Received: 3 August 2022 | Revised: 16 July 2023 | Accepted: 11 September 2023

DOI: 10.1111/jan.15881

EMPIRICAL RESEARCH QUALITATIVE

JAN Leading Global Nursing Research WILEY

Inactive nurses' willingness to return to active nursing during the COVID-19 pandemic: A qualitative study

Petra Lücker[1] | Esther Henning[2] | Anika Kästner[1] | Wolfgang Hoffmann[1]

[1]Department Epidemiology of Health Care and Community Health, Institute for Community Medicine, University Medicine Greifswald, Greifswald, Germany

[2]Department Methods of Community Medicine, Institute for Community Medicine, University Medicine Greifswald, Greifswald, Germany

Correspondence
Petra Lücker, Institute for Community Medicine, Ellernholzstr. 1-2, 17489 Greifswald, Germany.
Email: petra.luecker@med.uni-greifswald.de

Abstract

Aims: To investigate factors that influence the willingness of inactive nurses to return to nursing in a crisis situation and to identify aspects that need to be considered with regard to a possible deployment.

Design: A deductive and inductive qualitative content analysis of semi-structured focus group interviews.

Methods: Semi-structured focus group interviews with inactive or marginally employed nurses, nurses who have been inactive for some time and nursing home managers in October and November 2021. The participating inactive nurses had declared their willingness for a deployment during the COVID-19 pandemic or not. Data were analysed using qualitative content analysis.

Results: Communication was seen as essential by the participants for an informed decision for or against a temporary return to nursing and to potential or actual deployments. To make them feel safe, inactive nurses need to know what to expect and what is expected of them, for example, regarding required training and responsibilities. Considering their current employment status, some flexibility in terms of deployment conditions is needed.

A remaining attachment to care can trigger a sense of duty. Knowledge of (regular) working conditions in nursing can lead to both a desire to support former colleagues and a refusal to be exposed to these conditions again.

Conclusion: Past working experiences and the current employment situation play a major role in the willingness of inactive nurses to return to nursing in a crisis situation. Unbureaucratic arrangements must be provided for those who are willing to return.

Summary Statement:

- What already is known - In crisis situations, not every inactive nurse is willing or able to return to nursing and therefore, the 'silent reserve' may not be as large as suspected.
- What this paper adds - Inactive nurses need to know what to expect and what is expected of them for their decision regarding a return to active patient care during a crisis situation.

- Implications for practice/policy – Inactive nurses need to be informed and should be offered free training and refresher courses to ensure patient safety.

Impact: This research shows that the group of inactive nurses are not a silent workforce which can be activated anytime. Those who are able and willing to return to direct patient care in crisis situations need the best possible support – during and between crises.

Reporting Method: This study adhered to COREQ guidelines.

No Patient or Public Contribution: The involvement of patients or members of the public did not apply for the study, as the aim was to gain insight into the motivations and attitudes of the group of inactive nurses.

KEYWORDS
crisis, deployment, disaster nursing, former nurses, inactive nurses, nursing shortage, pandemic, reserve, return

1 | INTRODUCTION

During the COVID-19 pandemic, the nursing profession received high recognition worldwide, for example, through the famous clapping on balconies. Nurses became much more visible to politicians and the public and were referred to as 'heroes' in many countries (Halberg et al., 2021). At the same time, when the care of the sick and those in need of care became critical in some cases, the already existing nursing shortage became more apparent. Inactive nurses are seen as a valuable resource for staff augmentation and efforts were made to mobilize them.

2 | BACKGROUND

In Germany, around 1.2 million health care professionals are employed (Bundesagentur für Arbeit, 2022). Like many other countries, Germany already has a shortage of nurses. The number is currently estimated at 200,000 and is expected to increase to about 500,000 by 2030 (Deutsches Ärzteblatt, 2021). One of the reasons is that a significant number of nurses leave the profession prior to retirement. Factors contributing to the decision to leave are, for example, understaffing, emotional exhaustion, poor patient safety, performing non-nursing care, career options, shift patterns and working hours as well as remuneration (Lücker et al., 2022; Sasso et al., 2019), and more generally, job satisfaction, work environment and organizational culture (Chan et al., 2013). Nurses who have left the profession prior to retirement are referred to as 'retired', 'left', 'former' or 'inactive' nurses. For many of these inactive nurses some attachment to nursing remains (Kox et al., 2020; van der Cingel & Brouwer, 2021) and a large proportion of them subsequently continues to work in health or care-related jobs (e.g. Black et al., 2008: 40%). It is so precarious because this professional turnover is different from organizational turnover in that skills are lost to the profession as a whole (Parry, 2008).

The group of inactive nurses is considered a resource to draw on in the event of staff shortages (Castner et al., 2021) and is therefore often referred to as the 'silent reserve' or as the 'shadow workforce' (McIntosh et al., 2006). In Germany, the number of these nurses is estimated at about 864,000 (Auffenberg et al., 2022).

In this article, nurses are defined as those who have completed at least 3 years of nursing training. In Germany, this includes general, paediatric and geriatric nurses who are able to work in hospitals as well as in outpatient care. General nurses are qualified to care for adults in all medical fields. Paediatric nurses are specialized in care for children, and geriatric nurses in care for the elderly. This separation is not absolute, it is possible for all three groups to work in the other sectors as well. In Germany, nurses work mainly by delegation, that is, on the orders of doctors. Currently, many more nurses qualify through vocational training than through university studies and the definition of advanced competencies and tasks is ongoing (Prommersberger, 2020). Therefore, professional responsibilities of vocational and academic qualifications are currently still largely equivalent. In the German health care system, public and private (for profit) hospitals, nursing homes and outpatient care institutions co-exist.

However, unlike in many other countries, such as the United States of America (National Council of State Boards of Nursing [NCSBN], 2022) or the United Kingdom (Nursing & Midwifery Council [NMC], 2022), there is no mandatory registration of nurses in Germany and also no revalidation process to stay registered and being able to work in nursing. Only a one-time qualification as a nurse is required for working in the profession. For this reason, immediate deployment of trained nurses would be possible at any time. However, due to the lack of a register, the exact number of active and inactive nurses remains unknown and thus inactive nurses cannot be contacted directly.

Therefore, inactive nurses in Germany were called upon from various sides to register for a temporary return to patient care during the COVID-19 pandemic. The term 'registered' is used here exclusively in connection with the declaration of willingness for

deployment in the crisis situation, since, as mentioned, there is no mandatory professional register for nurses in Germany. These informal registration opportunities for a deployment during the pandemic were offered by a variety of providers, for example, by hospitals, public health services, medical services, specially founded placement platforms or even recruitment agencies (Mai, 2020).

For nursing home managers, the COVID-19 pandemic posed an extraordinary challenge. They had to manage an increased staff need due to additional tasks such as the implementation of infection control measures. A high number of infections among the residents also increased the risk of infection for the already scarce staff, who had to be substituted in the event of quarantine or illness (Sander et al., 2023).

Various studies have shown that only about a third of inactive nurses are willing to volunteer for a deployment during a crisis (Fothergill et al., 2005; Seah et al., 2021). Furthermore, the willingness of active nurses to respond to disasters depends, for example, on the type of disaster and concerns for family and about personal safety (Chaffee, 2009; Cone & Cummings, 2020; DeKeyser Ganz et al., 2019). For natural disasters, the willingness was higher than for man-made emergencies, such as radiological events or infectious diseases (Veenema, 2018). However, the data are ambivalent and willingness can also depend on the type of disease (Qureshi et al., 2005).

Earlier research by the authors (Lücker et al., 2022) elicited factors associated with the registration of inactive nurses for deployment during the COVID-19 pandemic in Germany. This led the authors to the current, more in-depth research.

3 | THE STUDY

3.1 | Aim

The aim of the study was to investigate factors that influence the willingness of inactive nurses to return to nursing in a crisis situation and to identify aspects to be considered with regard to a possible deployment.

3.2 | Design

Semi-structured focus group interviews were conducted. Focus groups were chosen as they allow open-ended responses and can provide an in-depth understanding of people's views, their attitudes, beliefs and opinions as well as influencing factors (Willis et al., 2009). Furthermore, new insights can be generated in focus groups through listening, interaction with others and reflection (Krueger & Casey, 2009). A qualitative content analysis (QCA) was then carried out as described by Kuckartz (2019). QCA is defined as 'the systematic reduction of content, analysed with special attention to the context in which it was created, to identify themes and extract meaningful interpretations of the data' (Roller & Lavrakas, 2015). The advantage of QCA is its flexibility: It is possible to proceed deductively or inductively or in combination and to consider both manifest and latent meaning (Cho & Lee, 2014). It is also very similar to thematic analysis. The main difference lies in the possibility to additionally quantify data in qualitative content analysis (Vaismoradi et al., 2013). When comparing the two methods (Figure 1), it becomes apparent that in qualitative content analysis, the research question is placed at the centre of a circular process and returned to repeatedly during the five phases of analysis (Kuckartz, 2019) rather than completing a more linear process in six steps (Braun & Clarke, 2022).

Study design and conduct are reported in line with the consolidated criteria for reporting qualitative studies COREQ guidelines (Tong et al., 2007).

3.3 | Participants

In qualitative research, the focus is on the characteristics of the population rather than representativeness (Ritchie et al., 2003).

Due to the difficulty of accessing the research population and in order to consider a diversity of perspectives (Ritchie et al., 2003), we used different sampling methods: convenient, opportunistic and snowball sampling (Isaacs, 2014; Ritchie et al., 2003) via e-mail, telephone or a call at an online congress. In this way, focus groups were attended by a few people known to individual researchers from their wider circle of (former) colleagues, but predominantly people with whom the researchers had their first contact on this occasion. Eligibility criteria for participation were as follows: (1) being an inactive or marginally (less than one shift or 8 h per week) employed qualified nurse (nurses are defined as those who have completed at least 3 years of nursing training) or being an active nursing home manager (who usually work full time) and (2) the willingness to provide informed consent for participation. Two intensive care unit nurses who had returned to nursing after a period of inactivity also responded and as their experiences were expected to be valuable, the inclusion criteria were expanded accordingly. Thereby, all interested participants were included. Communication prior to the focus group interviews was via e-mail.

3.4 | Data collection

Different focus groups were formed (non-registered inactive nurses, registered inactive nurses, returned nurses and nursing home managers) and conducted as video conferences. For the focus groups, a semi-structured interview guide was developed on the basis of results of a previously conducted online survey on the willingness of inactive nurses to return to nursing during the COVID-19 pandemic (Lücker et al., 2022). It was discussed with the research team, but due to the difficulty of reaching the main target groups, we decided against pilot testing. For the different groups, the guide was slightly adapted. It included the following questions (Table 1):

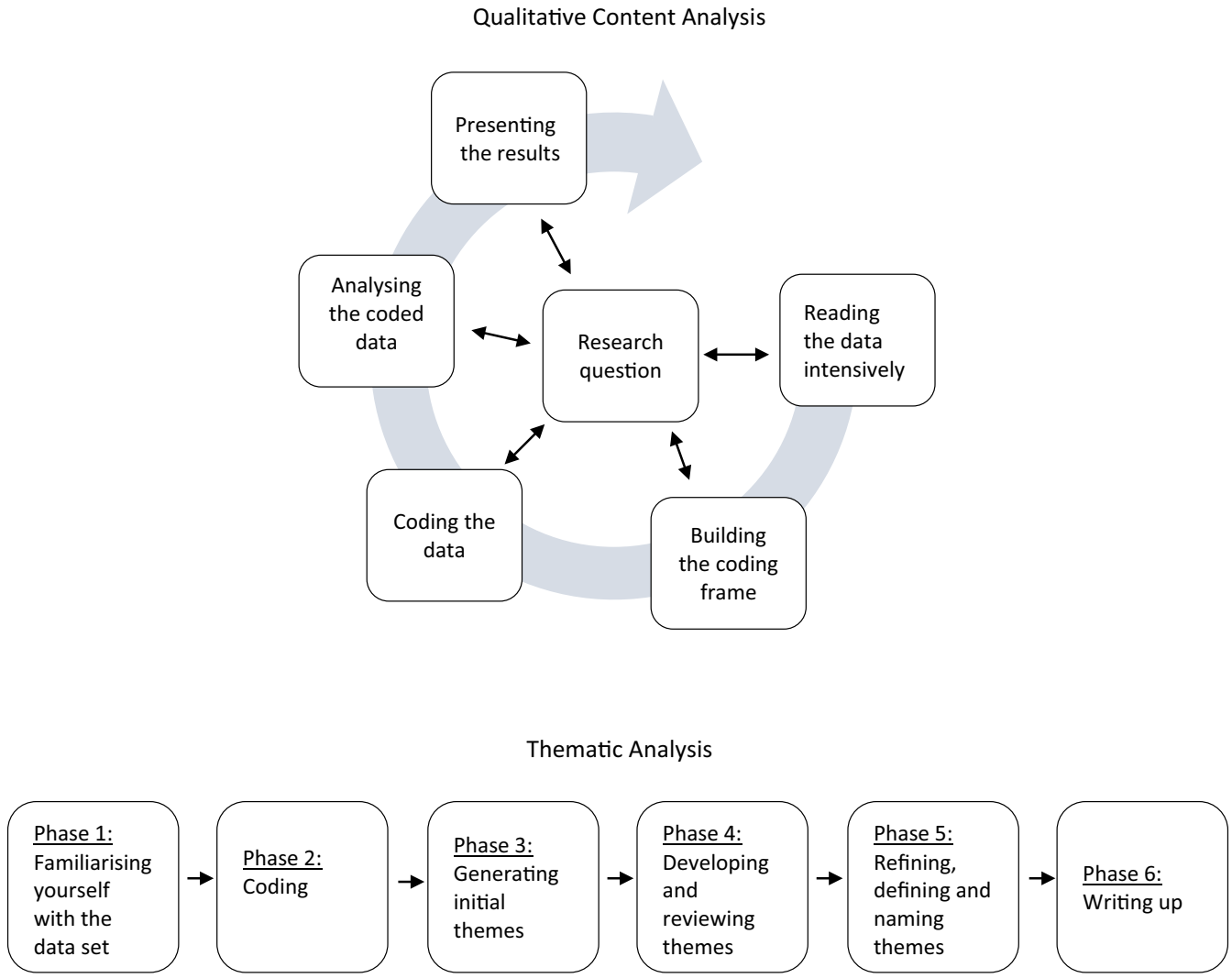

FIGURE 1 Comparison of qualitative content analysis (Kuckartz, 2019) and thematic analysis (Braun & Clarke, 2022).

The focus groups took place in October and November 2021 as video conferences lasting between 90 and 110 min. All were moderated by PL (Interviewer I) and all but two were co-moderated by EH (Interviewer II). An additional one-to-one telephone conversation with a participant who was initially registered but withdrew this willingness was conducted by PL. Participants were presented with some of the results of the previous online survey (Lücker et al., 2022). These included, for example, the proportion of participants who had registered for a deployment that many inactive nurses still feel a sense of belonging to the profession, and reasons against registration or a return to nursing.

It was accepted that participants went off topic as the discussion should remain open for additional but related topics. Participants were redirected when they deviated from the basic topic. After conducting the planned focus groups, the research team assumed data saturation.

No notes were taken and the video recordings of the focus group interviews were transcribed according to defined rules and the transcripts were again compared with the recordings. The transcripts were not returned to participants for checking.

3.5 | Ethical considerations

This study was approved by the Ethics Committee of the University Medicine Greifswald (BB168/21).

The participants were informed in advance about the purpose of the research, the procedure and their rights prior to the video-recorded focus group interviews. Informed consent was obtained by all participants. One participant was not able to join the focus groups. Instead, a telephone interview was conducted and audio-recorded. Before the focus groups started, the interviewers described again the aim of the research and their personal interest in the study as well as their professional background.

The recordings were stored on the secured server of the Institute for Community Medicine at the University Medicine

TABLE 1 Focus group interview questions.

Why do you think that significantly more people who were not registered took part in the online survey?
What do you think are or could be the reasons for the differences in the registration of academically qualified and vocationally qualified nurses?
In what way do you feel connected to the nursing profession or to your former colleagues?
Do you have an explanation for the fact that the most frequently cited reason against registration was that there was no perceived need?
What do you think can be done to overcome obstacles to registration? Do you see any chance to reach out to inactive nurses with a very negative attitude and motivate them to be available in a crisis?
What do you think regarding the expressions of thoughts about being back in direct patient care? Why are they so different? What conclusions should care institutions and health policy draw from them?
How do you interpret the results of the evaluation of deployments by nurses?
Which preparations/support measures for a return to patient care during a crisis would be necessary/desirable/helpful?
Do you think that there is a relevant so-called 'silent reserve' of inactive nurses who would be available in the event of a crisis? To what extent could these nurses provide support?

Greifswald. After transcription, only the pseudonymized transcripts were kept on the server and the recordings were deleted.

3.6 | Data analysis

The interviews were recorded and transcribed. Since the participants repeatedly drifted off topic and addressed rather general aspects of health care and nursing or a permanent return to nursing in the interviews, in a first step, we marked the contents of the transcripts that explicitly referred to a crisis situation. Only these text passages were included in the subsequent analysis. QCA was conducted in five phases as described by Kuckartz (2019).

During the initial reading, memos were written. The initial coding was done by PL (Interviewer I), followed by discussion and further coding in close consultation with EH (Interviewer II). Categories and subcategories were formed deductively on the basis of the interview guide and inductively in an iterative, systematic process (Kuckartz, 2019). The analysis was conducted directly without paraphrasing (audiotranskription, 2021) using MAXQDA.

The initially used word 'registration' was changed to 'willingness' for a return during a crisis in the course of the text work, since it became clear that a basic willingness to return to nursing in a crisis, which was the core question of our study, is independent of formal registration.

3.7 | Rigour

The two female interviewers (PL and EH) gained experience with focus groups and QCA through previous studies. They were inactive nurses (general/paediatric) and worked as research assistants (MSc/MA) in the field of health services research. The interest in the topic and the initiation of the study resulted from their own decision to register for possible deployment during the pandemic.

These aspects made them both insider researchers, with the associated advantages and disadvantages, such as having the experience of working in nursing, leaving the profession and making the decision to return during the pandemic as well as the risk of making assumptions based on these experiences (Johnston et al., 2017). To avoid bias, a reflexive approach and self-reflection (Holmes & Gary, 2020) were used during the interviews and the analysis. This was achieved by being open to new topics during the interviews and analysis, and the regular discussions of results and the category system within the team (Barrett et al., 2020), which consisted also of researchers who were not nurses but doctors with experience in qualitative research.

QCA according to Kuckartz relies on consensual coding, reliability and transferability as quality criteria (audiotranskription, 2021). The achievement of these criteria was agreed upon within the research team.

4 | FINDINGS

4.1 | Sample characteristics

Six focus groups and one individual telephone interview were conducted with a total of 18 people. The sample is described in Table 2.

The 18 participants came from different regions all over Germany. Fourteen of them had a qualification as general nurses, three as geriatric nurses and one person had no nursing background, but had been working for many years as a manager of care facilities. The work experience of those nurses who left the profession was between 1 and 13 years. The majority of the participants ($n = 15$) were no longer working in direct patient care, apart from one person who was still working less than one shift per week in nursing as a part-time job. Two people returned to direct patient care after working in different jobs, for reasons not related to the pandemic. The withdrawal of registration of one person was due to a change of operator of the registration platform from a civil foundation to the Federal Ministry of Health. All but two of the participants continued to work in the wider field of health and/or care.

The QCA covered the following three themes which resulted from the research questions with categories and subcategories (Table 3).

4.2 | Theme 1: Factors influencing the willingness of inactive nurses to return to nursing in a crisis situation

The willingness to return to patient care in the event of a crisis was considered in a very differentiated manner, taking many aspects into account.

TABLE 2 Description of the sample (participants of the focus groups).

Focus group	Pseudonym	Qualification(s)	Sex	Current occupation
Not registered I	A.	• General Nurse • Deg. Health Economy • Deg. Public Health	M	Public Health Service
	B.	• General Nurse • Deg. Nursing Science	F	Science & Research
	C.	• General Nurse • Training Intensive and Anaesthesia Care • Training mentoring nursing students	F	Controlling/Accounting (Hospital)
Not registered II	D.	• General Nurse • Training Intensive Care	M	IT in the care sector
	E.	• Geriatric Nurse • Deg. Nursing Science	F	Science & Research
	F.	• General Nurse • Training Intensive Care • Deg. Nursing Science	F	Science & Research
Registered I	G.	• General Nurse • Deg. Nursing Science	F	Science & Research
	H.	• General Nurse • Working experience in Intensive Care • Deg. Nursing Science	F	Science & Research Nurse in Intensive Care (10% part-time)
Registered II	I.	• General Nurse • Deg. Medical pedagogy	F	Freelance lecturer
	J.	• General Nurse • Training Operating Theatre Care • Deg. Arts and Humanities	F	Freelance lecturer
	K.	• General Nurse • Retail salesperson • Deg. Electronic	M	Electronics Engineer
	L.	• General Nurse • Various nursing-related additional qualifications, incl. Care Home management and Quality Management	F	Quality Management Auditing
Returnee	M.	• General Nurse • Training Intensive Care • Training mentoring nursing students	F	Nurse in Intensive Care (return after 3 months), freelance lecturer
	N.	• General Nurse • Various nursing-related additional qualifications, incl. nursing management	F	Nurse in Intensive Care (return after 15 years of work predominantly as nursing manager)
Care Home Manager	O.	• Geriatric Nurse • Deg. Care Management	M	Care Home Manager
	P.	• General Nurse • Training Care Home Manager	F	Owner Care Home, Care Home Manager
	Q.	• Deg. Law	F	Management of municipal social institutions
Registration withdrawn (telephone interview)	R.	• General Nurse • Deg. Nursing Science	F	Science & Research
Interviewers	Inter-viewer I	• General Nurse • Deg. Health & Social Care • Deg. Prevention & Health Psychology	F	Science & Research
	Inter-viewer II	• Paediatric Nurse • Deg. Care Management • Deg. International Health	F	Science & Research

Abbreviations: Deg., Degree; F, Female; M, Male.

TABLE 3 Category system.

Theme	Category	Subcategory
Theme 1: Factors influencing the willingness of inactive nurses to return to nursing in a crisis situation	Perception of a crisis and the need to return	Functioning health system
		Wait and see, observe
		'Nursing and care as a permanent crisis'
		Needs of the care institutions
	Role and Identity	Sense of duty
		Sense of belonging/Attachment to nursing
		Relevance of 'new' job
		Flexibility in the 'new' job
		Childcare
	Appreciation	Financial
		Social
		Differences in geriatric care and general/paediatric nursing
	Working conditions	Deteriorating working conditions in nursing/care
		Compensation for general staff shortages
		Fear of infection
	Competences, legal issues	Own competencies
		Fear of making mistakes, patient safety
	Communicating general conditions of deployment in advance	
	Non-willingness	Out of frustration, 'revenge', power
		Meaningfulness of convincing the unwilling
		Further reasons
	Promotional measures	Financial incentives
		Mandatory obligation
Theme 2: Aspects that need to be considered with regard to deployment	Self-determined employment conditions	Kind of institution, ward, medical field
	Support, knowledge and skills	Induction
		(Online-)Training, programmes
		Mentor, contact person
		Organizational matters
		Clarification of responsibilities
		Easing fears, offering mental support
	Existing team	Integration
		Thankfulness
		Volunteers as a burden
	Actual deployment of inactive nurses during the COVID-19 pandemic	
Theme 3: Further considerations	Organizing inactive nurses who are willing to return to nursing in a crisis situation	Maintaining a pool, a 'reserve'
		Implementer of the organization
	The 'silent reserve'	
	Reasons against the deployment of inactive nurses	

4.2.1 | Perception of a crisis and the need to return

Reasons for not registering were seen in the perception of a basically well-functioning German health system and pandemic management as well as the presentation of the situation in Germany in the media.

> And I think what I've heard in the media … that we had a bit of a head start, compared to Italy, because some measures were simply implemented much earlier in our country, … So, some things, like the lockdown, were introduced much earlier, so that the numbers wouldn't go up so much.
>
> (B., not registered)

Additionally, the situation in nursing has been precarious for many years and this is perceived as normal.

> Crisis situations occur every day and are no longer perceived as anything special. It's an infection.
>
> (D., not registered)

According to the focus group participants, these points led to the fact that many inactive nurses did not perceive a need to come forward and wanted to wait and observe the situation before declaring their willingness to help out in nursing.

Nursing home managers mentioned that institutions did not need additional staff all the time and therefore might have rejected offers of support.

> There might be a phase when I have two areas that are quarantined, where I think, oh God, where can I get someone to support me on short notice, because I don't have anyone at the moment. And maybe at another time, when my staff has returned, two or three [volunteers] come forward, where I say, well, at the moment I don't need them, fortunately.
>
> (O., nursing home manager)

In some cases, this may lead to the impression that care institutions can manage without any help.

4.2.2 | Role and identity

A return to nursing in a crisis situation can also be determined by the perception of one's identity and role. Willingness can be elicited by a sense of duty that relates both to the fact that the needed skills are available and to the knowledge of how much the active nurses need support in a crisis situation. The same applies to a feeling of belonging to the nursing profession or a feeling of still being a nurse. Participants explained that they often say that they are actually nurses before they name their current occupation (G., registered). A connection remains and the desire to support active nurses or to improve their situation, for example, by working in nursing science (H., registered). However, that inactive nurses could have a 'fire brigade mentality' (D., not registered) or could themselves see or be seen as heroes like 'Superman' (G., registered) were seen rather negatively. Both expressions imply that inactive nurses would immediately return to full duty, which was considered rather unrealistic. This is especially true for inactive nurses who left the nursing profession years ago and lack routine, which could pose a risk to patients.

The 'new' job has also a strong influence on the willingness and the possibility to help out in a crisis situation. Due to continued employment in the health sector, some of the participants did 'not consider' to return to nursing (A., not registered). One reason is the relevance of the current occupation for the functioning of the health system. This applies to nursing home managers who are also trained nurses, for example. They directly experience the distress of the active nurses, but the task of ensuring the organizational care of residents is of higher priority than directly supporting their staff.

The expectation to be able to just leave the current job is seen as 'disregarding its relevance' or the 'value' of the job holder (D., not registered). Therefore, the assumption that inactive nurses would 'jump out of corners to be there' (D., not registered) to support the system was met with incomprehension.

Another point is the flexibility in the new job. Flexible working hours, such as in academia, or part-time work in the regular job would make it possible to work in nursing during a crisis. In both cases, this means the deployment comes in addition to the regular job with a burden of additional working hours and organizational effort.

For those participants who have children, the question of childcare was less important, but the identity as a mother, breastfeeding the child and the fear of infecting the family were at the forefront of the decision not to help out in nursing.

4.2.3 | Appreciation

Appreciation of the profession or their members is an aspect that has been raised repeatedly by the participants. They mentioned the necessary financial appreciation of the profession as a whole, but also for those who are available in crisis situations. Apart from a salary for deployment, it was suggested that this should at least be treated as an honorary position, that is, to pay a lump sum for honorary work and to allow time off, for example, for further training. In the opinion of the participants, this financial appreciation could also increase social appreciation, which was only expressed at the beginning of the pandemic, but is missing overall, for example, by non-compliance with infection control measures.

> … how many [people] are behaving at the moment, …. That makes me pretty angry …. That many [people] simply don't have any understanding at all. That in the end the nursing staff is simply overburdened again …
>
> (F., not registered)

General differences in appreciation between care for the sick and care for the elderly to the disadvantage of the latter are also perceived, which may have an influence on the willingness of general nurses to help out in nursing homes.

4.2.4 | Working conditions in nursing

Fears, apprehensions, concerns and reflections are important aspects when considering returning to nursing. They were often related to negative working conditions, for example, high workload with staff shortages, shift work and low recognition of the work. These working conditions are often also the reason for leaving the profession, and the associated feelings seemed to be very present during the focus groups.

> You always think "Oh well, it will... get better again", and then there are also better days and then the next drama happens and at some point, enough is enough and you leave.
>
> (G., registered)

Participants compared the general working conditions in nursing as described above with their current job and the expectation that those in nursing were even worse due to the crisis situation. This also included a lack of personal protective equipment at the beginning of the pandemic and the risk of getting infected.

Furthermore, the fear was expressed that attempts could be made to compensate for the general lack of staff with inactive nurses (D., not registered) and thereby exploit their willingness to support former colleagues.

The nursing home managers pointed out that nursing in a nursing home is in many ways very different from nursing in a hospital. The higher responsibility, because a doctor is not available at all times, is challenging for many general nurses.

4.2.5 | Competencies, legal issues

Above all, concerns were also expressed that competencies and knowledge might no longer be sufficient and that the legal protection is probably unclear. In particular, being deployed in a nursing area where the inactive nurses had no previous experience (G., registered) or having to take responsibility for an area without having routine triggered fears.

> If I had been the only qualified staff member there, ... that would have been difficult, but if I had stepped in as a supporting staff member, then it might have been okay. But to take over the main responsibility for such a whole area, as an outsider, I don't think I would have dared to do that.
>
> (G., registered)

Patient safety was clearly a concern. It was expected that the already high workload would increase:

> Not four but eight intensive care patients would have to be cared for .... This can't be done.
>
> (C., not registered)

In intensive care, there are seriously ill patients and it is very easy to make mistakes (F., not registered). The participants doubted that they would receive support from the institution in case of making mistakes (C., not registered).

It was proposed to introduce courses and trainings for inactive nurses before and during deployments to refresh and impart knowledge, for example, via online courses (R., nursing home manager).

4.2.6 | Communicating general conditions of deployment in advance

Participants stressed the importance of announcing in advance the conditions under which a deployment would take place to reduce insecurity.

> So, when you step back in, what does that mean? Do I have to do a night shift alone on a 30-bed internal medicine ward? Or do I assist on day duty with tasks that the permanent staff on the ward can no longer manage? What is my role? Am I supporting, helping and reducing the workload? Or do I have to take complete responsibility for care?
>
> (H., registered)

To increase inactive nurses' willingness, they need to know what to expect if they come back in a crisis situation and what is expected from them.

4.2.7 | Non-willingness

Across all groups, there was empathy for those who left the profession in frustration and simply did not want to return to care. For some inactive nurses, it might be

> ... a kind of revenge, because it was predictable and there was no emergency plan and they felt exploited for years, and now those who are responsible for the health system are supposed to see how they cope.
>
> (H., registered)

However, it was also suspected that moral injuries resulting from working conditions in nursing might be so deep-seated that a return is ruled out (H., registered).

> So many mistakes and accidents happen and nothing changes and the care becomes more unsafe and at some point, it just doesn't work anymore.
>
> (G., registered)

In this context, the question arose to what extent it would make sense at all to try to persuade those who do not want to return. Nursing home managers 'don't have the energy to convince them' (R., nursing home manager) and they think that 'you wouldn't do the people in need of care any good' either (Q., nursing home manager), which relates to patient safety.

However, for some of the participants, it is not frustration or revenge that prevents a return. For them, nursing is simply a completed stage of life, which is over and done (D., not registered).

4.2.8 | Measures to promote willingness

Although the participants largely agreed that it might be helpful to approach people directly to encourage their willingness to work, concerns were also expressed that inactive nurses might feel pressured by former colleagues or others to declare their willingness (C., not registered), even though they really do not want to or do not actually feel able to work in nursing again. Intrinsic motivation (M., returnee) and the willingness to do this kind of work (K., registered) are seen as essential for this special job. In this respect, financial incentives were mentioned but are also viewed controversially:

> Money is an important thing, but it [nursing] is not only about the money.
>
> (K., registered)

For the reasons mentioned above, a mandatory return of inactive nurses was rejected by all groups:

> … I think that is the completely wrong approach, I can't force anyone who is out to continue doing it and I think that nursing in particular is a profession, if I don't enjoy it and I am obliged to do it, then there is no point, I might as well stay at home. That doesn't help my colleagues and it doesn't help anyone else.
>
> (J., returnee)

A forced return was seen as endangering patients and placing an additional burden on active nurses (M., returnee) who would have to work with unwilling colleagues and control their work.

4.3 | Theme 2: Aspects that need to be considered with regard to deployment

Apart from the willingness of inactive nurses to return to work in the event of a crisis, aspects regarding an actual deployment must also be considered.

Participants mentioned several times that they wanted to have a say in deployments, for example, in terms of working hours, locations or medical specialties. They would like to have a sense of control and not like to be simply assigned (B., not registered).

4.3.1 | Support, knowledge and skills

The focus group participants expressed different opinions about inactive nurses' skills. Some assumed that nursing, similar to riding a bicycle, is not unlearned (E., not registered), others said that the fire brigade also has to train regularly to be prepared (D., not registered) and to work successfully.

However, there was no doubt that induction is essential, but participants were also aware that this can hardly be guaranteed in a crisis situation (F., not registered). Nursing home managers confirmed that induction means a considerable effort. Especially since someone who only wants to help out for a week or two is gone just when they know what to do (S., nursing home manager). This was confirmed by one of the active intensive care nurses:

> And I personally, even if it sounds bad now, I found it more of a burden. I found it exhausting. I found it exhausting to take someone with me, to show them things where I know exactly that, at the end of the day, they'll come and help when the place is on fire, but more than helping me to turn the patient on his side and fetch a pillow … is not possible anyway.
>
> (M., returnee)

For preparation, participants suggested (online) trainings, for example, for first aid, medication or hygiene measures (C., not registered). Knowing the most important telephone numbers, knowing who is the main contact person, which patients one is responsible for and generally clarifying responsibilities should be among the first things inactive nurses get to know (C., not registered). A mentor, a fixed contact person (H., registered) or at least a fixed team (C., not registered) was considered important in order to convey security and alleviate fears. In this regard, at least for the inactive nurses, to offer psychological support was suggested (B., not registered).

4.3.2 | Existing team

For the inactive nurses, it was considered important that they can work in a permanent team and be integrated into this existing team (C., not registered). One participant expected that the active nurses would be grateful for the support and 'celebrate' inactive nurses (A., not registered). However, there were also opposing views, namely, that the already overworked nurses would perceive those who are not inducted as an additional burden. Participants mentioned inactive nurses who returned to their previous ward and were better able to get back to work as a result (G., registered).

4.3.3 | Actual deployment of inactive nurses during the COVID-19 pandemic

Only two of the participants were actually deployed, both not in direct patient care, but due to the greater flexibility in working hours in a vaccination centre and in a testing setting.

Although a well-founded induction was considered essential, the inactive nurses also knew that this would hardly be possible in a crisis situation. This was confirmed by the participating active nurses:

> … proper training is not possible at all at the moment. Because we are simply too few people.
>
> (N., returnee)

4.4 | Theme 3: Further considerations

The participants found it useful to maintain a pool of willing volunteers and keep their contact details even after the COVID-19 pandemic, so that they can be contacted quickly in future crisis situations or can have a look where they might be needed online. It seems to be important who would manage such a pool, as one participant withdrew registration due to a change of operator and uncertainty about what the personal data provided would be used for (R., registration withdrawn).

Outside crisis situations, it is suggested to offer training and maintain communication to create a positive attitude among inactive nurses.

4.4.1 | The 'silent reserve'

Participants were sceptical about the existence of a significant so-called 'silent reserve' of inactive nurses, whose services could be called upon in case of a crisis.

> … I think there are a lot of people who have gained experience in the profession or have done training, but who would no longer work, for different reasons.
>
> (G., registered)

4.4.2 | Reasons against the deployment of inactive nurses

However, the participants mentioned also reasons for not deploying inactive nurses. On the part of the nursing home managers, this wespecially true for those inactive nurses who can only cover for a very short time (S., nursing home manager). Although nursing home managers were sometimes desperate for staff, such applicants were usually rejected because the effort required to train them would have outweighed the benefits. For the other participants, another reason for not deploying inactive nurses would be that they want to help out solely for financial reasons (K., registered). As stated earlier, intrinsic motivation is seen as essential for the job (M., returnee). It was also seen very critically that there could be inactive nurses who might have an 'adventurous spirit' and be eager to rather perform certain procedures or operate machines than actually care for patients. This would take the focus off the patient (H., registered).

5 | DISCUSSION

The decision of active nurses to respond to disasters is well studied and depends, for example, on the type of disaster, concerns for family and about personal safety (Chaffee, 2009; Cone & Cummings, 2020),

For inactive nurses, there is a range of different aspects which contribute to their willingness and ability to return to nursing in a crisis situation (Qureshi et al., 2005). Our results are in line with findings that the reasons for leaving the profession, their current job and (perceived) skills and competencies (Chaffee, 2006; Grochtdreis et al., 2020; Lücker et al., 2022) play a role in deciding whether to return to nursing in such a situation or not. It was repeatedly found that only about one third of inactive nurses would return to nursing during a crisis (Fothergill et al., 2005; Lücker et al., 2022). In order to increase their number and to make deployments successful, various aspects need to be considered.

First of all, inactive nurses must perceive a crisis situation as such (Boin et al., 2018). Aoyagi et al. (2015) found confirmation of the hypothesis that when a threat is perceived as low, the willingness for a deployment is also low. Therefore, communication is crucial. Sørensen (2022) explains the role of inadequate communication in emergency responsiveness. Together with insufficient disaster health literacy as "the ability to read, understand, and use information to make informed decisions and follow instructions in the context of mitigating, preparing for, responding to, and recovering from a disaster" (Brown et al., 2014) and a lack of emergency preparedness, inadequate communication led to poor emergency responsiveness during a chemical incident in the Netherlands (Sørensen, 2022). In Germany, the situation in hospitals seemed to be under control at all times during the pandemic.

Another aspect is the identity as a nurse. Despite giving up the profession, very often, being a nurse remains part of the identity of those who have been trained in this profession (van der Cingel & Brouwer, 2021), accompanied by a sense of duty to use one's skills and help in a crisis (Lücker et al., 2022; Zipf et al., 2022). However, many inactive nurses continue to use their nursing knowledge and skills in jobs in the health sector (Black et al., 2008). This new job becomes also part of their identity (Cachia, 2017) and affects the willingness and even more the ability to return to nursing as the current profession may be equally important for the functioning of the health system and managing a crisis.

In their new job, inactive nurses may also feel more appreciated for their work. Feeling unappreciated is one of the reasons for leaving nursing (Ellison, 2021). The clapping from balconies and the hero narrative as a sign of appreciation, particularly at the beginning of the COVID-19 pandemic, were viewed rather negatively by many active and inactive nurses. The hero narrative, in particular, is seen as problematic because it implies invincibility and self-sacrifice and shifts the responsibility for solving problems from politics to hospitals and nurses (Halberg et al., 2021).

In many countries, the already difficult working conditions deteriorated further. Nurses reported a lack of equipment, knowledge and training and many of them experienced moral conflicts (Zipf et al., 2022). The risks of not having protective equipment and contracting an infection are among the reasons not to return (Chaffee, 2009). Even for active nurses, who have routines and up-to-date knowledge to fall back on, the COVID-19 pandemic was a major challenge and posed the risk of moral conflicts (Silverman et al., 2021).

Moral conflict or moral distress results from (repeatedly) performed or observed actions against one's values (Shay, 2014) on individual, relational, organizational and systemic levels (Silverman et al., 2021). Moral injury is a deep-rooted violation of these values. Senek et al. (2020) report demoralization that led to leaving the profession during the pandemic due to missed care and perceived lack of support. It remains unclear whether moral distress and moral injury continue to have long-term effects after leaving the profession, and if so, what these effects may be, and whether they may negatively influence the willingness to engage under emergency conditions. However, based on statements made in the focus group interviews, a lasting effect can be suspected.

To combat moral distress, effective leadership communication is seen as an important means (Lake et al., 2022). Inactive nurses need to know in advance what tasks and responsibilities they will face during a deployment in nursing, whether their skills and knowledge are sufficient or whether they can organize their private and regular professional commitments before they decide to return. Thus, there are several starting points for uncertainty and potential lack of autonomy. Lack of autonomy is known to be a negative factor for job satisfaction (Hendam et al., 2018) and one of the reasons for leaving the nursing profession. Therefore, the experience or expectation of a lack of autonomy may prevent willingness to return even for a limited time. The decision for or against deployments should be an informed one.

Theoretically, their nursing qualification enables a German nurse to work in all nursing areas, medical disciplines and health situations. Therefore, society and politics may expect them to be knowledgeable, qualified and ready to help and able to provide quick and quality support (Grochtdreis et al., 2020). However, nurses are not a homogenic group with identical competencies (Halberg et al., 2021) and even active nurses do not feel confident about their knowledge and skills in exceptional situations (Grochtdreis et al., 2020). Those who have not worked in nursing for many years may lack knowledge and doubt their skills, leading to uncertainty, anxiety and fear (Seah et al., 2021) and compromising patient safety. Additionally, a lack of knowledge is also an additional burden for regular staff that need to induct and supervise deployed personnel. In a literature review, Chaffee (2009) found evidence that education and training can generally increase nurses' willingness to respond to disasters.

Moreover, in Germany, the legal situation for employment of inactive nurses was a hurdle. The inactive nurses were not offered a uniform and, above all, simple and unbureaucratic regulation and assistance for short-term deployment during the COVID-19 pandemic. A deployment had to be agreed with the current employer, unpaid leave to be applied for or a second job to be registered and an employment contract with all the resulting rights and obligations to be signed with the institution (Vereinte Dienstleistungsgewerkschaft [Ver.di], 2022). This bureaucracy contradicts the need to be able to draw on qualified staff quickly in the event of a crisis. Against the background of a likely increase in pandemics and other crises in the future, it is essential to simplify the procedure. A generally applicable, unbureaucratic procedure should be established.

There should be a central point for inactive nurses where they can declare their general willingness for deployments in crisis situations and where they can get support with questions and concerns. Free training and refresher courses could also be offered via this platform. Although nursing, in general, is probably not unlearned, training and up-to-date knowledge are necessary.

In order to combat the nursing shortage and thereby make the health system, in general, less vulnerable to crises, the retention of active nurses needs to be promoted in the long term by improving working conditions in nursing, for example, reliable duty rosters and thus the ability to plan leisure time, sufficient number of staffs, possibly combined with a redistribution of tasks. Currently, a large number of people start nursing training but many of them drop out or leave the job within the first few years of employment (Kox et al., 2020).

The calculation of at least 263,000 and up to 583.000 full-time equivalents of inactive nurses ready to permanently return to nursing under improved working conditions in Germany, mentioned in the study by Auffenberg et al. (2022) could tempt one to regard this number also as a silent reserve for emergencies. However, it does not allow any conclusions to be drawn about the number of inactive nurses available in crisis situations, particularly as a considerable proportion of them not only work in other health and care jobs, but also work as active nurses abroad (OECD, 2019).

5.1 | Limitations

To our knowledge, this is the first qualitative study that investigated the willingness of inactive nurses regarding a temporary professional return to nursing during the COVID-19 pandemic and gathered opinions of different groups. However, we can only make statements about Germany.

During the focus groups, the participants touched on a variety of topics which do not exclusively refer to a temporary return to nursing during the crisis situation, but repeatedly also addressed a general return of inactive nurses to nursing. Thus, we cannot guarantee a strict distinction between statements on temporary and permanent return. However, it is important to emphasize that the willingness to return in a crisis situation should not be misunderstood as a willingness to return permanently.

6 | CONCLUSION

Particularly in times of a pandemic or other crisis situations, an already existing shortage of nursing staff pushes the health system to its limits. During the pandemic, the silent reserve of inactive nurses was considered as a possible solution in Germany. However, not every inactive nurse is willing or able to return to nursing during a crisis. In order to increase their number and make a deployment successful for all involved, some points should be considered in advance and integrated into the crisis management.

As an important point, the focus group participants emphasized the need for effective crisis communication that enables inactive nurses to assess the situation and their deployment options, as well as the need for (disaster) training opportunities that are compatible with regular work.

Inactive nurses usually take on another job, often related to health and care. Therefore, even if they are willing to return to nursing, they may not be able to leave their current job without jeopardizing the functioning of the health system. They need support of their employer and reliable information on the consequences of a return to nursing for a certain period of time, the legal situation or the continuation of their (often higher) salary. Therefore, inactive nurses should be offered targeted support, for example, in terms of information about the legal requirements for temporary employment and an offer of low-threshold professional training courses.

In summary, those who are able and willing to return to nursing need to know what to expect and what is expected from them and should get as much and unbureaucratic support as possible. They need the knowledge, skills and abilities to respond timely to disasters and various public health situations without putting themselves (Veenema, 2018) or patients at risk.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*): (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content. * http://www.icmje.org/recommendations/. Made substantial contributions to conception and design, or acquisition of data or analysis and interpretation of data; PL, EH. Involved in drafting the manuscript or revising it critically for important intellectual content; PL, EH, AK, WH. Given final approval of the version to be published and participated sufficiently in the work to take public responsibility for appropriate portions of the content; PL, EH, AK, WH. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved; PL, EH, AK, WH.

ACKNOWLEDGEMENTS

We thank all focus group participants for sharing their experiences and thoughts about inactive nurses, a deployment in crisis situations and nursing and care in general. We would like to thank Sabine Hindrichs for organizing two of the discussions. Open Access funding enabled and organized by Projekt DEAL.

FUNDING INFORMATION

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.15881.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ORCID

Petra Lücker https://orcid.org/0000-0003-1450-6814

Esther Henning https://orcid.org/0000-0003-1108-6746

REFERENCES

Aoyagi, Y., Beck, C. R., Dingwall, R., & Nguyen-Van-Tam, J. S. (2015). Healthcare workers' willingness to work during an influenza pandemic: A systematic review and meta-analysis. *Influenza and Other Respiratory Viruses*, *9*(3), 120–130. https://doi.org/10.1111/irv.12310

audiotranskription. (2021). *Qualitative content analysis - according to Mayring or according to Kuckartz?* https://www.audiotranskription.de/en/qualitative-content-analysis-according-to-mayring-or-according-to-kuckartz/

Auffenberg, J., Becka, D., Evans, M., Kokott, N., Schleicher, S., & Braun, E. (2022). *Ich pflege wieder, wenn …: Potenzialanalyse zur Berufsrückkehr und Arbeitszeitaufstockung von Pflegefachkräften*. https://arbeitnehmerkammer.de/fileadmin/user_upload/Downloads/Politik/Rente_Gesundheit_Pflege/Bundesweite_Studie_Ich_pflege_wieder_wenn_Langfassung.pdf

Barrett, A., Kajamaa, A., & Johnston, J. (2020). How to … be reflexive when conducting qualitative research. *The Clinical Teacher*, *17*(1), 9–12. https://doi.org/10.1111/tct.13133

Black, L., Spetz, J., & Harrington, C. (2008). Nurses working outside of nursing: Societal trend or workplace crisis? *Policy, Politics & Nursing Practice*, *9*(3), 143–157. https://doi.org/10.1177/1527154408319288

Boin, A., t' Hart, P., & Kuipers, S. (2018). The crisis approach. In *Handbook of disaster research* (pp. 23–38). Springer. https://doi.org/10.1007/978-3-319-63254-4_2

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE.

Brown, L. M., Haun, J. N., & Peterson, L. (2014). A proposed disaster literacy model. *Disaster Medicine and Public Health Preparedness*, *8*(3), 267–275. https://doi.org/10.1017/dmp.2014.43

Bundesagentur für Arbeit. (2022). *Anzahl der sozialversicherungspflichtig beschäftigten Krankenschwestern, −pfleger, Hebammen und Rettungsdienstler in Deutschland von 1999 bis 2021 [Graph]. In Statista*. https://de.statista.com/statistik/daten/studie/243449/umfrage/anzahl-der-beschaeftigten-krankenschwestern-und-hebammen-in-deutschland/

Cachia, M. (2017). The role of identity in the choice of employment. *New Vistos*, *3*(1), 34–38. https://repository.uwl.ac.uk/id/eprint/3355/1/Cachia-2017-The-role-of-identity-in-the-choice-of-employment.pdf

Castner, J., Bell, S. A., Castner, M., & Couig, M. P. (2021). National Estimates of the reserve capacity of registered nurses not currently employed in nursing and emergency nursing job mobility in the United States. *Annals of Emergency Medicine*, *78*(2), 201–211. https://doi.org/10.1016/j.annemergmed.2021.03.006

Chaffee, M. (2006). Making the decision to report to work in a disaster: Nurses may have conflicting obligations. *American Journal of Nursing*, *106*(9), 54–57. https://doi.org/10.1097/00000446-200609000-00027

Chaffee, M. (2009). Willingness of health care personnel to work in a disaster: An integrative review of the literature. *Disaster Medicine and*

Public Health Preparedness, *3*(1), 42–56. https://doi.org/10.1097/DMP.0b013e31818e8934

Chan, Z. C. Y., Tam, W. S., Lung, M. K. Y., Wong, W. Y., & Chau, C. W. (2013). A systematic literature review of nurse shortage and the intention to leave. *Journal of Nursing Management*, *21*(4), 605–613. https://doi.org/10.1111/j.1365-2834.2012.01437.x

Cho, J., & Lee, E.-H. (2014). Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences. *The Qualitative Report*, *19*(32), 1–20. https://doi.org/10.46743/2160-3715/2014.1028

Cone, D. C., & Cummings, B. A. (2020). Hospital disaster staffing: If you call, will they come? *American Journal of Disaster Medicine*, *14*(4), 237–245. https://doi.org/10.5055/ajdm.2019.0337

DeKeyser Ganz, F., Margalith, I., Benbenishty, J., Hirschfeld, M., Wagner, N., & Toren, O. (2019). A conflict of values: Nurses' willingness to work under threatening conditions. *Journal of Nursing Scholarship: An Official Publication of Sigma Theta Tau International Honor Society of Nursing*, *51*(3), 281–288. https://doi.org/10.1111/jnu.12466

Deutsches Ärzteblatt. (2021, October 12). *Wir wissen, dass 2030 circa 500.000 Pflegekräfte fehlen werden*. https://www.aerzteblatt.de/nachrichten/128103/Wir-wissen-dass-2030-circa-500-000-Pflegekraefte-fehlen-werden

Ellison, J. (2021). Why are experienced nurses leaving work? *Kai Tiaki Nursing New Zealand*, *27*(4), 22–31. https://kaitiaki.org.nz/article/why-are-experienced-nurses-leaving-work/

Fothergill, A., Palumbo, M. V., Rambur, B., Reinier, K., & McIntosh, B. (2005). The volunteer potential of inactive nurses for disaster preparedness. *Public Health Nursing (Boston, Mass.)*, *22*(5), 414–421. https://doi.org/10.1111/j.0737-1209.2005.220506.x

Grochtdreis, T., Schröder-Bäck, P., Harenberg, N., Görres, S., & de Jong, N. (2020). National disaster preparedness and emergency response of nurses in Germany: An exploratory qualitative study. *South Eastern European Journal of Public Health (SEEJPH)*, *15*(1), 1–14. https://doi.org/10.4119/seejph-3972

Halberg, N., Jensen, P. S., & Larsen, T. S. (2021). We are not heroes-the flipside of the hero narrative amidst the COVID19-pandemic: A Danish hospital ethnography. *Journal of Advanced Nursing*, *77*(5), 2429–2436. https://doi.org/10.1111/jan.14811

Hendam, D., Fakhy, S., & Mohamed, H. (2018). Relationship between professional autonomy and job satisfaction among staff nurses. *Port Said Scientific Journal of Nursing*, *5*(2), 237–256. https://doi.org/10.21608/pssjn.2018.54473

Holmes, A., & Gary, D. (2020). Researcher positionality - a consideration of its influence and place in qualitative research - a new researcher guide. *Shanlax International Journal of Education*, *8*(4), 1–10. https://doi.org/10.34293/education.v8i4.3232

Isaacs, A. (2014). An overview of qualitative research methodology for public health researchers. *International Journal of Medicine and Public Health*, *4*(4), 318. https://doi.org/10.4103/2230-8598.144055

Johnston, C. M., Wallis, M., Oprescu, F. I., & Gray, M. (2017). Methodological considerations related to nurse researchers using their own experience of a phenomenon within phenomenology. *Journal of Advanced Nursing*, *73*(3), 574–584. https://doi.org/10.1111/jan.13198

Kox, J. H. A. M., Groenewoud, J. H., Bakker, E. J. M., Bierma-Zeinstra, S. M. A., Runhaar, J., Miedema, H. S., & Roelofs, P. D. D. M. (2020). Reasons why Dutch novice nurses leave nursing: A qualitative approach. *Nurse Education in Practice*, *47*, 102848. https://doi.org/10.1016/j.nepr.2020.102848

Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research* (4th ed.). Sage Publications.

Kuckartz, U. (2019). Qualitative text analysis: A systematic approach. In G. Kaiser & N. Presmeg (Eds.), *ICME-13 monographs. Compendium for early career researchers in mathematics education* (pp. 181–197). Springer International Publishing. https://doi.org/10.1007/978-3-030-15636-7_8

Lake, E. T., Narva, A. M., Holland, S., Smith, J. G., Cramer, E., Rosenbaum, K. E. F., French, R., Clark, R. R. S., & Rogowski, J. A. (2022). Hospital nurses' moral distress and mental health during COVID-19. *Journal of Advanced Nursing*, *78*(3), 799–809. https://doi.org/10.1111/jan.15013

Lücker, P., Henning, E., & Hoffmann, W. (2022). To come back or not to come back during the coronavirus crisis-a cross-sectional online survey of inactive nurses. *Journal of Advanced Nursing*, *78*(11), 3687–3695. https://doi.org/10.1111/jan.15268

Mai, M. (2020). Stille Reserve gesucht: Freiwilligeninitiativen wider die Corona-Pandemie. *Die Schwester Der Pfleger*, *59*(12), 16–19.

McIntosh, B., Palumbo, M. V., & Rambur, B. (2006). Does a 'shadow workforce' of inactive nurses exist? *Nursing Economic$*, *24*(5), 231–237. https://www.researchgate.net/profile/mary-val-palumbo/publication/6666211_does_a_'shadow_workforce'_of_inactive_nurses_exist/links/56f1a96e08aed354e56fc05d/does-a-shadow-workforce-of-inactive-nurses-exist.pdf

National Council of State Boards of Nursing (Ed.). (2022). *Nurse Licensure Guidance*. https://www.ncsbn.org/nursing-regulation/licensure/nurse-licensure-guidance.page

Nursing & Midwifery Council (Ed.). (2022). *Who we are and what we do*. https://www.nmc.org.uk/about-us/our-role/

OECD. (2019). *Recent trends in international migration of doctors, nurses and medical students*. OECD Publishing. https://www.oecd-ilibrary.org/social-issues-migration-health/foreign-born-nurses-professional-and-associate-professional-nurses-working-in-oecd-countries-2000-01-2010-11-and-2015-16_6d9a6157-en, https://doi.org/10.1787/5571ef48-en

Parry, J. (2008). Intention to leave the profession: Antecedents and role in nurse turnover. *Journal of Advanced Nursing*, *64*(2), 157–167. https://doi.org/10.1111/j.1365-2648.2008.04771.x

Prommersberger, M. (2020). Advanced nursing practice: The German experience. *European Journal of Emergency Medicine: Official Journal of the European Society for Emergency Medicine*, *27*(1), 11–12. https://doi.org/10.1097/MEJ.0000000000000666

Qureshi, K., Gershon, R. R. M., Sherman, M. F., Straub, T., Gebbie, E., McCollum, M., Erwin, M. J., & Morse, S. S. (2005). Health care workers' ability and willingness to report to duty during catastrophic disasters. *Journal of Urban Health: Bulletin of the new York Academy of Medicine*, *82*(3), 378–388. https://doi.org/10.1093/jurban/jti086

Ritchie, J., Lewis, J., & Elam, G. (2003). Designing and selecting samples. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 77–108). Sage Publications.

Roller, M. R., & Lavrakas, P. J. (2015). *Applied qualitative research design: A total quality framework approach*. The Guilford Press. https://fid.fachportal-paedagogik.de/ebscoProxySearch/login.aspx?direct=true&-scope=site&db=nlebk&db=nlabk&AN=877928

Sander, M., Dano, R., Bieber, A., Dammermann, A., Fleischer, S., Dinand, C., Müller, M., Möhler, R., Schultes, K., Köpke, S., & Dichter, M. N. (2023). Challenges, strategies and consequences from the perspective of German nursing home managers during the first wave of the COVID-19 pandemic - a qualitative interview study. *BMC Geriatrics*, *23*(1), 164. https://doi.org/10.1186/s12877-023-03787-4

Sasso, L., Bagnasco, A., Catania, G., Zanini, M., Aleo, G., & Watson, R. (2019). Push and pull factors of nurses' intention to leave. *Journal of Nursing Management*, *27*(5), 946–954. https://doi.org/10.1111/jonm.12745

Seah, B., Ho, B., Liaw, S. Y., Ang, E. N. K., & Lau, S. T. (2021). To volunteer or not? Perspectives towards pre-registered nursing students volunteering frontline during COVID-19 pandemic to ease healthcare workforce: A qualitative study. *International Journal of Environmental Research and Public Health*, *18*(12), 6668. https://doi.org/10.3390/ijerph18126668

Senek, M., Robertson, S., Ryan, T., King, R., Wood, E., Taylor, B., & Tod, A. (2020). Determinants of nurse job dissatisfaction - findings from

a cross-sectional survey analysis in the UK. *BMC Nursing*, *19*(1), 88. https://doi.org/10.1186/s12912-020-00481-3

Shay, J. (2014). Moral injury. *Psychoanalytic Psychology*, *31*(2), 182–191. https://doi.org/10.1037/a0036090

Silverman, H. J., Kheirbek, R. E., Moscou-Jackson, G., & Day, J. (2021). Moral distress in nurses caring for patients with Covid-19. *Nursing Ethics*, *28*(7–8), 1137–1164. https://doi.org/10.1177/0969733021 1003217

Sørensen, K. (2022). Lack of alignment in emergency response by systems and the public: A Dutch disaster health literacy case study. *Disaster Medicine and Public Health Preparedness*, *16*(1), 25–28. https://doi.org/10.1017/dmp.2020.226

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398–405. https://doi.org/10.1111/nhs.12048

van der Cingel, M., & Brouwer, J. (2021). What makes a nurse today? A debate on the nursing professional identity and its need for change. *Nursing Philosophy: An International Journal for Healthcare Professionals*, *22*(2), e12343. https://doi.org/10.1111/nup.12343

Veenema, T. G. (2018). *Disaster nursing and emergency preparedness* (4th ed.) ed.). Springer Publishing Company. https://books.google.com/books?id=6mGytAEACAAJ&dq=veneema+disaster+nursing+and+emergancy&hl=de&newbks=1&newbks_redir=1&sa=X&ved=2ahUKEwj9l57widb7AhXjR_EDHZhjAe4Q6AF6BAgOEAI

Vereinte Dienstleistungsgewerkschaft (Ed.). (2022). *FAQ: Zurück in den Beruf*. https://gesundheit-soziales-bildung.verdi.de/coronavirus/++co++009ffaf2-6e6d-11ea-905e-001a4a160100

Willis, K., Green, J., Daly, J., Williamson, L., & Bandyopadhyay, M. (2009). Perils and possibilities: Achieving best evidence from focus groups in public health research. *Australian and New Zealand Journal of Public Health*, *33*(2), 131–136. https://doi.org/10.1111/j.1753-6405.2009.00358.x

Zipf, A. L., Polifroni, E. C., & Beck, C. T. (2022). The experience of the nurse during the COVID-19 pandemic: A global meta-synthesis in the year of the nurse. *Journal of Nursing Scholarship*, *54*(1), 92–103. https://doi.org/10.1111/jnu.12706

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Lücker, P., Henning, E., Kästner, A., & Hoffmann, W. (2024). Inactive nurses' willingness to return to active nursing during the COVID-19 pandemic: A qualitative study. *Journal of Advanced Nursing*, *80*, 1043–1057. https://doi.org/10.1111/jan.15881