al., 2016). NOVA- rapporten som blant annet forsket på sykepleierbemanningen i norske sykehjem og i hjemmesykepleien, fant at hele 50% av sykepleierne ønsket å slutte- eller var usikker på om de ønsket å slutte i jobben (Gautun, 2020; Gautun et al., 2016).

Det er flere faktorer som spiller inn på hvorvidt en person vurderer å slutte i jobben sin eller ikke. Labrague et al. (2020) fant at hovedårsaken til faktisk turnover er jobbtilfredshet, psykisk stress og utbrenthet. Hovedfaktorene til TIAN er forstyrrelser i arbeidslivet, som eksponering for aggressive og krevende pasienter, trakassering fra pasienter/pårørende, kolleger og/eller sjefen (Deery et al., 2011; Søbstad et al., 2020), samt stor arbeidsbelastning som kan resultere i utbrenthet (Gautun et al., 2016; Hu et al., 2017; Moloney et al., 2018). Andre avgjørende faktorer til TIAN er blant annet: stress, jobbtilfredshet (De Simone et al., 2018; Labrague et al., 2018), tilstrekkelig lønn, skiftarbeid (Yoon, 2020), dårlig relasjoner til kollegaer, muligheten for karriereutvikling, lederstil og jobbautonomi (Gautun et al., 2016). Richer et al (2006) fant at jo mer en person tenker på å slutte i jobben, jo større sannsynlighet er det for at han faktisk slutter. Likevel tyder en tverrsnittstudie på at sammenhengen mellom turnoverintensjon og faktisk turnover på individnivå er relativ svak(Cohen et al., 2016).

Helsevesenet hadde manglende forberedelser for pandemien, både i forhold til bemanning, kompetanse og essensielt smittevernutstyr. Koronapandemien har påvirket helsearbeideres mentale helse, det er rapportert angst, depresjon, søvnproblemer og stress (Muller et al., 2020). Med bakgrunn i overstående vil jeg i denne studien undersøke underliggende faktorer for turnoverintensjon blant sykepleiere (TIAN) under Covid-19 pandemien.

1.2. Hensikten med studien og problemstilling

Hensikten med studien er å identifisere hva som er de underliggende faktorer for TIAN under Covid- 19 pandemien. Det er kjent at å jobbe som sykepleier kan være krevende. I 2009 fant studien «Hverdagsbeskrivelser fra norske sykehus», som er en del av et EU- finansiert internasjonalt prosjekt kalt «RN$_4$CAST: Nurse forecasting in Europe», at hele 25% av deltagerne hadde turnoverintensjon (Sjetne, 2011). Som nevnt i innledningen hadde 10% av norske sykepleiere turnoverintensjon og 18,3% vurderte å forlate arbeidsplassen sin i 2016 (Leineweber et al., 2016). Covid- 19 situasjonen har ført til økt fysisk og psykisk arbeidsbelastning for sykepleiere. Intensjonen med denne studien er å sette fokus på de underliggende faktorene som har ført til TIAN under Covid- 19 slik at det kan jobbes mer konkret for å bevare sykepleiere i jobben. Med bakgrunn i det overstående kom jeg frem til problemstillingen:

> *«What are the underlying factors for turnover intention among nurses (TIAN) during the Covid- 19- pandemic?"*
>
> *"Hva er de underliggende faktorer for turnoverintensjon blant sykepleiere (TIAN) under Covid- 19 pandemien?»*

2.0. Teoretisk rammeverk og begrepsavklaringer

I denne delen vil jeg gjøre rede for teoretiske referanserammer. Jeg vil også gi en beskrivelse av relevante begreper som er brukt i studien.

2.1. Turnoverintensjon

Det er ofte flere og gjerne sammensatte faktorer som leder til turnoverintensjon. Kuvaas og Dysvik (2020, s. 62) hevder at høy grad av indre motivasjon har stor betydning for organisasjonsforpliktelse. I indre motivasjon legger de belønninger som tilfredshet, glede eller mening knyttet til oppgavene som blir utført. Ansatte som opplever å ha jobbautonomi er mer tilfredse i jobben, med ledelsen, med kolleger, med lønnen og med muligheter for

avansement, vekst og utvikling (Kuvaas & Dysvik, 2020, s.70). Kuvaas og Dysvik påpeker at «jobbautonomi står i en særstilling når det gjelder å forklare indre motivasjon ...». Gjennom metaanalyser har Kuvaas og Dysvik (2020, s.53-58) redegjort for hva som får det beste ut av medarbeidere og ledere. De fant blant annet at indre motivasjon, jobbengasjement og mestringsorientering samt autonomi var av stor betydning. Organisatorisk støtte var også en viktig faktor. Forskning som Kuvaas og Dysvik (2020, s.219) viser til fant at jobbtilfredshet, ansatte som føler at organisasjonen behandler dem bra, er sterkt positivt relatert til for eksempel ekstrarolleatferd og negativt relatert til turnoverintensjon, faktisk turnover og stress (Meyer et al., 2002; Riketta, 2002). Turnoverintensjon er relatert til sosiodemografiske faktorer som alder, kjønn, sivil status, barn, utdanningsnivå, ansiennitet og stilling (Labrague et al., 2018; Yoon, 2020).

2.2. Stress og mestring

Stress er en naturlig del av menneskers liv. Dette fremkommer i utsagnet til Hans Selye «Totalt frihet fra stress er døden» (1978, s.32). I dagligtalen forbindes stress med noe negativt. Innen helsepsykologien skilles det mellom negativt stress, distress, og positivt stress, eustress. Distress kjennetegnes ved stress hvor man føler ubehag og ulyst (Renolen, 2008) og oppstår når individet mener at det ikke har tilstrekkelige ressurser til å møte utfordringen (Ursin & Zahl-Begnum, 1993, s.221). Langvarig negativt stress kan føre til sykdom. Faglitteraturen bruker ofte begrepene frykt, redsel, stress og angst om hverandre, følelsene fører til indre ubehag og uro som gir ubalanse i kropp og sinn (Normann-Eide, 2020, s.220). Frykten omfatter spesifikke adferdsmønstre som flukt. På den andre siden er redsel en følelse som omfatter hvordan vi tolker og oppfatter fysiske og psykiske signaler, den kan virke på ulike måter: kroppslig, mentalt, personlighetsmessig, relasjonelt og sosialt (Normann-Eide, 2020, s.220).

Arbeid utgjør en stor del av menneskers liv. Dersom personer mistrives i jobben over tid, vil det på sikt gå ut over helsen. Både for høye, men også for lave krav i jobben har sammenheng med negativt stress (Renolen, 2008). En studie (Theorell et al., 1990) som Renolen (2008) henviser til, fant at høye arbeidskrav kombinert med følelse av mestring ikke nødvendigvis fører til negativt stress. Motsetningen blir høye arbeidskrav hvor man ikke opplever kontroll,

noe som øker opplevelsen av negativt stress. En studie av Oksavik og Kirchhoff (2019) viser at moralsk stress er utbredt blant sykepleiere som jobber på sykehusavdelinger. Avdelingstilhørighet, manglende bemanning, antall pasienter og type vaktordning var kontekstuelle faktorer som førte til økt moralsk stress. Studien viste at alder, tidspress, utdanningsnivå og antall år i jobben var individuelle faktorer av mindre betydning for moralsk stress.

Langvarig negativt stress kan, som nevnt over, føre til sykdom men også utbrenthet eller «burnout». Stress er en individuell opplevelse, hvor mye stress vi tåler er også individuelt. «Utbrenthet er sett på som et produkt av samfunnet, arbeidsstrukturen og menneskelige relasjoner» (Renolen, 2008, s.141). Utbrenthet er velkjent innen helsevesenet som preges mye av krav og forventninger fra pasienter og pårørende, stort arbeidspress og tidsknapphet. Med denne kunnskapen i bunn ser man viktigheten av mestringsstrategier for å kunne forebygge negativt stress og utbrenthet slik at sykepleiere kan beholdes i yrket.

Lazarus og Folkman definerer mestring som «kognitive og atferdsmessige tiltak for å klare indre og ytre krav som overstiger personens ressurser» (Lazarus & Folkman, i Renolen, 2008, s.149). Det er viktig for sykepleiere å ha kunnskap om stressmestringsstrategier, både for å håndtere situasjoner på jobb, men også for å kunne anvende strategiene hos pasienter. Begrepet salutogenese handler om hva som gjør eller holder oss friske. Antonovskys salutogenesemodell går ut på hans teori om *opplevelse av sammenheng* (OAS) som består av begripelighet, håndterbarhet og meningsfullhet (Renolen, 2008, s.152). De tre faktorene virker sammen og påvirker hverandre. Motivasjonen til å finne ulike mestringsressurser øker ved høy meningsfullhet og begripelighet. Mestringsressurser kan være følgende moment: opplevelse av å ha oversikt og kontroll, egoidentitet, sosial støtte, materielle verdier, kultur, religion og verdier (Renolen, 2008, s.152).

2.3. Sykepleiefaglige utfordringer- mangel på helsepersonell

Mangel på helsepersonell har vært tema i flere år. I 2016 viste en vurdering av Samhandlingsreformen at over halvparten av norske kommuner hadde sykepleiermangel (EVASAM, 2016). NAVs bedriftsundersøkelse estimerte en mangel på 4500 sykepleiere og

1100 spesialsykepleiere i 2019 (Kalstø, 2019). Statistisk sentralbyrå (SSB) sine beregninger viser at det vil mangle 80 000 sykepleier-, helsefagarbeider- og jordmorsårsverk innen 2035 i forhold til det økende behovet. Helse- og omsorgssektoren i kommunene har i følge en rapport størst mangel på sykepleiere (Theie et al., 2018). Rapporten viser at sykepleiermangelen ble doblet fra 2015 til 2018. Det er klar sammenheng mellom antall pasienter per sykepleier på en vakt, og mengden arbeidsoppgaver som ikke blir gjennomført (Ball et al., 2014). Underbemanning fører også lettere til avvik i jobben som utføres, noe som kan få fatale konsekvenser. Det trengs tilstrekkelig med ressurser for å utføre en faglig forsvarlig pasientbehandling- og omsorg. Når avdelinger er underbemannet må færre hender utføre flere oppgaver – noe som tærer på kreftene til sykepleierne som er på jobb. Sykepleiere er en av yrkesgruppene med høyest sykefravær. I 2018 var sykefraværet blant sykepleier- og spesialsykepleiere på 8, 3 prosent i 4. kvartal (SSB, 2018).

2.4. Sykepleiefaglige retningslinjer

All sykepleie bygger på respekt for menneskers liv og verdighet. En sykepleier plikter å utføre jobben sin i tråd med yrkesetiske retningslinjer. Retningslinjene omhandler blant annet sykepleieren og profesjonen, herunder står det «sykepleieren har et personlig ansvar for at egen praksis er faglig, etisk og juridisk forsvarlig» (Norsk sykepleierforbund, 2019, punkt 1.3), videre står det at «sykepleieren erkjenner grensene for egen kompetanse, praktiserer innenfor disse og søker veiledning i vanskelige situasjoner» (Norsk sykepleierforbund, 2019, punkt 1.7).

2.5. Kommunikasjon

Kommunikasjon betyr «å gjøre felles» (Orvik, 2009, s.270). Når Covid- 19 kom var situasjonen uoversiktlig, det var viktig med klar og tydelig informasjon til folket, men også til kommuneoverleger, sykehusledere- og ansatte i helsesektoren. Dette var avgjørende for å redusere og forsøke å stoppe smitten. I januar 2021 slo kommuneoverleger i landet alarm om at kommunikasjonen fra regjerningen ikke var god nok (rbnett.no, 2021). Informasjonen ble gitt sent, i tillegg var den utydelig. Dette førte til at de som stod i frontlinjen, og skulle sette ord ut i handling måtte bruke tid på å tolke informasjon om smitteverntiltakene. Det er lett

for at informasjonen da blir tolket ulikt slik praksisen av retningslinjene blir ulik, og i verstefall feil. Klar og tydelig informasjon kan bidra til trygghet i en ellers utrygg situasjon.

3.0. Metode og data

Denne studien er en del av den pågående longitudinelle SUSSH- studien- Spørreundersøkelsen om skiftarbeid, søvn og helse hos sykepleiere. SUSSH- studien startet i 2008/2009 og har årlig, bortsett fra 2019, sendt ut spørreskjema til et utvalg av medlemmer i Norsk Sykepleierforbund (NSF). Hensikten med SUSSH- studien er å få kunnskap om hvordan arbeidsmiljøet påvirker norske sykepleieres helse og trivsel over tid. I den årlige runden for 2020 ble det lagt til et kvalitativt spørsmål som fokuserte på turnoverintensjon blant sykepleiere (TIAN) under koronapandemien.

3.1. Studiepopulasjon og utvalg

Spørreskjema ble sendt til 2964 deltagere. Spørsmålet *«Har koronapandemien ført til at du vurderer å slutte som sykepleier når krisen er over?»* hadde svaralternativene: 1: Ja, 2: Nei og 3: Vet ikke/usikker. Spørsmålet var en betinging for deltagelse i studien, det vil si at dersom man svarte ja ble deltageren inkludert i utvalget. Inkluderte deltagere måtte også svare på det kvalitative oppfølgingsspørsmålet; *«Hvis ja, vennligst beskriv hvorfor»*. Deltagere måtte være i jobb som sykepleier og ha en stilling på minimum 50%. Deltagelsen stilte ikke krav til type turnus og det var heller ikke krav til hvor deltagerne jobbet.

131 deltagere svarte på betingingen. 30 av disse hadde ikke TIAN, 3 hadde TIAN men svarte ikke på oppfølgingsspørsmålet, disse ble dermed ekskludert. Totalt 98 deltagere ble inkludert i studien. De kvalitative dataene som studeres fremkommer fra de 98 svarene på oppfølgingsspørsmålet. De som deltok var med i en trekning av 25 gavekort på 500 NOK.

3.2. Datainnsamling og analyse

Dataene ble innhentet fra 1. juni til 30. september 2020. Spørreskjemaet ble sendt per post med forhåndsbetalt konvorlutt, det var også mulig å svare via internett (SurveyXact på www.sussh.no). Det ble sendt ut to påminnelser. Alle deltagerne var anonyme.

Jeg brukte CAQDAS (Computer assisted qualitative data analysis software) NVivo 1.3. til koding og analysering av data. «Thematic analysis, step- by step guide» av Braun og Clarke (2006) er brukt i analysearbeidet (Drejer & Skjelstad, 2014; Juvik, 2018) for å sammenligne likheter og ulikheter mellom svarene (Polit & Beck, 2012, s.569). Analysemodellen er brukt veiledende og jeg har måttet hoppe litt frem og tilbake i trinnene gjennom oppgaven. Analysemodellen består av 6 faser; "Familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report"(Braun & Clarke, 2006). Tekstene ble oversatt til Engelsk i artikkelmanuskriptet.

1.fase: I første fase ble svarene manuelt transkribert fra papirformat til Word, deretter ble de importert til NVivo. I søken etter meninger og mønstre ble svarene lest gjennom flere ganger (Braun & Clarke, 2006) på den måten ble jeg kjent med- og kunne tilegne meg en tydeligere helhet av innholdet. Allerede under transkriberingen startet fortolkningsprosessen ved at jeg fikk innsikt i sykepleiernes opplevelser og erfaring som førte til TIAN.

2. fase: I andre fase ble interessante deler av dataene systematisk satt opp og samlet under relevante koder (tabell 3.2.1.). Svarene ble lest nøye gjennom på nytt for å se om de ble ilagt en annen mening. Dersom innholdet fikk en ny mening ble det lagt til en annen kode eller tatt bort.

Tabell 3.2.1. Eksempel på ekstraksjon av tekst til koding.

Data ekstraksjon	Kodet for
«Usikkerhet og følelse av å bli «kastet ut i det» dersom det skulle bli rød beredskap, at personlige hensyn ikke tas på alvor. Usikkerhet i forhold til viruset, dårlig opplæring i bruk av smittevernutstyr, redd for å bli smittet og smitte sårbare nære familiemedlemmer/relasjoner, dårlig	(1) Frykt (3) Smittevern (7) Arbeidstid-, turnus- og arbeidssted

smittevernutstyr på jobb (masker som ikke sitter godt på, (lite heldekkende utstyr), usikkerhet til hvor man blir plassert på jobb (omorganisering + andre avdelinger/pasientgrupper), Usikkerhet i forhold til mottak av pasienter, om de kan være smittsomme (ØH- pasienter) ...». (P02)	
«Intensivsykepleieryrket mitt utvaskes av «hurtiglærte» sykepleiere, vi (intensivsykepleiere) får flere «assistentoppgaver». Status/stolthet reduseres». (P03)	(2) Lite verdsatt
«Dårlig ivaretagelse av ansatte av ledelsen. Belastning på jobb, endring av arbeidsoppgaver og lite hørt av ledelsen.» P15	(5) Arbeidsbelastning (8) Ledelsen

3. fase: Gjennom tredje fase ble kodene samlet i potensielle tema ved å samle all relevant data for hvert tema (tabell 3.2.2).

4.fase: I fjerde fase sjekket jeg om temaene passet til de kodede utdragene og hele datasettet.

5.fase: I femte fase definerte og navngav jeg åtte følgende undertematema: (1) Frykt i arbeidshverdagen, (2) følelsen av å være lite verdsatt, (3) inadekvat smittevern, (4) lønn, (5) arbeidsbelastning (6) underbemanning, (7) skiftarbeid-, turnus- og arbeidssted, (8) misnøye med ledelsen (tabell 3.2.2).

Tabell 3.2.2. Oversikt over prosessen fra koding til tema:

Koder	Kategorier	Definerte og navngitte tema
Frykt	Psykologiske faktorer	Frykt i arbeidshverdagen
Verdi		Følelse av å være lite verdsatt
Smittevern	Organisatoriske faktorer	Inadekvat smittevernutstyr
Lønn		Misnøye med lønn
Arbeidsbelastning		Økt arbeidsbelastning
Underbemanning		Underbemanning
Upassende arbeidstid- turnus- og arbeidssted		Upassende skiftarbeid- turnus- og arbeidssted
Ledelse		Misnøye med ledelsen

Denne studien har et kvalitativt design da hensikten med masteroppgaven er å finne underliggende faktorer til TIAN under Covid- 19. Kvalitativ forskning har som formål å få frem

dybdekunnskap og helhetlig forståelse (Thornquist, 2018, s.236). Studien bruker en hermeneutisk tilnærming for å beskrive og fortolke sykepleiernes personlige opplevelse av hva som er faktorene til TIAN under Covid-19. Hvordan man tolker en tekst varierer ut ifra hvilken forforståelse man innehar. Den tyske filosofen Hans Georg Gadamer hevder at når en forsker skal tolke en tekst kan han ikke skille seg fra betydningen av teksten, men en må streve for å forstå mulighetene som teksten kan avsløre (Polit & Beck, 2012, s. 568).

3.3. Hermeneutikk

Med utgangspunkt i problemstillingen har studien en hermeneutisk tilnærming. Hermeneutikk er en vitenskapsteoretisk retning som er knyttet til fortolkningslære og fortolkningskunst (Thornquist, 2018, s.167). Studien ønsker å få frem data om personlige opplevelser og erfaringer som leder til at sykepleiere vurderer å slutte i yrket sitt. Med dette fokuseres det på hvordan deltagerne, som sosiale og historiske betingede individer, tolker sin verden innenfor deres gitte kontekst (Polit & Beck, 2012, s.490). Hermeneutikken gir oss innsikt i å forstå hvordan vi forstår og dermed forstå helheten ut fra delene og delene ut fra helheten. Det er viktig at man er tro mot teksten til tross for at man selv har med seg bagasje og egne opplevelser. Jeg har i flere år jobbet på en infeksjonsavdeling og har erfaring med bruk av personlig smittevernutstyr i møte med pasienter som har smittsomme sykdommer. Under min intensivsykepleierutdanning var jeg med på mottak- og behandling av kritisk syke Covid- 19 pasienter. Første gang jeg deltok i mottak av en kritisk syk Covid- 19 pasient som skulle intuberes fikk jeg kjenne på usikkerheten selv. Jeg gjenkjenner flere av faktorene til TIAN som deltagerne i studien beskriver. Mine opplevelser kan farge min forståelse av dataene, men det er viktig at deltagernes svar får komme frem i sin helhet. Jeg har, ved å jobbe med dataene, utvidet min kunnskapshorisont. Hermeneutikk kan forstås med «å finne meningen i de skrevne ord» og som «tolking av tekst» (Byrne, 2001). Teksten i denne studien, er blitt fortolket gjennom Braun og Clarke (2006) sin tematiske analysemodell. Gadamer hevdet at en sak kommer til ordet gjennom tekst (2010, s.428) slik som saken i studien kommer frem i resultatdelen gjennom den fortolkede teksten.

4.0. Etiske vurderinger

Studien er godkjent av Regional etisk komité (REK.nr. 088.08). Det foreligger også konsesjon fra Norsk samfunnsvitenskapelig datatjeneste (NSD). Hver deltager gav skriftlig samtykke til deltagelse i studien (spørreskjema-SUSSH, 2020 vedlegg1). Deltagerne har blitt informert om at de når som helst kan trekke seg fra studien.

5.0. Resultat

Studien beskriver sykepleiere sine personlige opplevelser og erfaringer under koronapandemien som leder til deres vurdering om å slutte i yrket når pandemien er over. 98 deltagere er inkludert.

Ved å anvende Braun og Clarke (2006) sin tematiske analysemodell og gjennom hermeneutisk tilnærming ble resultatet to hovedkategorier; psykologiske faktorer og statlige og organisatoriske faktorer med åtte undertema: (1) Frykt i arbeidshverdagen, (2) følelse av å være lite verdsatt (3) inadekvat smittevern, (4) misnøye med lønn, (5) arbeidsbelastning, (6) underbemanning, (7) upassende arbeidstid-, turnus- og arbeidssted og (8) misnøye med ledelsen.

5.1. Psykologiske faktorer

5.1.1. Frykt i arbeidshverdagen

Flere av sykepleierne beskrev frykt som underliggende faktor til at de vurderer å slutte i jobben sin. Frykt kan kobles til usikkerhet og uforutsigbarhet, den kan virke skjerpende, men den kan også være destruktiv ved stort arbeidspress og høyt tempo (Orvik, 2009, s.227). Mye av frykten som deltagerne bar på bunnet i det ukjente rundt pandemien, blant annet bekymring for å bli smittet, og å smitte pasienter og familie. Sykepleiere beskrev faktorene som førte til TIAN slik:

«Risiko for å ta med smitte fra arbeidsplassen og hjem. Økt risiko for å bli smittet selv» (P74)

«Mentalt utfordrende med tanke på smittefare. Ikke redd for å bli smittet selv, men smitte noen som blir veldig syke». (P10)

Sykepleierne som jobbet i frontlinjen måtte gå på jobb til tross for frykt for egen helse. En sykepleier beskrev det slik:

«Da det kom/stod på som verst, tenkte jeg en periode at å jobbe som sykepleier er for risikofylt da jeg selv er i en sårbar gruppe. Når andre kunne skjerme seg hjemme, måtte jeg møte på jobb og omgås mennesker- som førte til økt risiko. Det var skummelt». (P29)

I forbindelse med Covid- 19 ble det gjort flere omorganiseringer i organisasjonene For å tilrettelegge for nye koronarelaterte oppgaver ble arbeidsoppgavene omfordelt. Dette førte til at flere sykepleiere og spesialsykepleiere konstant gikk rundt med frykt for å plutselig bli overflyttet til en ukjent avdeling hvor han/hun ikke følte seg kompetent. De beskrev frykten for å møte på jobb uten å vite hvilken avdeling eller pasientgruppe de skulle jobbe med slik:

«Usikkerheten og følelsen av å bli «kastet ut i det» ... Usikkerhet til hvor man blir plassert på jobb ... Usikkerhet i forhold til mottak av pasienter, om de kan være smittsomme (ØH- pasienter) ...» (P02)

Det etiske aspektet ligger til grunn i all sykepleie. Det ble rapportert om travle avdelinger med stor arbeidsbelastning og tidspress hvor sykepleierne ikke hadde mulighet til å fullføre arbeidsoppgavene. Frykt for å ikke kunne fullføre oppgavene ble pekt på som en underliggende faktor for TIAN under koronapandemien.

«Pandemien krever penger og fører til reduksjon i bemanningen, men arbeidsoppgavene er de samme, dette regnestykket går ikke opp. Man gruer seg til å gå på jobb. Slik skal det ikke være!!!» (P33)

En sykepleier beskrev den avgjørende faktoren for TIAN slik:

«Jeg er usikker på om det å jobbe som sykepleier er verdt alle bekymringene.» (P75)

5.1.2. Følelse av å være lite verdsatt

Alle mennesker har et behov for å bli sett. Flere sykepleiere i studien hadde en følelse av å «å bli brukt» (P20) i koronatiden, blant annet som følge av pålagte turnuser-, endrede ferier-,

hyppigere ekstravakter og nye og flere arbeidsoppgaver uten noen form for kompensasjon. Sykepleierne følte at de «ble behandlet som brikker i et spill. ...» (P22) og at «jobben ble sett på som dugnad ...» (P51). Flere påpekte at de ikke fikk lønn som stod i forhold til jobben de gjør og det ansvaret det er å jobbe med kritisk- og akutt syke mennesker døgnet rundt, i tillegg til risikoen de satte seg selv- og sine nærmeste i ved å gå på jobb. Lav grad av autonomi og «ingen medbestemmelser ...» (P20) i arbeidshverdagen bidro til at sykepleiere vurderer å slutte i jobben sin. En sykepleier svarte at: «Vi blir ikke regnet som viktige med tanke på smittefare, lønn, risikotillegg, vi blir pålagt oppgaver og flyttet rundt.» (P61)

Noen intensivsykepleiere begrunnet TIAN med en følelse av at profesjonen «viskes ut» med annet personale som ikke har intensivsykepleierkompetanse. De påpeker også at jobben i intensivavdelingene er tyngre enn vanlig, spesielt i koronaperioden, men at det ikke tas hensyn til. Intensivsykepleiere beskrev faktorer til TIAN som følger:

> «Fordi rettigheter som sykepleier blir ikke tatt hensyn til, det tas ikke hensyn til at jobben på intensivavdelingen er tyngre enn vanlig.» (P97)
>
> «Intensivsykepleieryrket mitt vaskes ut av «hurtiglærte» sykepleiere, vi intensivsykepleiere får flere «assistentoppgaver». Status/stolthet reduseres.» (P03)
>
> «... Lite verdsetting av intensivsykepleierkompetanse.» (P24)

5.2. Statlige og organisatoriske faktorer

5.2.1. Inadekvat smittevern

Koronapandemien spredte seg raskt noe som resulterte i akutt behov for enorme mengder smittevernutstyr verden over. Etterspørselen på utstyr overskred beholdningen, noe som førte til mangel flere steder (Larsen et al., 2020). Sykepleiere er utsatt for yrkesmessige farer på jobb. Når man ikke føler seg trygg på jobb øker det psykiske stresset betydelig.

> «Svært mye stress knyttet til tilgjengelighet på smitteutstyr». (P90)
>
> «Lite smitteutstyr, vi måtte til og med gjenbruke engangs- smitteutstyr! Det føles ikke trygt for meg eller familien min.» (P91)

Noen sykepleiere var bekymret i forhold til dårlige forberedelser og opplæring i praktisk håndtering av smittevernutstyret.

> «... dårlig opplæring i bruk av smittevernutstyr» (P02)
>
> «... opplever å ikke bli tatt på alvor i forhold til smittevern.» (P11)
>
> «Store forskjeller på kommunalt ansatt og sykepleier på sykehus.. angående opplæring og bruk av smitteutstyr. ...» (P39)

5.2.2. Lønn

Lav lønn ble identifisert som en faktor til hvorfor sykepleierne vurderte å slutte i jobben sin når krisen er over. Gjentatte ganger ble det påpekt at de ikke fikk lønnskompensasjon for risikofaktorene, her smitten, de ble utsatt for. Mange hevdet at de gjorde en viktig jobb, men følte ikke at de fikk den lønnen som de fortjente.

> «... Vi får ikke lønn som fortjent.» (P83)

Deltagerne belyste også at de synes ansvarsområdet og arbeidspresset var for høyt i relasjon til lønnen.

> «... dårlig lønn i forhold til ansvar og arbeidspress.» (P86)
>
> «Mange krav og pålegg, ingen kompensasjon i forhold til lønn eller fritid.» (P16)
>
> «... Har ikke risikotillegg.» (P09)

5.2.3. Økt arbeidsbelastning

En av fem sykepleiere rapporterte stor eller svært stor arbeidsbelastning under pandemien (Melby et al., 2020). Høye smittetall øker arbeidsbelastningen, men rapporten viste ikke store forskjeller på arbeidsbelastningen hos kommuner med høy- eller lav smitte. Sykepleierne brukte mye tid på av/påkledning og desinfisering av utstyr og overflater. Personell ble også plukket ut til koronaprøvetaking. For noen førte dette til nye arbeidsoppgaver, samtidig som det for andre kunne føre til økt belastning på grunn av manglende personell. En sykepleier i denne studien sa følgende:

> «Sliten fordi jobben gjør at jeg ikke klarer å være den personen jeg vil på fritiden min, det går ut over barn, samboer og øvrig familie. Jeg føler at jeg konstant ikke strekker til på noen arena.» (P78)

Andre sykepleiere vurderer å slutte som sykepleier når pandemien er over

> «På grunn av arbeidsbelastning og utbrenthet.» (P50)
>
> «En bekreftelse på at belastningen man påføres i helsevesenet, og til vanlig, ikke er noe jeg orker på lang sikt». (P32)
>
> «Høyt arbeidspress over tid.» (P32)
>
> «Har allerede sagt opp min stilling som spesialsykepleier blant annet på grunn av økt arbeidsbelastning på en avdeling med lav grunnbemanning.» (P53)
>
> «... så stort arbeidspress på jobb at det går utover min egen helse (stress, sliten) til vanlig, nå under pandemien- enda verre.» (P84)
>
> «Krevende å jobbe med smittepasienter over tid, med lite pauser til å kunne drikke og spise etc.» (P82)

5.2.4. Underbemanning

Deltagere i studien forteller om mangel på sykepleiere og hvordan det har medført økte krav og økt psykisk stress i arbeidshverdagen. Oppgavene er de samme men fordelt på færre hender- dermed blir sykepleiernes grunnleggende fysiologiske behov som sult, tørste og toalettbesøk ofte nedprioritert. Resultatene viser at det er utfordrende å arbeide under slikt press over tid, noe som kan øke. Deltagerne i denne studien bekreftet dette.

> «Har allerede sagt opp min stilling som spesialsykepleier, delvis relatert til økt arbeidsmengde i en avdeling med lav grunnbemanning.» (P53)
>
> «Det er rett og slett for dårlig bemanning. Har ikke tid til å tisse før skiftet er over. På grunn av helsen min ønsker jeg å omskolere meg. Vil stå i jobb i mange flere år. Jeg vil nå utdanne meg til lærer.» (P30)

Lav bemanning gir også flere etiske dilemma:

> «Lav bemanning, økte arbeidsmengder, man rekker ikke å få jobben gjort slik man føler den burde gjøres.» (P41)

5.2.5. Arbeidstid-, turnus og arbeidssted

Upassende arbeidstid- og turnus var en felles faktor for TIAN i flere av sykepleiernes svar. Det er ikke overraskende at det har vært en økning i upassende skift og endring av turnuser under

pandemien, flere fikk endret turnusene til en såkalt «koronaturnus». En rapport av SINTEF viser at nesten halvparten av sykepleierne fikk endret turnus som følge av pandemien (Melby et al., 2020). For en sykepleier var faktoren til TIAN «Trusler om nød- turnus ...» (P25). Flere sykepleiere ble omplassert på kort varsel, det medførte «usikkerhet til hvor man blir plassert på jobb (omorganisering, andre avdelinger og ukjente pasientgrupper)» (P02). Endringer kan føre til at ansatte føler seg utilstrekkelig og mindre kompetent.

Flere sykepleiere i studien relaterte arbeidstid-, turnus- og arbeidssted som avgjørende faktor til TIAN. De trakk frem følgende i svarene:

> «Har arbeidet i pandemiturnus i to måneder, uten kompensasjon.» (P66)
>
> «Lange skift ...» (P64)
>
> «Upassende arbeidstid.» (P51)
>
> «Fordi en må endre arbeidstid på kort varsel ...» (P46)
>
> «I forhold til familiesituasjonen ble det veldig krevende med endring av arbeidstider på kort varsel og veldig sen utlevering av turnus.» (P43)
>
> "Liten grad av selvbestemmelse relater til arbeidstid, fritid og ferier.» (P42)
>
> «Døgnrytmen, hjemmeskole- og hjemme- barnehage. En har til tider gått døgnet rundt:» (P92)
>
> «Mye ekstra jobb, lite igjen annet enn god- ord.» (P85)

5.2.6. Ledelsen

Til tross for at man så Covid- 19 pandemiens raske utvikling i Kina, og hvordan viruset spredte seg til andre land, var det Norske samfunnet og helsevesenet her i liten grad forberedt på pandemien. Sykehusene manglet plass, utstyr og personale (Melby et al., 2020). Sykepleierne i denne studien opplevde ikke ledelsen som forberedt og klar til å ta utfordringene som pandemien medførte. Flere sykepleiere beskrev underliggende faktor til TIAN slik:

> «Uorganisert ledelse.» (P86)
>
> «Dårlig ivaretagelse av ansatte av ledelsen. ... lite hørt av ledelsen.» (P15)
>
> «På grunn av uklar/fraværende ledelse, hyppig endrende håndtering av pandemien. Uklare retningslinjer osv.» (P67)

Det er regjeringen som avgjør hvilke smitteverntiltak og restriksjoner som er gjeldene til enhver tid. Retningslinjene har vært mange og de har hyppig blitt endret på. For noen sykepleiere har håndteringen av krisen ført til at de vurderer å slutte i jobben sin. De begrunner TIAN med:

> «Elendig håndtering av krisen.» (P04)
>
> «Ingen planer for beredskap før pandemien traff oss.» (P01)

Økonomi spiller også en stor rolle oppi det hele. Covid- 19 skapte et enormt behov for ressurser. I en allerede presset arbeidssituasjon, med flere arbeidsoppgaver og behov for flere kvalifiserte sykepleiere, vurderer en sykepleier å slutte i jobben sin på grunn av

> «... ledere som får beskjed om å redusere på arbeidstakere. ...» (P22)

6.0. Diskusjon

6.1. Resultatdiskusjon

Etter min kunnskap er dette en av de første kvalitative studiene som fokuserer på underliggende faktorer til TIAN i Norge under Covid- 19 pandemien. Studien identifiserer åtte underliggende faktorer for TIAN under Covid- 19 pandemien, disse er: frykt i arbeidshverdagen, følelsen av å være lite verdsatt, inadekvat smittevern, misnøye med lønn, arbeidsbelastning, underbemanning, upassende arbeidstid-, turnus- og arbeidssted og misnøye med ledelsen. Resultatene fra studien har stor grad av sammenheng til studier med faktorer til TIAN uten Covid- 19 som faktor (De Simone et al., 2018; Hu et al., 2017; Labrague et al., 2018; Moloney et al., 2018; Søbstad et al., 2020; Yoon, 2020). Disse studiene har blant annet identifisert sosiodemografiske faktorer, jobbtilfredshet, jobbstress, mobbing på arbeidsplassen, arbeidsbelastning, utbrenthet og forstyrrelser i arbeidslivet som faktorer til TIAN.

De underliggende faktorene til TIAN i denne studien, som skiller seg ut fra tidligere studier på feltet hvor Covid- 19 ikke var en faktor er: frykt i arbeidshverdagen og inadekvat smittevern. Frykt er fremtredende hos flere av sykepleierne noe som kan sees i sammenheng med pandemiens omfang og manglende forberedelse (Melby et al., 2020). Rapporten til SINTEF

bekrefter at over halvparten av sykepleierne i stor eller svært stor grad fryktet å smitte andre uten at de selv visste at de var smittet (Melby et al., 2020). Restriksjonene om sosial distansering kan også ha hatt en påvirkning da mange sykepleiere isolerte seg hjemme i frykt for smitte og å smitte andre. Minimal sosial kontakt har ført til negative psykiske konsekvenser for en av ti sykepleiere og to av ti under 29 år (Melby et al., 2020).

For mange opplevdes jobbhverdagen under Covid- 19 som utrygg. Jobbhverdagen skapte stress da sykepleieren ikke følte de hadde tilstrekkelige ressurser for å imøtekomme utfordringene. Manglende smitteutstyr-, opplæring og trening i praktisk bruk skapte frykt. Sykepleiere har blant annet ansvar for akutte- og kritisk syke koronapasienter i isolasjon som trenger behandling og overvåking hele døgnet. For å stå i en slik jobb kreves det tilstrekkelig smittevernutstyr samt kunnskap om bruken og behandling for å føle seg trygg. I følge yrkesetiske retningslinjer for sykepleiere har sykepleieren personlig ansvar for at jobben utføres på en trygg og forsvarlig måte, samtidig skal man erkjenne grensen for egen kompetanse og søke veiledning i vanskelige situasjoner (Norsk sykepleierforbund, 2019, punkt 1.3 og 1.7). Dette kan i seg selv være utfordrende i en travel arbeidshverdag preget av underbemanning og flere nye arbeidsoppgaver. Moralsk stress kan øke dersom man opplever å ikke få utført oppgavene slik man føler de burde utføres. Tidspress kan resultere i mangel på kontroll og følgelig gå ut over pasientsikkerheten På den andre siden kan sykepleieren oppleve det positivt dersom man føler at den nye jobbhverdagen er meningsfull og håndterbar, en slik opplevelse vil gi mestringsfølelse og dermed bidra til å redusere turnoverintensjon (Renolen, 2008, s. 152). Med tanke på den økte arbeidsbelastningen Covid-19 har medført, ble jobbautonomien redusert for flere sykepleiere. Dette som følge av stadige omorganiseringer, pålagte vakter og hyppig endrede skift. Flere deltagere i undersøkelsen påpekte at redusert autonomi førte til mistrivsel i jobben, misnøye med lederen/ledelsen og lønnen som faktorer for intensjonen om å slutte i jobben.

Den økte arbeidsbelastning førte til at mange sykepleiere tok mye ansvar og jobbet flere- og lengre vakter enn vanlig, dermed ble flere utslitt. Melby et al. (2020) fant at seks prosent av sykepleierne i SINTEF- rapporten vurderte å slutte i yrket når pandemien er over. Pandemiens strenge restriksjoner har i tillegg rammet flere sykepleieres hjemmesituasjon på ulike måter og kan ha påvirket sykepleiernes overskudd på jobb. Redusert jobbtilfredshet har vist sterk

effekt på TIAN (De Simone et al., 2018). Denne studien viser misnøye med ledelsen blant annet i form av kommunikasjon, derimot fant en studie av SINTEF (Melby et al., 2020), utført i deler av samme tidsrom, at nesten to av tre sykepleiere syntes at ledelsen klarte å kommunisere endringer i rutiner etterhvert som de ble innført.

Faktorene som leder til TIAN under Covid- 19 er som beskrevet svært sammensatte. Hvor fremtredende de ulike underliggende faktorene er varierer nok avhengig av hvor deltagerne jobber. Resultatene peker også på at deltagerne opplevde ulik tilgang på smitteutstyr samt ulik grad av opplæring ut fra hvor de jobbet. Ulikheter i lønn, statlig og kommunalt, ble også nevnt. Det var også store ulikheter i hvor hardt befolkningen og personalet i de ulike kommunen, sykehusene og avdelingene ble rammet av smitte fra viruset. For enkelte førte situasjonen til ekstra høy arbeidsbelastning og mangel på personale som følge av at flere i samme personalgruppe måtte i isolasjon og karantene samtidig.

Hvorfor Covid-19 har ledet til turnoverintensjon for noen sykepleiere og ikke andre kan studien ikke med sikkerhet svare på. Hvorvidt man håndterer stress og utfordringer er ulikt. På samme måte er det ulikt hvorvidt man opplever mestring. Dersom sykepleierne opplevelser kontroll, og at arbeidet er meningsfullt til tross for høy arbeidsbelastning og ukjente oppgaver, kan en i større grad oppleve mestring i situasjonen og dermed trolig forebygge TIAN (Renolen, 2008, s. 152; Theorell et al., 1990).

6.2. Svakheter og styrker

Oppfølgingsspørsmålet, spørsmål 37 (vedlegg1), ønsket svar på hvorfor sykepleierne vurderer å slutte i yrket når pandemien er over. Spørreskjemaet beregnet 1½ linje hvor deltagerne kunne utdype hvorfor, det kunne med fordel vært viet større plass. Det kunne også vært hensiktsmessig og utført et semistrukturert dybdeintervju for å få en dypere forståelse av hvorfor de vurderer å slutte i yrket. Flere av deltagerne svarte kort på det kvalitative oppfølgingsspørsmålet, med ett eller to ord. Mulig på grunn av at spørreskjemaet hovedsakelig var et kvantitativt avkryssingsskjema. Vi kan ikke vite hvordan dette har påvirket de kvalitative svarene. Det kan være hensiktsmessig å utføre en kvantitativ oppfølgingsstudie blant annet med fokus på hvor mange som faktisk slutter i yrket når krisen er over.

Hvordan omfanget av pandemien var på det gitte tidspunktet, samt situasjonen deltagerne befant seg i når de svarte kan ha påvirket svarene. Studien omfatter ikke hvem, eller hvor stor andel av deltagerne som jobbet i nærkontakt med komplekse og kritisk syke smittede pasienter. Dødstallene i Norge var blant de laveste i Europa. I løpet av 2020 ble det registrert 461 døde i Norge, samtidig ble det registret mer enn 1,7 millioner døde på verdensbasis (Folkehelseinstituttet, 2021). Til tross for store forskjeller ser vi likevel at flere av de underliggende faktorene til TIAN her i Norge har stor grad av sammenheng med sykepleieres opplevelse og erfaring med Covid-19 pandemien i hardt rammede land.

At denne studien er en kvalitativ studie er hensiktsmessig da den utforsker et nytt og ukjent tema. Studien styrkes også av at deltagerne svarer med egne ord. Resultatene i studien gir økt kunnskap om faktorer til TIAN og viser hvor viktig det er å forebygge turnoverintensjon blant sykepleiere.

7.0. Konklusjon

Covid- 19 pandemien har satt fokus på sykepleiernes vitale rolle i samfunnet. Studien belyser hvorfor flere sykepleiere vurderer å slutte i yrket når pandemien er over. Studien viser at flere av de underliggende faktorene til TIAN under Covid- 19 har høy grad av sammenheng til underliggende faktorer for TIAN uten Covid- 19 som faktor. Faktorene som skiller seg ut fra tidligere studier, uten Covid-19 som faktor, er frykt i arbeidshverdagen og utilstrekkelig beskyttelsesutstyr, herunder mangel på praktisk trening i håndtering av utstyret. Det er behov for videre forskning på om disse faktorene fører til faktisk turnover, samt hvordan og hvilke tiltak som kan iverksettes for å beholde sykepleiere i yrket sitt. Resultatene kan gi en indikasjon på hva som kan gjøres for å styrke sykepleieprofesjonen i møte med fremtidige pandemier.

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9.0. Vitenskapelig artikkel

A qualitative study investigating the underlying factors for turnover intention among nurses during the Covid- 19 pandemic.

Forfatterveiledning til BMC Nursing i vedlegg 3

Antall ord: 4777

A qualitative study investigating the underlying factors for turnover intention among nurses (TIAN) during the COVID-19 pandemic

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A qualitative study investigating the underlying factors for turnover intention among nurses (TIAN) during the COVID-19 pandemic

Abstract

Background: In light of the increased workload Covid- 19 has led to, this study seeks to find what are the underlying factors for turnover intention among nurses (TIAN) during the Corona virus outbreak. Methods: This is a quality study with a hermeneutic approach. Data were retrieved from the 2020 annual round from the ongoing longitudinal cohort-study "Survey of Shift work, Sleep and Health SUSSH)" among Norwegian nurses. 98 participants were included. The analysis work was done on the basis of Braun and Clarkes' thematic analysis model. NVivo 1.3. was used to encode and analyze the data. Results: This study identified two main categories: Psychological factors, and governmental and organizational factors, with eight underlying themes: (1) fear in everyday work, (2) an underlying feeling of being underappreciated, (3) inadequate protective equipment, (4) dissatisfaction with salary, (5) workload, (6) lack of staff, (7) inappropriate working time-, schedule- and workplace (8) dissatisfaction with management. Conclusion: The result of this study showed that nurses consider leaving the profession when the Covid- 19 pandemic is over as a result of physical and mental strain, as well as reduced job satisfaction during the Corona virus pandemic. We can see that underlying factors for turnover intention among nurses (TIAN) during Covid- 19 has a large degree of connection to other studies that not include Covid- 19 as a factor. The

underlying factors that stand out from previous studies is fear in everyday work and inadequate- and lack of training in handling personal protective equipment.

Key words: Turnover intention, nurses, Covid- 19.

Background

Nursing holds a vital role in the health care system, and this became even more clear during the COVID- 19 pandemic. COVID- 19 was detected in humans in Wuhan, China at the end of 2019 (1). The virus rapidly spread and 11th of March 2020 WHO's leader declared the Coronavirus outbreak for a pandemic (2). COVID- 19 gives mild to severe symptoms with many complications and multiple organ failure which can lead to a deadly outcome (1). Medical treatment for Covid- 19 is under research, but at present only symptomatic treatment exists (1). WHO's weekly epidemiological update from 19th of January 2021 had registered 93 217 278 infected- and 2 014 957 deaths as a result of COVID- 19 (3). Such a high increase in patients leads to huge mobilization of nursing resources, increased workload and work pressure, both physical and mental (4, 5). By standing in the frontline nurses was and are exposed to many occupational hazards like concerns about becoming infected themselves, and infecting others (5, 6). With the current shortage of nurses it will be challanging to balance demand and supply in the years to come (7). The shortage of nurses is, and will be an increasing problem worldwide (8). The shortage will lead to major problems for the quality of the profession. This is confirmed by the NOVA- report 2016 which states that

around 50% of nurses consider quitting, mainly due to the fact that there are too few nurses at work. Lack of nurses at work will lead to enhanced burden for those who stay in work, and with this increase turnover intention and probably actual turnover among nurses.

Turnover intention can be defined as an emploee's intent to find a new job with another employer (9). Turnover intention has a negative impact on healthcare system, staff and patients outcome (10). The health care system has difficulty retaining nurses due to understaffing, this leads to a vicious circle (7) Three out of ten nurses fully or partially agreed that unnecessary patient injuries (such as pressure ulcers, falls, infections and worsening of the disease) often occur as a result of understaffing (4). A study from 2007, that included 3266 Colombian nurses, found that approximately 13 % of newly licensed nurses had changed principal jobs after one year, and 37 % had turnover intention (11). In 2016 10,0% of Norwegian RNs intend to leave the profession and 18,3% intend to leave their workplace (12). 1 of 5 does not work in the healthcare sector after 10 years (13).

Whether a person intend to quit his job, or not, depends on several factors. The major factors contributing to actual turnover is job satisfaction, mental stress and burnout (10). The main factors for TIAN is work- life interference, as exposure to aggressive and troublesome patients, harassment from patients/relatives, colleagues and/or the boss (9, 14), as well as a large workload that can result in burnout (4, 15, 16). Other crucial factors for TIAN is among other things: stress, job satisfaction (17, 18), adequate pay, shift work (19), relationships with

collegues, the opportunities for cereer advancement, leader' styles og management and job autonomy (4). Richer et al. (20) found that people who have a high degree of intention to quit their job were more likely to actually quit. Nevertheless a cross-sectional study indicate that the relationship between turnover intention and actual turnover, at the individual level, is relatively weak (21).

The corona pandemic had a wide lack of preparednes for the crises, both in terms of staffing, competence and essential infection control equipment. The coronapandemic has affected healthworkers mental health, it has been reported anxiety, depression, sleep problems and distress (22-24). With this backdrop this qualitative study will investigate the underlying factors for turnover intention among nurses (TIAN) during the COVID- 19 pandemic.

Methods

Procedure and participants

This study is part of the ongoing longitudinal cohort-study; The Norwegian SUrvey of Shift work, Sleep and Health (SUSSH) which started in 2008/2009, and since then have been conducted annually. As part of the 2020 annual round additional questions focusing on turnover intention among nurses were included. The questions where formulated as follows: *"Has the Corona pandemic made you consider quit working as a nurse when the crisis is over?"*, with the follow up question: *"If yes, please describe why"*. A hermeneutic approach has been used to describe and interpret the nurses experience of working during the Covid-

19 and find the underlying factors for TIAN during the pandemic. Hermeneutic is an encounter with existence through language (25, s. 121, 428). Hermeneutic can be described as "finding meaning in the written word" and as "textual interpretation" (26). Gadamer emphasizes that in our understanding we must let "the matter itself" appear on its own terms as far as possible (25, s.303). Therefore, the answers to the qualitative question were read several times to bring out the participants' lived experience of the phenomenon in a best possible way.

The participants in the study where randomly selected from the Norwegian Nurses' Organizations' (NNO) membership. Postal questionnaire with prepaid return envelopes and online request (SurveyXact at www.sussh.no) was conducted, including two reminders. The questionnaire was sent to 2964 nurses around the country in 2020. A total of 98 participants was included in the study. We included the participants who answered yes to the following condition; *"Has the Corona pandemic made you consider quit working as a nurse when the crisis is over?"* The answer options where; yes, no or unsure. Included participants also had to answer the follow- up question; *"If yes, please describe why."* 30 participants were excluded because they answered no to the first question, they did not have a turnover intention. 3 participants were excluded because they did not answer the follow- up question and the remaining participants did not answer the questions at all. The included participants had to work at least 50%. The following shifts were included; daytime only, evening only, two- shifts schedule (day/evening), nightshifts only, three- shift schedule (day/evening/night) or other schedule as include nightshifts. It was no requirement as to which ward the nurses had to

work in. The participants work at hospital wards, outpatient clinics, psychiatric wards inside and outside hospitals, nursing homes, health care centers and elsewhere. All the participants were anonymous. The nurses who participated took part in a lottery were 25 participants could win a gift card with a value at 500 NOK.

The CAQDAS (Computer assisted qualitative data analysis software) NVivo1.3. was used to manage coding and analysis of the data. The text was translated to English. 1. Phase: The answers where then manually transcribed in Word, then imported to NVivo. The answers were read several times to get acquainted with the contents. We based the thematic analysis on the step-by step guide of Braun and Clarke (27). The six phases in the guide are as follows: Familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report (27-29). In the first phase the texts manually were transcribed from paper to Word, then imported to NVivo. The texts were read through several times to acquire a whole of the content. In the second phase, interesting parts of the data were systematically set up and collected under relevant codes. Through third phase the codes were collected in potential topics by collecting all relevant data for each topic. In fourth phase we checked whether the themes matched the coded excerpts and the entire dataset. In the fifth phase we defined and named eight underlying themes: 1) fear in everyday work, 2) underlying feeling of being underappreciated, 3) inadequate protective equipment, 4) dissatisfaction with salary, 5) workload, 6) lack of staff, 7) working time-, schedule and workplace, and 8) dissatisfaction with management.

Ethical considerations

All the participants gave written informed concent to participate in the study. Ethical approval was obtained from the Regional Commettee for Medical and Health Research Ethics of Western Norway (REK-West, no 088.08).

Results

The study describes nurses' personal experiences during the corona- pandemic and the factors that led them to consider quitting their profession when the pandemic is over. Answers from 98 participants were included in the analysis.

By using Braun and Clarke's (2006) thematic analysis and through a hermeneutic approach, the results became two main categories: psychological factors, and governmental and organizational factors with eight following themes: 1) fear in everyday work, 2) an underlying feeling of being underappreciated, 3) inadequate protective equipment, 4) dissatisfaction with salary, 5) workload, 6) lack of staff, 7) inappropriate working time- schedule- and workplace and 8) dissatisfaction with management.

Psychological factors

Fear in everyday work

Several of the nurses cited fear as the underlying factor why they considered quitting their job. Fear can be linked to uncertainty and unpredictability, it can have an aggravating effect , but can also be destructive in the event of great work pressure and a high pace (30, s.227). Much of the fear was rooted in concern of being infected themselves or transmit the infection to patients or family. Nurses have a huge responsibility as they work with human life. Some of the participants described the underlying reason for their turnover intention as follows:

> "Risk of bringing the infection home and increased risk of becoming infected yourself" (P74)

> "Mentally challenging in terms of risk of infection. Not afraid of being infected myself, but infect someone who will become critically ill" (P10)

Nurses in frontline had to go to work, despite fear for their own health. One nurse describes her concern:

> "When the pandemic came and went at its worst, I thought for a while that working as a nurse is too risky as I am in a vulnerable group. When others shield themselves at home, I had to meet at work and socialize with people – which led to increased risk. It was scary" (P29)

For others, the fear was that they would be placed in unknown wards in which they did not feel competent to work.

> "Uncertainty in relation to "being thrown into it…" Uncertainty in relation to where one is placed at work… Uncertainty in relation to patient reception, whether the patient may be contagious" (P02)

The ethical aspect is the basis of all nursing. Some nurses reported busy wards with a large workload and time pressure This resulted in that the nurses did not being given the opportunity to complete their work tasks, thus, fear of not being able to complete their work tasks was pointed out as an underlying cause of turnover intention:

> "The pandemic requires money, leads to reduction in staffing, but the work tasks are the same. This calculation does not go up. One dread going to work. This is not how it should be!!!" (P33)

One nurse described the decisive factor for TIAN as follows:

> "I am not sure if working as a nurse is worth all the worries…" (P75)

Feeling of being underappreciate

A large proportion of nurses in this study had a feeling of being "used" (P20) in the corona period. The feeling was a result of imposed shifts, changed holidays in addition to more frequent extra shifts. The corona period also led to new and several additional assignments without any form of compensation. The nurses felt that they were "treated like pieces in a game …" (P22) and that the "job was seen as volunteer work …" (P51). Several pointed out that they did not receive a salary that was in proportion to the job they did and the responsibility it is to work with critically ill patient around the clock, in addition to the risk

they put themselves and their loved ones in by going to work. Low degree of autonomy and "no-codetermination …" (P20) in everyday work contributed to TIAN when the pandemic is over. One nurse replied that: "We are not treated as important in terms of risk of infection, salary and high- risk pay. We are assigned several new tasks and moved around" (P61).

Some intensive care nurses justify TIAN with a feeling that the profession is "erased" with other staff who do not have intensive care nurse competence. They also point out that the work in the intensive care units is heavier than usual, especially in the corona period, but that is not taken into account. Some intensive care nurses described their factors for TIAN as follows:

> "Because rights as a nurse are not taken into account, it is not taken into account that work in the intensive care unit is heavier than usual" (P97)

> "My intensive care profession is washed out by "quick- trained" nurse. We (intensive care nurses) get more "assistant tasks". Status and pride are reduced…" (P03)

> "Little appreciation of intensive care nurse competence" (P24)

Governmental and organizational factors

Protective equipment

As the pandemic spread rapidly, there was an urgent need for personal protective equipment worldwide. The lack of protective equipment led to concern for many nurses. Nurses are exposed for occupational hazards at work. When one does not feel safe at work, the mental stress increases considerably.

> "Very much stress related to the availability of infection control equipment" (P90)

> "Little infection equipment, we had to reuse disposable equipment! It does not feel safe for me or my family" (P91)

The nurses also worried due to poor preparation- and training. Clear information and well-planned workplace protocols contributes to sense of security.

> "…poor preparation in use of infection control equipment…" (P02)

> "… experience not to be taken seriously in relation to infection control." (P11)

> "Large differences between municipal employees and nurses in hospital… …regarding to training and use of infection equipment…" (P39)

Payment

The participants identified low salary as one of the major reasons why they considered quitting as a nurse. There was a recurring factor that they did not receive wage compensation for the infection they were exposed to. Several pointed out that they were doing an important job, but they did not feel that they were getting the salary they deserved.

> "… We do not get the salary we deserve" (P83)

They also highlighted the responsibilities and work pressure in relation to salary

> "Poor pay in relation to responsibility and work pressure" (P86)

> "Many requirements and orders, but no compensation in relation to salary or leisure" (P16)

> "… does not have a risk supplement in relation to salary." (P09)

Workload

Several of the participants identified workload as underlying factor for TIAN during the Covid-19 pandemic. The nurses describe an increased workload that has led to stress. For some, it has over time led to burnout. The nurses spent a lot of extra time dressing- and undressing personal protective equipment and disinfecting surfaces and equipment. Personnel were also taken from their ward to help with sampling and infection tracking. For many the reorganization led to "high work pressure over time…" (P32). Nurses describes their factors for TIAN as follows:

> "Tired because of work, I don't manage to be the person I want to be on my leisure- it affects my children, my partner and other family. It makes me feel insufficient …" (P78)

> "Because of workload and burnout" (P50)

> "A confirmation that the burden one inflicts in the health care system, also to the ordinary, is not something I can handle anymore" (P27)

"Has already resigned as a specialist nurse because of, among other things, increased workload in a ward with low basic staffing." (P53)

"… so much work pressure at work that it goes beyond my own health (stress, tired), to normal, now during the pandemic- even worse." (P84)

"Demanding to work with infected patients over time, with few breaks to be able to drink, eat etc." (P82)

Lack of staff

The participants in the study talk about the lack of nurses and how it has led to increased demands and increased mental stress in everyday work. The work tasks are the same but distributed in fewer hands- thus, the nurses' basic physiological needs such as hunger, thirst and going to the toilet are often downgraded. The results show that it is challenging to work under such pressure over time, there is a risk that more nurses will quit in their jobs or in their profession. Some of the participants in the survey conformed this.

"Have already resigned as a specialist nurse, partly due to increased workload in a ward with low basic staffing" (P53)

"It is simply to poor staffing. Do not have time to pee until the shift is over. Because of my health I want to retrain. I will be at work for many more years. I will now become a teacher" (P30)

"Low staffing, increased workload. You do not have enough time and do not get the job done as you feel it should be done" (P41)

Working time-, schedule and workplace

Inappropriate working time- and schedule was common in several of the answers from the nurses. It is well known that many nurses have though schedules as frequent quick returns (shorter than 11 hours leisure between two following shifts), as well as a lot of night shift work. It is not inconceivable that inappropriate working time- and schedules have been increasing during the pandemic, several have had to change rotation to "corona rotation". A report by SINTEF shows that almost half of the nurses had their rotation changed as a result of the pandemic (31). For one nurse, the factor for TIAN was "threats of emergency shifts" (P25). Several nurses were relocated at short notice, which led to "uncertainty as to where one will be placed at work (reorganization, other wards or unknown patient groups)" (P02). Changes can make employees feel inadequate and less competent.

Several of the nurses in the study related working time, rotation and place of work as decisive factors to TIAN. They highlighted the following:

"Worked in pandemic rotation lasting for two months, without compensation" (P66)

"Long shifts…" (P64)

"Inconvenient working time" (P51)

"Because you may have to change working hours at short notice…" (P46)

"It became very demanding considering the family situation with changes of working hours at short notice and very late delivery of schedule" (P43)

"Small degree of self- determination related to working hours, leisure and holidays" (P42)

"The circadian rhythm, home schooling and kindergarten children at home. One has at times walked around the clock" (P92)

"A lot of extra work, little left of anything but good words" (P85)

Management

Despite the rapid development of the Covid- 19 pandemic in China, and how it spread to other countries, society and health care system here where poorly prepared for the pandemic. Nurses explored the management as unprepared and unclear, several of the nurses described the situation as follows:

"Disorganized management" (P86)

"Management has poor care of employees…little listened to by the management" (P15).

"Due to unclear and absent management, frequently changed handling of the pandemic. Unclear guidelines and so on" (P67)

It is the government that decides which infection control measures and restrictions are in force at any given time. The guidelines have been many, and they have been frequently changed. The handling of the crisis has led to TIAN being justified by:

> "Poor handling of the crisis" (P04)

> "No plans for emergency before the pandemic hit us" (P01)

Finances also play an important role in the whole thing. Covid- 19 created an enormous need for more resources. In an already pressured work situation, with increased work tasks and the need for more qualified nurses, a nurse is considering leaving her profession due to:

> "…leaders who are notified to downsizing" (P22) during an ongoing crisis.

Discussion

There have previously been several studies on the underlying factors for TIAN. To our knowledge, this is one of the first qualitative study focusing on the underlying factors for TIAN in Norway during the Covid- 19 pandemic. This study identified eight findings as underlying factors for TIAN during the Covid- 19 pandemic: fear in everyday work, an underlying feeling of being underappreciated, inadequate protective equipment, dissatisfaction with salary, workload, lack of staff, inappropriate working time-, schedule- and workplace and dissatisfaction with management. We see that the result of this study has a large degree of connection to studies where factors for turnover intention is found among nurses, but without Covid- 19 as a factor (9, 12, 15-19). These studies have focused on socio-

demographic factors, job satisfaction, job stress, bullying in the workplace, workload, burnout and disturbance in working life as factors for TIAN.

The underlying factors in this study, which differ from previous studies without Covid- 19 as a factor are: fear in everyday work and inadequate protective equipment. Fear is prominent in several of the nurses, which can be seen in connection with the extent of the pandemic and lack of preparation (31). SINTEF's report confirms that more than half of the nurses, to a large or very large extent, feared infecting others without even knowing that they were infected (31). The restrictions on social distancing may also have had an impact on the results as many nurses isolated themselves at home for fear of infection and infecting others. Minimal social contact has led to negative psychological consequences for one in ten nurses and as many as two in ten under the age of 29 (31).

For many, everyday work life under Covid- 19 was characterized by insecurity and stress when the nurses did not feel that they had sufficient resources to meet the challenges. Lack of infection equipment and training created fear. Nurses who are responsible for acute- and critically ill Covid- 19 patients require sufficient infection equipment as well as knowledge of use, this to feel safe and to be able to do a good job. According to professional ethics guidelines for nurses in Norway, the nurse has a personal responsibility for the job being performed in a safe and responsible manner (32, punkt 1.3). One must at the same time recognize the limit of one's own competence and seek guidance in difficult situations (32,

punkt 1.7). This in itself can be challenging in a busy workday characterized by understaffing and several new tasks. Moral stress can increase if one experiences not being able to perform the tasks as one feel they should be performed. Time pressure can result in a lack of control, and thus weaken patient safety. When the experience of control is reduced in this way, one can experience the situation unmanageably. On the other hand the nurse can experience it as positive if one feels that the new workday is meaningful and manageable, such an experience will provide mastery and thus help to reduce turnover intention (33, s. 152, 34). In view of the increased workload caused by Covid- 19, job autonomy was reduced for more nurses in this study. This is due to constant reorganization, imposed shifts and frequently changed shifts. Several participants in the survey pointed out that reduced autonomy led to dissatisfaction at work, dissatisfaction with manager/management and salary as factors for the intention to quit the job.

There has generally been an increasing workload among nurses during the pandemic, many have taken a lot of responsibility and worked more and longer shifts than usual. This has led to more people being exhausted. According to SINTEF's report, six per cent of nurses are considering leaving the profession when the crisis is over (31). The pandemic's strict restrictions have also affected nurses' home situation. Those who have children living at home had to work at day and night during periods of ordering home school and home kindergarten. This may affect the nurses' profits at work. Reduced job satisfaction has shown strong effect on TIAN (17). This study showed dissatisfaction with management connected to unclear and lack of communication, however, SINTEF's report, conducted in parts of the same

period, found that almost two out of three nurses thought that the management was able to communicate changes in routines as they were introduced (31).

The factors that led to TIAN during Covid- 19 are as described very complex. How prominent the various factors are, probably varies depending on where the participants work. The results indicate that there was different access to infection control equipment based on where they worked, municipal or special health care service, in the addition differences were pointed out in how good training in use of infection control equipment the participants felt they had received. Inequalities in wages, state and municipal, were also mentioned as factor for TIAN. There were also large differences in how hard the population and staff in the various municipalities, hospitals and wars were affected by the infection. For some the infection led to extra increased workload and lack of staff as several in same staff group had to be quarantined or isolated at the same time.

Why Covid- 19 has led to turnover intention for some but not others, the study can't answer with certainty. Whether one handles stress and challenges is different. In the same way, it is different whether one experiences coping the situation. If the nurses experience control and that the work is meaningful, despite a high workload and unknown tasks, one can to a greater extent experience handling the situation and thus probably prevent TIAN (34). Although the mortality rate in Norway was among the lowest in Europe, at 461 dead, and worldwide more than 1,7 million dead, both by 2020. Despite the differences, we can see that the underlying

factors for TIAN have a large degree of connection with nurses' experience with the Covid- 19 pandemic in hard-hit countries.

Weaknesses and strengths

The follow-up question wanted answer to why nurses are considering leaving the profession when the pandemic is over. The questionnaire calculated 1 ½ line where the participants could elaborate on why, it could with advantage have been calculated larger space to answer. It could have been appropriate to conduct a semi-structured in-depth interview to gain a deeper understanding of why the participants are considering leaving the profession. Several of the participants answered the qualitative follow-up question briefly, in one or two words. Possible because the questionnaire was mainly a quantitative checklist. We do not know how this has affected the answers. It may be appropriate to carry out a quantitative follow-up study focusing on, among other things, how many of the participants actually leave the profession when the crisis is over.

How the extent of the pandemic was at the given time, as well as the situation the participants were in when they answered the questions may have influenced the answers. The study does not include who, or what proportion of the participants worked bedside with complex and critically ill infected patients.

It is appropriate that this is a qualitative study as it explores a new and unknown topic. The study is also a strengthened by the participants responding in their own words. The results of the study provide increased knowledge about factors of TIAN and in view of the future shortage of nurses that has been predicted, it shows the importance of preventing turnover intention among nurses.

Conclusion

The pandemic has highlighted the vital role of nurses in the society and how dependent we are on a health care system that works optimally, especially when the crises strikes. Covid- 19 have been a huge burden for the frontline nurses. This study highlights why several nurses considering to quit in their profession when the Covid- 19 pandemic is over. The underlying factors for TIAN during Covid- 19 that occurred is: fear in everyday work, an underlying feeling of being underappreciated, inadequate personal protective equipment, dissatisfaction with salary, increased workload, lack of staff, inappropriate working time-, schedule- and workplace and dissatisfaction with management. We can see that underlying factors for TIAN during Covid- 19 has a large degree of connection to other studies that not include Covid- 19 as a factor. The underlying factors for TIAN that stand out from previous studies without Covid- 19 is fear in everyday work and inadequate personal protective equipment. The findings show that there is a need for further research to be done on the relationship between turnover intention and actual turnover behavior among nurses after Covid- 19 and to find strategies to retain the nurses. More focus on retaining nurses in their profession is needed. In the future it will probably occur more pandemics like Covid- 19, it is then crucial

that the nurse density is adequate. It should be clear strategies and guidelines for taking care of the nurses in their profession. The knowledge of these underlying factors can be used preventively in further work with Covid patients. Thus, in form of planning, clear information and good training in the use of personal infection control equipment to reduce fear.

Declarations

Ethics approval and consent to participate

All the participants gave written informed concent to participate in the study. Ethical approval was obtained from the Regional Commettee for Medical and Health Research Ethics of Western Norway (REK-West, no 088.08).

Consent for publication

We do not use any personal information in this publication.

Availability of data and materials

With regard to the participants' anonymity, we choose not to share the dataset here. In case of special interest, authors can be contacted.

Competing interests

The author declares that there are no competing interests.

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Authors' contributions

JE analyzed and interpreted the participants' answers and wrote the article.

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10.0. Vedlegg

Vedlegg 1: Spørreskjema - SUSSH 2020

HELSE BERGEN
Haukeland Universitetssjukehus

SPØRRESKJEMA - SUSSH 2020

Tusen takk for at du har svart på tidligere skjema fra
"Spørreundersøkelsen om skiftarbeid, søvn og helse"!

Vi forstår at mange av dere har hektiske dager pga. koronapandemien, og vi har derfor valgt å lage et kortfattet spørreskjema denne gangen. Fokuset er på hvordan det er å jobbe som sykepleier etter at koronapandemien kom til Norge. Vi håper du finner tid til å besvare undersøkelsen - gjerne i løpet av en ukes tid.

Alle som sender inn skjema er med i trekningen av 25 gavekort pålydende kr. 500,-.

Vennligst les spørsmålene nøye og svar med det som passer best for deg.
Det finnes ikke "rette" eller "feile" svar.
Det er viktig at du besvarer alle spørsmålene!

Undersøkelsen er godkjent av Regional komité for medisinsk og helsefaglig forskningsetikk Vest-Norge, og har konsesjon fra Datatilsynet.

Resultater av forskning fra tidligere runder kan du lese om på www.sussh.no

1. ☐ **Jeg samtykker til å delta i undersøkelsen.**

2. **Er du gift, registrert partner eller samboer?**
   ☐ Ja ☐ Nei

3. **Har du barn som bor hjemme hos deg fulltid/deltid?**
   ☐ Ja _____ antall barn
   ☐ Nei

4. **Er du i arbeid som sykepleier nå?**
   ☐ Ja ☐ Nei
   Dersom du ikke jobber som sykepleier nå, vennligst gå til spørsmål 12

5. **Hvilken kategori beskriver best din arbeidsplass (hos hovedarbeidsgiver)?**
   ☐ Somatisk sykehusavdeling/poliklinikk
   ☐ Psykiatrisk sykehusavdeling/poliklinikk/ambulante tjenester
   ☐ Sykehjem
   ☐ Hjemmesykepleie
   ☐ Helsestasjon
   ☐ Annet

6. **Har du som følge av koronapandemien endret arbeidssted (avdeling/post)?**
   ☐ Ja ☐ Nei

7. **Hvor stor stillingsprosent har du hos din hovedarbeidsgiver?**
   ☐ Mindre enn 50%
   ☐ 50-75%
   ☐ 76-90%
   ☐ Mer enn 90%

8. **Hvilken kategori beskriver best din arbeidstidsordning i din nåværende jobb (hos hovedarbeidsgiver)?**
   ☐ Bare dag
   ☐ Bare kveld
   ☐ Både dag og kveld
   ☐ Bare natt
   ☐ Tre-skift turnus (dag/kveld/natt)
   ☐ Annen ordning som inkluderer nattarbeid

9. **Har du som følge av koronapandemien endret arbeidstid?**
   ☐ Ja ☐ Nei

10. **Dersom din arbeidstid ble endret etter pandemien kom til Norge, hvordan vil du bekrive disse endringene (du kan svare mer enn ett alternativ)?**
    ☐ Flere lange arbeidsdager (mer enn 8 timer)
    ☐ Færre fridager mellom arbeidsperiodene
    ☐ Flere nattskift
    ☐ Flere springskift/sein-tidligvakter (dvs. mindre enn 11 timer fri mellom to etterfølgende skift)
    ☐ Flere dagskift
    ☐ Flere kveldsskift

11. **Etter at pandemien kom til Norge, hvor ofte har du opplevd å få endringer i arbeidstid mindre enn 3 døgn før du skal arbeide?**
    ☐ Aldri
    ☐ Sjelden
    ☐ Av og til
    ☐ Ofte
    ☐ Svært ofte

12. **Etter at pandemien kom til Norge, har du blitt pålagt å arbeide i en ferie du hadde planlagt?**
    ☐ Ja ☐ Nei

13. Har du selv blitt smittet av koronaviruset?

☐ Ja ☐ Nei ☐ Vet ikke/usikker

14. Hvis ja, er du syk nå?

☐ Ja ☐ Nei

15. Hvis ja, hvor syk er/var du?

☐ Ingen symptomer
☐ Lette symptomer
☐ Moderate symptomer
☐ Alvorlige symptomer

16. Hvis ja, hvilken behandling fikk du (sett ett kryss)?

☐ Behandlet/observert hjemme
☐ Innlagt på vanlig sykehusavdeling
☐ Innlagt på intensivavdeling
☐ Respiratorbehandling

17. Har du vært i karantene på grunn av koronaviruset?

☐ Ja ☐ Nei

18. Har noen av de du bor sammen med blitt smittet av koronaviruset?

☐ Ja ☐ Nei ☐ Vet ikke/usikker

19. Tilhører du selv en sårbar gruppe (f.eks. diabetes, hjertesykdom, lungesykdom eller annen sykdom som medfører redusert immunforsvar) med tanke på infeksjon av koronaviruset?

☐ Ja ☐ Nei

20. Tilhører noen av dine nærmeste (familie/partner) en sårbar gruppe (f.eks. diabetes, hjertesykdom, lungesykdom eller annen sykdom som medfører redusert immunforsvar) med tanke på infeksjon av koronaviruset?

☐ Ja ☐ Nei ☐ Vet ikke/usikker

21. Hvor ofte har du på grunn av koronapandemien følt at du savner noen å være sammen med på fritiden?

☐ Aldri
☐ Sjelden
☐ Av og til
☐ Ofte
☐ Svært ofte

22. Før koronapandemien kom til Norge, omtrent hvor lenge sov du per døgn?

☐ Under 5 timer
☐ 5-5,9 timer
☐ 6-6,9 timer
☐ 7-7,9 timer
☐ 8-8,9 timer
☐ 9-9,9 timer
☐ 10 timer eller mer

23. Etter koronapandemien kom til Norge, omtrent hvor lenge sover du per døgn?

☐ Under 5 timer
☐ 5-5,9 timer
☐ 6-6,9 timer
☐ 7-7,9 timer
☐ 8-8,9 timer
☐ 9-9,9 timer
☐ 10 timer eller mer

24. Etter koronapandemien kom til Norge, sover jeg ... ☐☐☐☐

- ☐ Mye dårligere enn før
- ☐ Litt dårligere enn før
- ☐ Som før
- ☐ Litt bedre enn før
- ☐ Mye bedre enn før

	Mer enn 1 time tidligere enn før	Mellom 15 og 60 min tidligere enn før	Som før (mindre enn 15 min forskjell)	Mellom 15 og 60 min seinere enn før	Mer enn 1 time seinere enn før
25. Etter koronapandemien kom til Norge, legger jeg meg ...	☐	☐	☐	☐	☐
26. Etter koronapandemien kom til Norge, sovner jeg ...	☐	☐	☐	☐	☐
27. Etter koronapandemien kom til Norge, våkner jeg ...	☐	☐	☐	☐	☐
28. Etter koronapandemien kom til Norge, står jeg opp ...	☐	☐	☐	☐	☐

	Helt uenig	Uenig	Verken enig eller uenig	Enig	Helt enig
29. Dersom du ikke har vært smittet av koronaviruset: Jeg bekymrer meg for at jeg kommer til å bli smittet av koronaviruset	☐	☐	☐	☐	☐
30. Jeg bekymrer meg for at noen av mine nærmeste (familie/venner) kommer til å bli smittet av koronaviruset	☐	☐	☐	☐	☐
31. Jeg sover dårligere enn før på grunn av bekymringer knyttet til de *helsemessige* konsekvensene av koronaviruset	☐	☐	☐	☐	☐
32. Jeg sover dårligere enn før på grunn av bekymringer knyttet til de *økonomiske* konsekvensene av koronaviruset	☐	☐	☐	☐	☐
33. Jeg sover dårligere enn før pga. bekymringer knyttet til de *sosiale* konsekvensene av koronaviruset	☐	☐	☐	☐	☐

De siste fire spørsmålene er kun for de som jobber som sykepleier nå:

34. På grunn av koronapandemien opplever jeg at risikoen for arbeidsrelaterte ulykker/uhell som kan føre til skader på meg selv eller andre/pasienter eller utstyr har økt	☐	☐	☐	☐	☐
35. Jeg opplever å ha fått tilstrekkelig opplæring i bruk av smittevernutstyr til å håndtere pasienter under koronapandemien	☐	☐	☐	☐	☐

36. Har koronapandemien ført til at du vurderer å slutte som sykepleier når krisen er over?

☐ Ja ☐ Nei ☐ Vet ikke/usikker

37. Hvis ja, vennligst beskriv hvorfor: _____

_____

Takk for din deltagelse!

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Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups

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Abstract

Background. Qualitative research explores complex phenomena encountered by clinicians, health care providers, policy makers and consumers. Although partial checklists are available, no consolidated reporting framework exists for any type of qualitative design.

Objective. To develop a checklist for explicit and comprehensive reporting of qualitative studies (indepth interviews and focus groups).

Methods. We performed a comprehensive search in Cochrane and Campbell Protocols, Medline, CINAHL, systematic reviews of qualitative studies, author or reviewer guidelines of major medical journals and reference lists of relevant publications for existing checklists used to assess qualitative studies. Seventy-six items from 22 checklists were compiled into a comprehensive list. All items were grouped into three domains: (i) research team and reflexivity, (ii) study design and (iii) data analysis and reporting. Duplicate items and those that were ambiguous, too broadly defined and impractical to assess were removed.

Results. Items most frequently included in the checklists related to sampling method, setting for data collection, method of data collection, respondent validation of findings, method of recording data, description of the derivation of themes and inclusion of supporting quotations. We grouped all items into three domains: (i) research team and reflexivity, (ii) study design and (iii) data analysis and reporting.

Conclusions. The criteria included in COREQ, a 32-item checklist, can help researchers to report important aspects of the research team, study methods, context of the study, findings, analysis and interpretations.

Keywords: focus groups, interviews, qualitative research, research design

Qualitative research explores complex phenomena encountered by clinicians, health care providers, policy makers and consumers in health care. Poorly designed studies and inadequate reporting can lead to inappropriate application of qualitative research in decision-making, health care, health policy and future research.

Formal reporting guidelines have been developed for randomized controlled trials (CONSORT) [1], diagnostic test studies (STARD), meta-analysis of RCTs (QUOROM) [2], observational studies (STROBE) [3] and meta-analyses of observational studies (MOOSE) [4]. These aim to improve the quality of reporting these study types and allow readers to better understand the design, conduct, analysis and findings of published studies. This process allows users of published research to be more fuller informed when they critically appraise studies relevant to each checklist and decide upon applicability of research findings to their local settings. Empiric studies have shown that the use of the CONSORT statement is associated with improvements in the quality of reports of randomized controlled trials [5]. Systematic reviews of qualitative research almost always show that key aspects of study design are not reported, and so there is a clear need for a CONSORT-equivalent for qualitative research [6].

The Uniform Requirements for Manuscripts Submitted to Biomedical Journals published by the International Committee of Medical Journal Editors (ICMJE) do not provide reporting guidelines for qualitative studies. Of all the mainstream biomedical journals (Fig. 1), only the British Medical Journal (BMJ) has criteria for reviewing qualitative research. However, the guidelines for authors specifically record that the checklist is not routinely used. In addition, the checklist is not comprehensive and does not provide specific guidance to assess some of the criteria. Although checklists for critical appraisal are available for qualitative research, there is no widely endorsed reporting framework for any type of qualitative research [7].

We have developed a formal reporting checklist for in-depth interviews and focus groups, the most common methods for data collection in qualitative health research.

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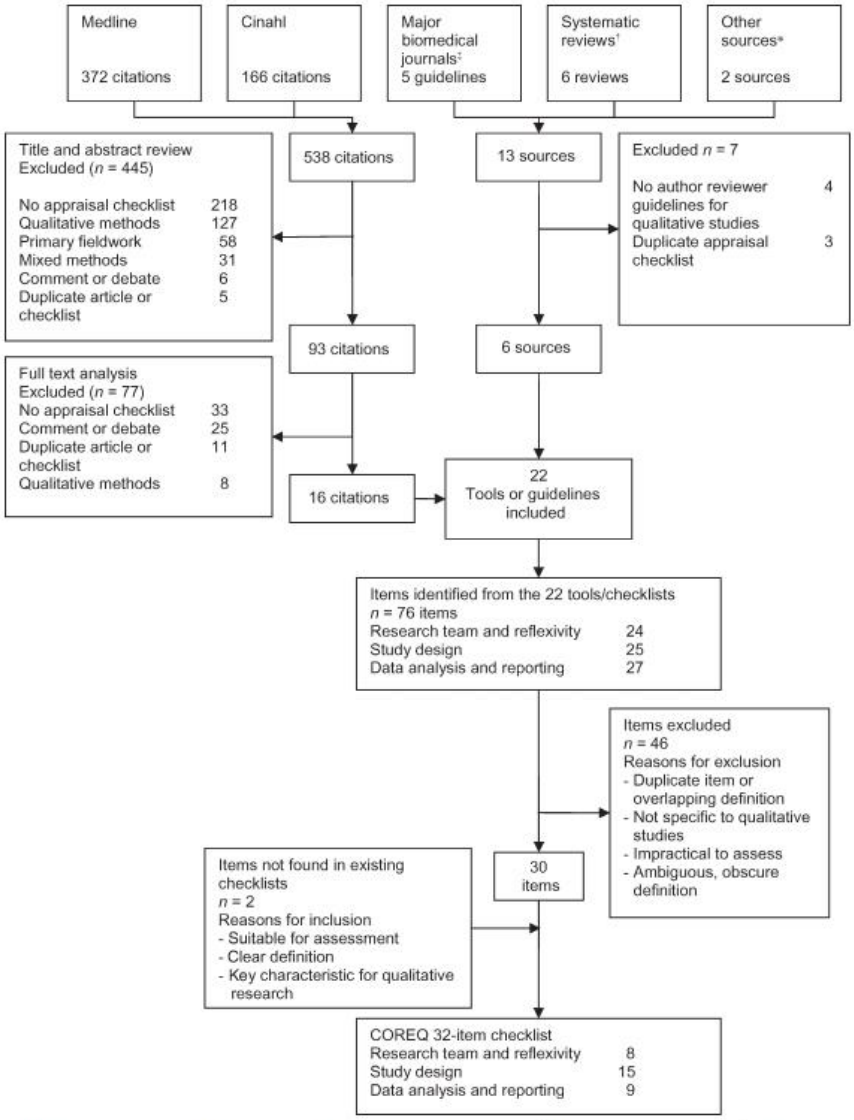

Figure 1 Development of the COREQ Checklist. *References [26, 27], †References [6, 28–32], ‡Author and reviewer guidelines provided by BMJ, JAMA, Lancet, Annals of Internal Medicine, NEJM.

These two methods are particularly useful for eliciting patient and consumer priorities and needs to improve the quality of health care [8]. The checklist aims to promote complete and transparent reporting among researchers and indirectly improve the rigor, comprehensiveness and credibility of interview and focus-group studies.

Basic definitions

Qualitative studies use non-quantitative methods to contribute new knowledge and to provide new perspectives in health care. Although qualitative research encompasses a broad range of study methods, most qualitative research

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publications in health care describe the use of interviews and focus groups [8].

Interviews

In-depth and semi-structured interviews explore the experiences of participants and the meanings they attribute to them. Researchers encourage participants to talk about issues pertinent to the research question by asking open-ended questions, usually in one-to-one interviews. The interviewer might re-word, re-order or clarify the questions to further investigate topics introduced by the respondent. In qualitative health research, in-depth interviews are often used to study the experiences and meanings of disease, and to explore personal and sensitive themes. They can also help to identify potentially modifiable factors for improving health care [9].

Focus groups

Focus groups are semi-structured discussions with groups of 4–12 people that aim to explore a specific set of issues [10]. Moderators often commence the focus group by asking broad questions about the topic of interest, before asking the focal questions. Although participants individually answer the facilitator's questions, they are encouraged to talk and interact with each other [11]. This technique is built on the notion that the group interaction encourages respondents to explore and clarify individual and shared perspectives [12]. Focus groups are used to explore views on health issues, programs, interventions and research.

Methods

Development of a checklist

Search strategy. We performed a comprehensive search for published checklists used to assess or review qualitative studies, and guidelines for reporting qualitative studies in: Medline (1966—Week 1 April 2006), CINAHL (1982—Week 3 April 2006), Cochrane and Campbell protocols, systematic reviews of qualitative studies, author or reviewer guidelines of major medical journals and reference lists of relevant publications. We identified the terms used to index the relevant articles already in our possession and performed a broad search using those search terms. The electronic databases were searched using terms and text words for research (standards), health services research (standards) and qualitative studies (evaluation). Duplicate checklists and detailed instructions for conducting and analysing qualitative studies were excluded.

Data extraction. From each of the included publications, we extracted all criteria for assessing or reporting qualitative studies. Seventy-six items from 22 checklists were compiled into a comprehensive list. We recorded the frequency of each item across all the publications. Items most frequently included in the checklists related to sampling method, setting for data collection, method of data collection, respondent validation of findings, method of recording data, description of the derivation of themes and inclusion of supporting quotations. We grouped all items into three domains: (i) research team and reflexivity, (ii) study design and (iii) data analysis and reporting. (see Tables 2–4)

Within each domain we simplified all relevant items by removing duplicates and those that were ambiguous, too broadly defined, not specific to qualitative research, or impractical to assess. Where necessary, the remaining items were rephrased for clarity. Based upon consensus among the authors, two new items that were considered relevant for reporting qualitative research were added. The two new items were identifying the authors who conducted the interview or focus group and reporting the presence of non-participants during the interview or focus group. The COREQ checklist for explicit and comprehensive reporting of qualitative studies consists of 32 criteria, with a descriptor to supplement each item (Table 1).

COREQ: content and rationale (see Tables 1)

Domain 1: research team and reflexivity

(i) Personal characteristics: Qualitative researchers closely engage with the research process and participants and are therefore unable to completely avoid personal bias. Instead researchers should recognize and clarify for readers their identity, credentials, occupation, gender, experience and training. Subsequently this improves the credibility of the findings by giving readers the ability to assess how these factors might have influenced the researchers' observations and interpretations [13–15].

(ii) Relationship with participants: The relationship and extent of interaction between the researcher and their participants should be described as it can have an effect on the participants' responses and also on the researchers' understanding of the phenomena [16]. For example, a clinician–researcher may have a deep understanding of patients' issues but their involvement in patient care may inhibit frank discussion with patient–participants when patients believe that their responses will affect their treatment. For transparency, the investigator should identify and state their assumptions and personal interests in the research topic.

Domain 2: study design

(i) Theoretical framework: Researchers should clarify the theoretical frameworks underpinning their study so readers can understand how the researchers explored their research questions and aims. Theoretical frameworks in qualitative research include: grounded theory, to build theories from the data; ethnography, to understand the culture of groups with shared characteristics; phenomenology, to describe the meaning and significance of experiences; discourse analysis, to analyse linguistic expression; and content analysis, to systematically organize data into a structured format [10].

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Table 1 Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description
Domain 1: Research team and reflexivity		
Personal Characteristics		
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?
2.	Credentials	What were the researcher's credentials? *E.g. PhD, MD*
3.	Occupation	What was their occupation at the time of the study?
4.	Gender	Was the researcher male or female?
5.	Experience and training	What experience or training did the researcher have?
Relationship with participants		
6.	Relationship established	Was a relationship established prior to study commencement?
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. *Bias, assumptions, reasons and interests in the research topic*
Domain 2: study design		
Theoretical framework		
9.	Methodological orientation and Theory	What methodological orientation was stated to underpin the study? *e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*
Participant selection		
10.	Sampling	How were participants selected? *e.g. purposive, convenience, consecutive, snowball*
11.	Method of approach	How were participants approached? e.g. *face-to-face, telephone, mail, email*
12.	Sample size	How many participants were in the study?
13.	Non-participation	How many people refused to participate or dropped out? Reasons?
Setting		
14.	Setting of data collection	Where was the data collected? e.g. *home, clinic, workplace*
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?
16.	Description of sample	What are the important characteristics of the sample? *e.g. demographic data, date*
Data collection		
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?
20.	Field notes	Were field notes made during and/or after the interview or focus group?
21.	Duration	What was the duration of the interviews or focus group?
22.	Data saturation	Was data saturation discussed?
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?
Domain 3: analysis and findingsz		
Data analysis		
24.	Number of data coders	How many data coders coded the data?
25.	Description of the coding tree	Did authors provide a description of the coding tree?
26.	Derivation of themes	Were themes identified in advance or derived from the data?
27.	Software	What software, if applicable, was used to manage the data?
28.	Participant checking	Did participants provide feedback on the findings?
Reporting		
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. *participant number*
30.	Data and findings consistent	Was there consistency between the data presented and the findings?
31.	Clarity of major themes	Were major themes clearly presented in the findings?
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?

(ii) Participant selection: Researchers should report how participants were selected. Usually purposive sampling is used which involves selecting participants who share particular characteristics and have the potential to provide rich, relevant and diverse data pertinent to the research question [13, 17]. Convenience sampling is less optimal because it may fail to capture important perspectives from difficult-to-reach people [16]. Rigorous attempts to recruit participants and reasons for non-participation should be stated to reduce the likelihood of making unsupported statements [18].

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Table 2 Items included in 22 published checklists: Research team and reflexivity domain

Item	References																					
	[26][a]	[27][a]	[6][b]	[28][b]	[32][b]	[13]	[15]	[14]	[17]	[33]	[34]	[35]	[16]	[19]	[36]	[7]	[37]	[23]	[38]	[39]	[22]	BMJ
Research team and reflexivity																						
Nature of relationship between the researcher and participants		•		•	•		•		•						•				•			
Examination of role, bias, influence	•	•			•	•	•	•							•						•	
Description of role		•		•					•	•				•	•					•	•	
Identity of the interviewer		•		•		•					•		•		•							
Continued and prolonged engagement		•				•							•	•					•	•		
Response to events	•	•				•	•	•														
Prior assumptions and experience		•						•									•			•		
Professional status		•					•								•							
Journal, record of personal experience		•								•				•								
Effects of research on researcher		•				•	•															
Qualifications		•													•							
Training of the interviewer/facilitator			•		•																	
Expertise demonstrated		•																	•			
Perception of research at inception								•						•								
Age							•															
Gender							•															
Social class							•															
Reasons for conducting study		•																				
Sufficient contact													•									
Too close to participants													•									
Empathy																	•					
Distance between researcher and participants							•															
Background								•														
Familiarity with setting																					•	

[a]Other publications, [b]Systematic review of qualitative studies; BMJ, British Medical Journal—editor's checklist for appraising qualitative research); •, item included in the checklist.

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Table 3 Items included in 22 published checklists: Study design

Item	References																							
	[26][a]	[27][a]	[6][b]	[28] [b]	[32][b]	[13]	[15]	[14]	[17]	[33]	[34]	[35]	[16]	[19]	[36]	[7]	[37]	[23]	[38]	[39]	[22]	BMJ
Study design																						
Methodological orientation, ontological or epistemological basis		•		•				•	•					•					•	•	•	•
Sampling—convenience, purposive	•	•			•	•	•	•	•	•	•	•	•	•		•		•	•	•	•	•
Setting		•		•	•			•			•				•					•		
Characteristics and description of sample		•			•			•			•		•	•								
Reasons for participant selection	•	•				•		•			•											
Non-participation	•	•		•	•																	
Inclusion and exclusion, criteria		•			•	•													•			
Identity of the person responsible for recruitment				•	•						•				•							
Sample size		•		•	•						•										•	
Method of approach		•									•					•						
Description of explanation of research to participants	•				•										•							
Level and type of participation														•								
Method of data collection, e.g. focus group, in-depth interview	•	•	•	•	•	•		•	•		•	•	•	•		•				•	•	
Audio and visual recording	•	•	•	•	•	•				•	•		•						•		•	•
Transcripts			•	•	•	•			•		•		•						•			•
Setting and location	•	•		•	•		•		•		•				•						•	•
Saturation of data	•	•	•			•			•				•	•							•	
Use of a topic guide, tools, questions	•	•	•								•					•			•	•		
Field notes			•	•	•	•													•			•
Changes and modifications	•	•		•	•														•		•	
Duration of interview, focus group		•				•					•									•		
Sensitive to participant language and views		•										•		•								
Number of interviews, focus groups		•				•																
Time span																					•	
Time and resources available to the study		•																				

[a]Other publications, [b]Systematic review of qualitative studies; BMJ, British Medical Journal—editor's checklist for appraising qualitative research; •, item included in the checklist.

Table 4 Items included in 22 published checklists: Analysis and reporting

Item	References																						
	[26][a]	[27][a]	[6][b]	[28][b]	[32][b]	[13]	[15]	[14]	[17]	[33]	[34]	[35]	[16]	[19]	[36]	[7]	[37]	[23]	[38]	[39]	[22]	BMJ
Respondent validation	•	•	•		•		•		•	•			•	•			•	•	•	•		
Limitations and generalizability	•	•		•	•		•		•		•		•	•				•	•			
Triangulation	•	•		•	•	•	•	•	•					•			•		•			
Original data, quotation		•	•	•	•			•	•		•			•		•				•	•	•
Derivation of themes explicit	•	•	•	•	•		•	•			•								•			•
Contradictory, diverse, negative cases	•	•		•	•		•			•				•					•			•
Number of data analysts	•	•	•			•			•			•	•						•			•
In-depth description of analysis	•			•	•			•			•			•							•	•
Sufficient supporting data presented	•	•		•	•		•				•					•						
Data, interpretation and conclusions linked and integrated		•		•	•							•		•						•		
Retain context of data		•					•	•						•					•			
Explicit findings, presented clearly	•	•		•					•	•												
Outside checks													•	•				•	•			
Software used		•				•													•			•
Discussion both for and against the researchers' arguments	•	•		•	•																	
Development of theories, explanations		•					•			•		•										
Numerical data		•									•							•				•
Coding tree or coding system		•					•												•		•	
Inter-observer reliability		•									•										•	
Sufficient insight into meaning/perceptions of participants		•								•												
Reasons for selection of data to support findings		•			•																	
New insight		•						•														
Results interpreted in credible, innovative way									•													
Eliminate other theories													•									
Range of views														•								
Distinguish between researcher and participant voices								•														
Proportion of data taken into account														•								

[a]Other publications, [b]Systematic review of qualitative studies; BMJ, British Medical Journal—editor's checklist for appraising qualitative research, •, item included in the checklist.

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Researchers should report the sample size of their study to enable readers to assess the diversity of perspectives included.

(iii) Setting: Researchers should describe the context in which the data were collected because it illuminates why participants responded in a particular way. For instance, participants might be more reserved and feel disempowered talking in a hospital setting. The presence of non-participants during interviews or focus groups should be reported as this can also affect the opinions expressed by participants. For example, parent interviewees might be reluctant to talk on sensitive topics if their children are present. Participant characteristics, such as basic demographic data, should be reported so readers can consider the relevance of the findings and interpretations to their own situation. This also allows readers to assess whether perspectives from different groups were explored and compared, such as patients and health care providers [13, 19].

(iv) Data collection: The questions and prompts used in data collection should be provided to enhance the readers' understanding of the researcher's focus and to give readers the ability to assess whether participants were encouraged to openly convey their viewpoints. Researchers should also report whether repeat interviews were conducted as this can influence the rapport developed between the researcher and participants and affect the richness of data obtained. The method of recording the participants' words should be reported. Generally, audio recording and transcription more accurately reflect the participants' views than contemporaneous researcher notes, more so if participants checked their own transcript for accuracy [19–21]. Reasons for not audio recording should be provided. In addition, field notes maintain contextual details and non-verbal expressions for data analysis and interpretation [19, 22]. Duration of the interview or focus group should be reported as this affects the amount of data obtained. Researchers should also clarify whether participants were recruited until no new relevant knowledge was being obtained from new participants (data saturation) [23, 24].

Domain 3: analysis and findings

(i) Data analysis: Specifying the use of multiple coders or other methods of researcher triangulation can indicate a broader and more complex understanding of the phenomenon. The credibility of the findings can be assessed if the process of coding (selecting significant sections from participant statements), and the derivation and identification of themes are made explicit. Descriptions of coding and memoing demonstrate how the researchers perceived, examined and developed their understanding of the data [17, 19]. Researchers sometimes use software packages to assist with storage, searching and coding of qualitative data. In addition, obtaining feedback from participants on the research findings adds validity to the researcher's interpretations by ensuring that the participants' own meanings and perspectives are represented and not curtailed by the researchers' own agenda and knowledge [23].

(ii) Reporting: If supporting quotations are provided, researchers should include quotations from different participants to add transparency and trustworthiness to their findings and interpretations of the data [17]. Readers should be able to assess the consistency between the data presented and the study findings, including the both major and minor themes. Summary findings, interpretations and theories generated should be clearly presented in qualitative research publications.

Discussion

The COREQ checklist was developed to promote explicit and comprehensive reporting of qualitative studies (interviews and focus groups). The checklist consists of items specific to reporting qualitative studies and precludes generic criteria that are applicable to all types of research reports. COREQ is a comprehensive checklist that covers necessary components of study design, which should be reported. The criteria included in the checklist can help researchers to report important aspects of the research team, study methods, context of the study, findings, analysis and interpretations.

At present, we acknowledge there is no empiric basis that shows that the introduction of COREQ will improve the quality of reporting of qualitative research. However this is no different than when CONSORT, QUOROM and other reporting checklists were introduced. Subsequent research has shown that these checklists have improved the quality of reporting of study types relevant to each checklist [5, 25], and we believe that the effect of COREQ is likely to be similar. Despite differences in the objectives and methods of quantitative and qualitative methods, the underlying aim of transparency in research methods and, at the least, the theoretical possibility of the reader being able to duplicate the study methods should be the aims of both methodological approaches. There is a perception among research funding agencies, clinicians and policy makers, that qualitative research is 'second class' research. Initiatives like COREQ are designed to encourage improvement in the quality of reporting of qualitative studies, which will indirectly lead to improved conduct, and greater recognition of qualitative research as inherently equal scientific endeavor compared with quantitative research that is used to assess the quality and safety of health care. We invite readers to comment on COREQ to improve the checklist.

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Preparing tables

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The title page should:

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Abstract

The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. Reports of randomized controlled trials should follow the CONSORT extension for abstracts. The abstract must include the following separate sections:

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- the type of statistical analysis used, including a power calculation if appropriate

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This should include the findings of the study including, if appropriate, results of statistical analysis which must be included either in the text or as tables and figures.

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Conclusions

This should state clearly the main conclusions and provide an explanation of the importance and relevance of the study reported.

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- Ethics approval and consent to participate
- Consent for publication
- Availability of data and materials
- Competing interests
- Funding
- Authors' contributions
- Acknowledgements
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Acknowledgements

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Always use footnotes instead of endnotes.

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Healthwise Knowledgebase. US Pharmacopeia, Rockville. 1998. http://www.healthwise.org. Accessed 21 Sept 1998.

Supplementary material/private homepage

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University site

Doe, J: Title of preprint. http://www.uni-heidelberg.de/mydata.html (1999). Accessed 25 Dec 1999.

FTP site

Doe, J: Trivial HTTP, RFC2169. ftp://ftp.isi.edu/in-notes/rfc2169.txt (1999). Accessed 12 Nov 1999.

Organization site

ISSN International Centre: The ISSN register. http://www.issn.org (2006). Accessed 20 Feb 2007.

Dataset with persistent identifier

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Vedlegg 4: Cover letter BMC Nursing

JEANETTE EDVARDSEN

Intensive Care Nurse at Haukeland University Hospital, Norway. Adress: Stongafjellsbakken 21, 5301 Kleppestø. Norway. nette27b@gmail.com

Dear Editors,

This article is a qualitative article with a hermeneutic approach. The article is part of the ongoing cohort-study, The Norwegian "SUrvey of Shift work, Sleep and Health (SUSSH)". The study started in 2008/2009 and has published articles in national and several international journals. The study conducts annual questionnaires to randomly selected nurses with membership in the Norwegian Nurses' Organization (NNO).

In conjunction to the Corona pandemic, two qualitative questions were added in the annual round for 2020. The questions focused on turnover intention among nurses during the Covid- 19 pandemic. As far as I know, this is the first study on this theme in Norway. Covid- 19 has highlighted the vital role of nurses in society. With the currant shortage of nurses, I see the importance of having knowledge about the underlying factors of turnover intention among nurses during the pandemic. This, to maintain and prevent further turnover intention in future pandemics.

I declare that there are no competing interests related to this article.

The content of this manuscript has not been published, or submitted for publication elsewhere.

Looking forward to hear from you.

Yours sincerely, Jeanette Edvardsen