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The willingness of inactive nurses to return to patient care for a limited time in a crisis situation - using the example of the COVID-19 pandemic

Inaugural-Dissertation

zur

Erlangung des akademischen

Grades

Doktor der Wissenschaften in der Medizin

(Dr. rer. med.)

der

Universitätsmedizin

der

Universität Greifswald

2023

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Tag der Disputation: 02.04.2024

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Article overview

This dissertation is based on the results of the study RETURN ('F**re**iwillige Regis**t**rier**u**ng ehemaliger Pflegefachpe**r**sonen im Krise**n**fall') and consists of two articles published in peer-reviewed journals:

1. 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, 3687–3695. https://doi.org/10.1111/jan.15268.
2. Lücker, P.; Henning, E.; Kästner, A.; Hoffmann, W. (2023). Inactive Nurses' Willingness to Return to Active Nursing during the COVID-19 Pandemic: A Qualitative Study. *Journal of Advanced Nursing,* 00, 1-15. https://doi.org/10.1111/jan.15881.

Introduction

During the pandemic, the importance of nurses became as apparent as the fact that they are a scarce resource.

Background

Even before the pandemic, the WHO reported a global shortage of nurses (World Health Organization [WHO], 2020). It is predicted that another nine million nurses and midwives will be needed by 2030 (WHO, 2022). In Germany, up to 50,000 additional nurses are currently required in intensive care units alone (Simon, 2022).

The shortage of qualified nursing staff is not a new phenomenon – searching for ‘nursing shortage’ in PubMed on 25 April 2022 yielded 1.372 entries, the oldest publication (from the USA) dates from 1927 (Ames, 1927). In the past, for instance, wars and disasters led to an increased need for nurses and ideas on how to deal with this shortage, e.g. by using less qualified staff for certain tasks (“Hospital and Institutional News,” 1915, 27 March). Fottler et al. (1995) describe periodic nursing shortages in the USA during the 20th century and a persistent nursing shortage since the mid-1980s.

Although the number of treatment cases in German hospitals increased between 1991 and 2014 and the length of stay of patients was shortened - which leads to an intensification of work - the number of nurses has remained roughly the same (Figure 1).

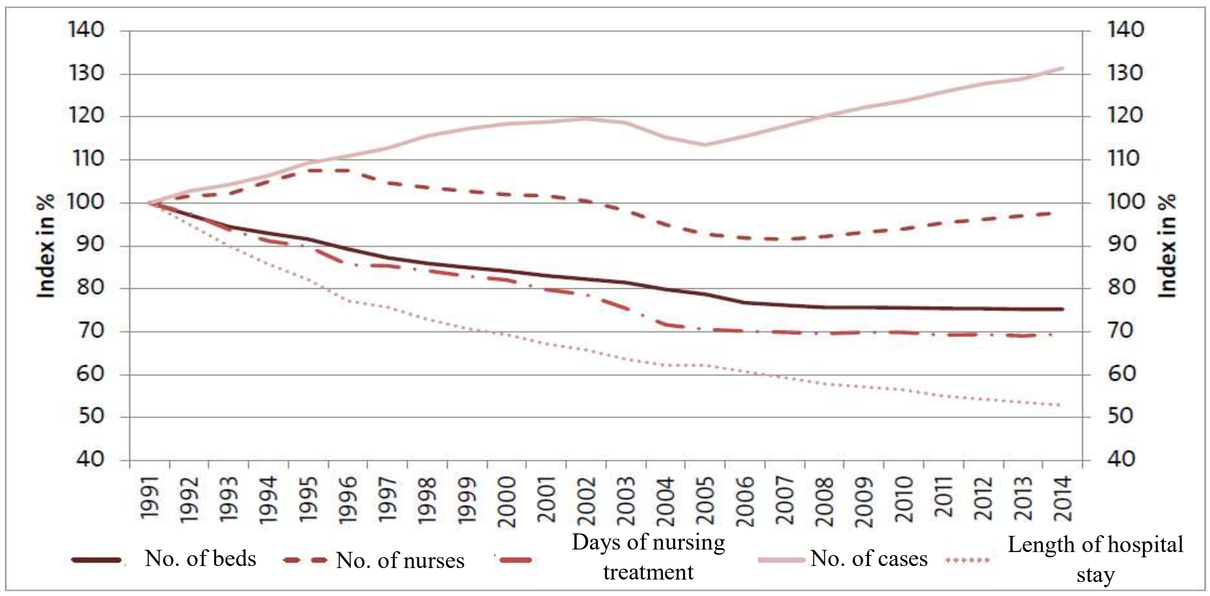

FIGURE 1 – Development of hospital treatment indicators (Schreyögg & Milstein, 2016). (The index of 100% describes the initial situation in 1991**)**

One reason for the nursing shortage is seen in nurses leaving the profession prior to retirement, which means that many qualified nurses are no longer available for direct patient care.

There is no uniform term for those who have completed the three-year training as a general nurse, paediatric nurse or geriatric nurse or a corresponding course of study qualifying them for clinical nursing and have left the profession prior to retirement. In Germany, these nurses are called 'former' or 'inactive' nurses, in English sometimes also 'retired' nurses. In this work, the term 'inactive' is used.

Across Europe, the following reasons for nurses leaving the profession have long been identified (Ellison, 2021; Golombek & Fleßa, 2011; Kerzman et al., 2020; Kox et al., 2020):

- Lack of support (organisational, managerial, appreciation and relationship with co-workers, lack of autonomy, physical and mental stress)
- Workload (patient acuity, poor staffing, high workload and thus less qualitative care, health being rather a business than patient-centred, work-life imbalance)
- Professional development (aspiration for professional advancement and career development, lack of participation in hospital affairs)
- Financial (inadequate salary)

In Germany, the inactive nurses are seen as one resource that can be used to cope with the existing nursing shortage (Bundesministerium für Gesundheit et al., 2020). Nevertheless, there are hardly any improvements with regard to working conditions, which are often the reason for changing professions (Breinbauer, 2020). During the COVID 19 pandemic, these conditions have even worsened, (Arnetz et al., 2020; Kennedy, 2021). This raises the question of whether inactive nurses are widely willing to return to nursing in a crisis situation and can really be seen as a resource for such events.

The COVID-19 pandemic and the need for nurses

The emergence and spread of COVID-19 posed major challenges to the health sector and led to an increased demand for nurses due to an increased workload caused by outbreaks of the disease among patients and staff, but also by infection control and quarantine measures (Wolf-Ostermann et al., 2020). This affected all types of care providers, such as hospitals, nursing homes, or outpatient care services.

The so-called 'silent reserve' or 'shadow workforce' of inactive nurses was relatively quickly identified as a potential resource to compensate for the additional demand for nurses caused by

the pandemic. Due to their qualification, they could be quickly deployed to provide direct patient care in a crisis situation.

The number of inactive nurses is difficult to quantify due to the lack of a professional register in Germany. A study published in 2018 (Paul Hartmann AG, 2018) states a number of 120,375 - 200,625 inactive nurses who could imagine a general - i.e. outside the COVID-19 pandemic - return to the nursing profession. At least these figures were presumably also assumed with regard to the silent reserve for deployment during the COVID-19 pandemic.

As there is no professional register for nurses in Germany, there is also no way to contact inactive nurses directly. As a result, at the beginning of the pandemic, a wide variety of agencies set up registration options and called for inactive nurses to register, mostly online, for possible deployment during the pandemic (e. g., Die Senatorin für Gesundheit, Frauen und Verbraucherschutz Freie Hansestadt Bremen, 2022; Thüringer Ministerium für Arbeit, Soziales, Gesundheit, Frauen und Familie et al., 2020). Such registration was offered by state governments, hospitals, health offices, the Medical Service (Medical Service of the Health Insurance Funds, MDK), nursing chambers, but also by recruitment and temporary employment agencies as well as specially founded registration platforms such as #pflegereserve (Mai, 2020).

Objectives and research questions

The aims of the study were to identify the factors that promote or prevent the temporary return of inactive nurses in a crisis situation and to develop recommendations on how to mobilise the largest possible number of them for deployment in such a crisis event.

These objectives led to the following research questions:

- What factors promote the willingness of inactive nurses to temporarily return to nursing in a crisis situation?
- What factors have a negative influence on the willingness of inactive nurses to temporarily return to nursing in a crisis situation?
- Which measures or support services can promote the willingness of inactive nurses to return to nursing in a crisis situation?

Methods

The study was conducted in two steps: In the first step, an online survey of inactive nurses was conducted (Lücker et al., 2022); in the second step, semi structured focus group discussions (Lücker et al., 2023) with registered and non-registered inactive nurses were planned to gain deeper insights into the results of the online survey and wider aspects.

Online Survey

For the first part of the study we used an online survey to identify facilitating and hindering factors that play a role in the decision of inactive nurses to register for a return to nursing for a limited period of time during the COVID-19 pandemic (Lücker et al., 2022).

The research questions in this first part of the study were:

- What are the characteristics of those who registered and those who did not?
- What factors promote the registration of inactive nurses for a possible deployment in nursing during the COVID-19 pandemic?
- Which factors prevent or hinder a registration of inactive nurses for a possible deployment during the COVID-19 pandemic?

The questionnaire (Appendix 3) was developed at the Institute for Community Medicine at the University Medicine Greifswald after a semi-structured literature search. As the two research assistants who conducted the research are trained nurses (general/paediatric), their experiences were also integrated into the questionnaire.

The survey captured a variety of aspects which could influence the decision for or against registration (Lücker et al., 2022):

- Professional experience: e.g. qualification(s), physical and/or mental stress, organisation, leadership
- Internal aspects: e.g. emotions, self-efficacy, identity, personality, the psychological construct ‘helping behaviour’
- External aspects: e.g. current job, care responsibilities, own chronic disease or chronic disease of relatives and thereby vulnerability against the coronavirus, social relationships
- Expectations: e.g. risk of infection, physical and/or mental stress, organisation, leadership, working conditions.

For the most part, a dichotomous response format was chosen, and often multiple response options and additional free text fields were offered in order to be open to further aspects and to obtain the most comprehensive possible information. A filter was used for the question about registration: Those who had registered or not registered were asked to explain the reasons for their respective decision, those who still wanted to wait and observe the situation could give reasons both for and against registration.

The survey was online between 27 April and 15 June 2020.

Focus Group Discussions

In the second part of the study, deeper insights were to be gained through focus group discussions based on the results of the online survey (Lücker et al., 2022). Both the quantitative results and the open text responses were considered, as these revealed further issues related to a willingness to register and a possible deployment as well as an actual deployment.

The following research questions emerged and were used in a semi-structured interview guide (Appendices 4 and 6). Results from the online survey were shown on slides (Appendices 5 and 7):

- Does a sense of connection with the profession and the active nurses remain even after leaving nursing?
- What explanation could there be for the frequently cited reason ‘can’t see a reason/need for registration’?
- What reasons could there be for the fact that academically qualified participants registered more often?
- Why did more non-registered than registered inactive nurses participate in the survey?
- How is the possibility of convincing those who have categorically ruled out a (temporary) return to nursing to change their minds assessed?
- What special offers or what kind of support should there be in preparation to facilitate the readiness to return to care and an actual deployment in a crisis situation?
- How do participants assess the so-called ‘silent reserve’ in terms of the availability of relevant support in a crisis situation?

Detailed information on this part of the study can be found at Lücker et al. (2023).

Recruitment of participants for the online survey and focus groups

Due to the lack of a professional register and the associated inability to directly address inactive nurses, alternative ways had to be found to recruit participants for both the online survey and the focus groups. For the online survey, requests for participation in the survey or publication and/or forwarding of the link were made on a forum for clinical coders ('mydrg.de'), at health insurances, at the Medical Service, via the Nursing Network Germany ('Pflegenetzwerk Deutschland', Federal Ministry of Health), via the Federal Association of Nursing Management ('Bundesverband Pflegemanagement'), at universities, at the registration platform '#pflegereserve', at the German Network for Health Services Research ('Deutsches Netzwerk Versorgungsforschung'), and on Facebook. We also used single personal and professional contacts to spread the survey link.

Initially, only individual professional contacts of the authors were used to recruit participants for the focus groups. Subsequently, further people were approached in a snowball system. During the recruitment process, two nurses were approached who had returned to nursing permanently after a period of inactivity of varying lengths. In addition, one inactive nurse came forward who had originally registered on the #pflegereserve registration platform, but withdrew this registration due to a change of the platform's operator. Additionally, the opportunity arose to discuss the (possible) deployment of inactive nurses in another focus group with four nursing home managers (three of them were also qualified nurses).

Therefore, in addition to the four focus groups (two groups each with registered and not-registered inactive nurses), two further focus group discussions were conducted: one with nurses who had returned to nursing and one with care home managers. A telephone interview was conducted with the inactive nurse who had withdrawn her registration. None of the participants in the focus groups had taken part in the online survey.

For both parts of the study, the sampling procedure resulted in self-selective samples recruited via a snowball system.

Compliance with Ethics Guidelines

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

Results

Important results are summarised here and the two parts of the study are put into context. A detailed description of the respective results can be found in the two publications (Lücker et al., 2022; Lücker et al., 2023).

Study population

Participants in the online survey

The online survey (Lücker et al., 2022) was started by 618 and completed by 463 respondents. One hundred and fifteen respondents dropped out of the survey on the first two pages, where they were asked about age, gender and nursing qualifications. There was no discernible pattern among those who dropped out in the course of the survey.

Three hundred and thirty-two questionnaires could be included in the analysis. The following exclusion criteria were applied (Figure 2):

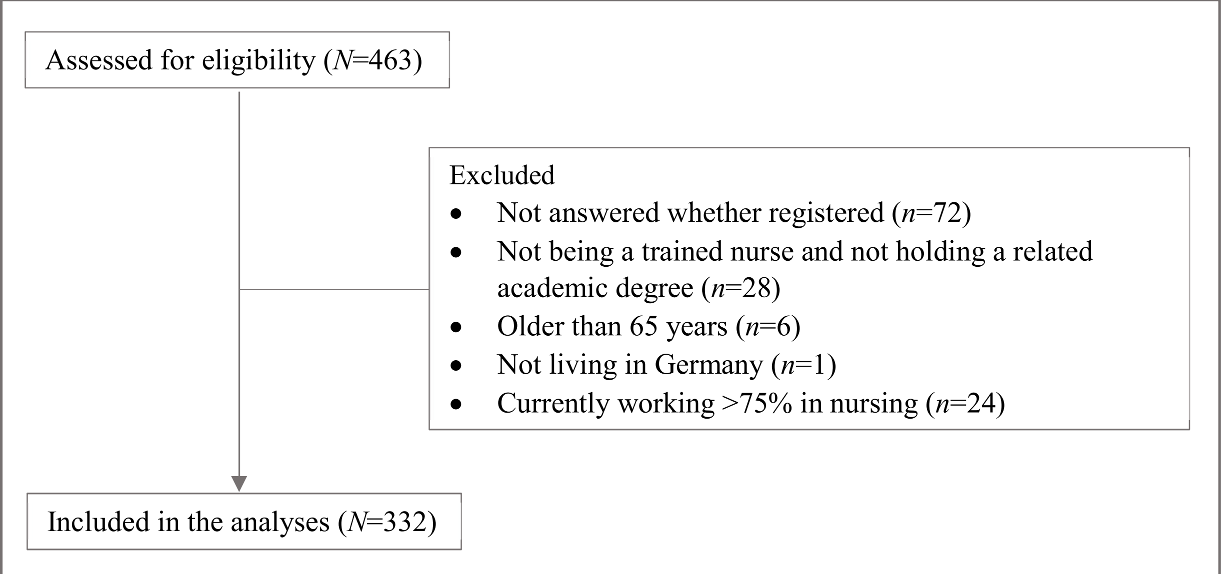

FIGURE 2 – CONSORT Flow Diagram: Exclusion criteria of the study

The characteristics of the participants in the online survey are described in Table 1.

TABLE 1 – Sample characteristics participants online survey (by registered/not registered)

Variable	Attribute	registered *n* (%)	not registered *n* (%)
Demographic Information			
Gender	female male diverse	76 (74.5) 25 (24.5) 1 (1.0)	162 (71.7) 64 (28.3) -
Age (years, *n*=327)		*M*=44.5 *SD*=11.04	*M*=45.8 *SD*=10.53
Qualification			
Nursing Qualification	General nurse Paediatric nurse Geriatric nurse	87 (85.3) 7 (6.9) 8 (7.8)	175 (76.8) 13 (5.7) 40 (17.5)
Professional experience (years)		*M*=13.3 *SD*=7.53	*M*=15.8 *SD*=10.20
Duration of inactivity (years)		*M*=9.8 *SD*=8.42	*M*=8.2 *SD*=8.00
Academic degree/title (multiple answers possible)			
Academic degree/title (*n*=111)	Bachelor Master PhD and/or Professor	22 (41.5) 29 (54.7) 2 (3.8)	40 (47.1) 38 (44.7) 7 (8.3)
Degree/title awarded in health or care (*n*=62)		24 (96.0)	33 (89.2)
Additional professional specialisation (multiple answers possible)			
Additional professional specialisation (*n*=142)	ICU nurse Anaesthetic nurse Hygiene expert Quality management Teaching and training Ward or area management	21 (33.9) 11 (17.7) 6 (9.7) 12 (19.4) 6 (9.7) 6 (9.7)	54 (35.8) 20 (13.2) 7 (4.6) 39 (25.8) 20 (13.2) 11 (7.3)

M=Mean, *SD*=Standard Deviation

When given the opportunity to provide multiple answers, the majority of respondents (61.1%, *n*=196) reported that they were still employed in the health, care, or nursing sector; most of them were employed in administration in the health sector (25.4%, *n*=97).

Participants of the focus groups

A total of 18 participants were recruited for six focus groups and one individual telephone interview. The study population can be described as follows (Table 2).

TABLE 2 – Sample characteristics (focus groups, telephone interview)

Focus group	Pseudo-nym individual participant	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 month), 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	Interviewer I	- General Nurse - Deg. Health & Social Care - Deg. Prevention & Health Psychology	F	Science & Research
	Interviewer II	- Paediatric Nurse - Deg. Care Management - Deg. International Health	F	Science & Research

Note: Deg.=Degree, M=Male, F=Female

Only two of the 20 inactive nurses (incl. the two interviewers who work at a university hospital) were not employed in a job related to health, care, or nursing. Two of the participants were deployed during the COVID-19 pandemic – both not in direct patient care, but in a vaccination centre or testing visitors in a care home.

Results of the online survey and the focus group discussions

Since the results of the survey served as the basis for the focus group discussions, some of the most important results are briefly summarised (for detailed results, see Lücker et al., 2022):

- More unregistered than registered inactive nurses participated in the survey.
- Being able to provide multiple answers, the main reasons given for not having registered was that respondents ‘could not see a reason at the moment’, had health concerns (risk of infection, existing illness or pregnancy in themselves or relatives), and ‘other relevant job commitments’. Some of the participants vehemently and categorically ruled out to ever work in nursing again.
- Being able to give multiple answers, the main reasons given for having registered was that inactive nurses ‘wanted to do their bit’ to manage the crisis, felt it was ‘their duty’ and ‘have got a sense of belonging to the nursing profession’.
- The most frequently cited reason for leaving nursing was professional reorientation. Nevertheless, the majority of respondents still had jobs related to health, care or nursing.

These results are then linked to the results of the qualitative analysis of the focus group discussions. Topics discussed in the focus groups included (Lücker et al., 2023):

- Perception of the pandemic as a crisis
- Identity as a nurse and sense of professional commitment
- Role of current occupation in the decision to register
- Winning over inactive nurses with a negative attitude towards returning to care during a crisis situation
- Support measures and offers regarding a deployment in nursing

The study aimed to investigate which factors could promote or hinder the registration of inactive nurses for possible deployment during the COVID-19 pandemic. While in the online survey (Lücker et al., 2022) we assumed formal registration with one of the registration platforms or other bodies, the focus of the focus group discussions was rather on a general willingness to temporarily return to direct patient care and not on a formal declaration to do so. This was done against the background that participants in both parts of the study indicated that although they

had not officially registered, had informed their former employer or colleagues that they would be available in case of an emergency.

Willingness to temporarily return to patient care during the COVID-19 pandemic

Of the 332 participants in the online survey, 102 (30.7%) indicated that they were registered and thus willing to temporarily return to nursing. Not registered were 229 (69,3%) of the inactive nurses of which 39 (11.7%) were observing the situation and wanted to wait and see (Lücker et al., 2022).

Perception of the need to register

One third (30.8%, n=108) of the respondents who did not register or wanted to wait and see stated that they had not seen any reason to register at the time of the survey (Lücker et al., 2022). The focus group participants (Lücker et al., 2023) suspected that one reason for this was that the pandemic was perceived as nothing special amidst the everyday disasters in nursing. Nursing had been in a permanent crisis for many years.

The participants of the focus groups assessed the wait-and-see attitude as a consequence of the media coverage of the COVID-19 pandemic. The infection control measures taken and the health care system in Germany compared to other countries were perceived as effective and well-functioning so that an 'emergency deployment' due to the pandemic for these participants did not seem necessary.

On the other hand, it was also noted that the need for support in various areas of care existed also prior to the COVID-19 pandemic in Germany and that this explanation may have been only a ‘pretext’ to avoid having to justify one’s own refusal to return.

On the part of the care home managers, it was reported that the need for additional staff actually varied greatly. This depended on the number of infected residents of the care homes, but especially on how many of the active nurses were absent due to illness or quarantine.

Some of the participants in the focus groups felt it would be more promising to address the inactive nurses directly to encourage their willingness to help in crisis situations.

Sense of professional commitment regarding a return in the event of a crisis

Many of the inactive nurses who participated in the online survey felt a sense of duty to do their part in managing the COVID-19 pandemic (Lücker et al., 2022). This professional commitment was explicitly expressed by 18.4% (n=59) of the respondents.

However, some of the focus group participants perceived this professional commitment as negative as it is linked to ‘have to’ rather than ‘want to’. Statements such as ‘If I'm needed, I'm there’ are also rated negatively, as this reflects a ‘firefighter mentality’ or has ‘Superman-like’ connotations (Lücker et al., 2023). Focus group participants pointed out that, unlike the fire brigade, which regularly practices for emergencies, the deployment of (inactive) nurses seems to be seen as a possible option and solution to shortages at any time and in any medical field without preparation.

Sense of connection/belonging to nursing, appreciation of the profession and nurses

Given the opportunity to select multiple answers in the online survey (Lücker et al., 2022), 17.5% of participants reported a sense of belonging to the profession as a reason for their registration and 14.1% wanted to support their former colleagues (nurses in general).

This sense of connection or belonging was also evident in the focus groups. In many cases, there was still contact with former colleagues and the inactive nurses often used ‘we’ when talking about nurses (Lücker et al., 2023).

The inactive nurses were also concerned about improving working conditions and the reputation of the profession. The participants of the focus groups largely agreed that neither the profession nor the nurses receive adequate appreciation - neither by society nor by politics. With the clapping on the balconies this seemed to have improved for a short time, but the participants did not believe that the appreciation had increased overall and lastingly.

Role of current occupation in the decision to return temporarily

The willingness to return to nursing during the COVID-19 pandemic also depended on the current occupation of the inactive nurses and to the extent they were needed there during the COVID-19 pandemic. Many of the participants in the online survey (61.1%, n=196) and also in the focus groups (90%, n=18, including the interviewers) were still employed in the health and care sector and thus continue to contribute to the functioning of the system (Lücker et al., 2022; Lücker et al., 2023). A deployment in nursing could therefore jeopardise the system.

The focus group participants expressed their lack of understanding for the notion that they could easily leave their current job for a while in order to return to patient care. Among other things, this assumption would devalue the relevance of the current job and their work (Lücker et al., 2023).

Inactive nurses with a negative attitude towards a (temporary) return to nursing

Of the 190 non-registered and 39 inactive nurses who indicated in the survey that they wanted to wait and observe the situation further before registering, many provided additional information about their reasons or used the free text fields to express their thoughts.

Sample statements suggest a great deal of frustration:

> *'Why? For the people who despise you for the activity and don't even allow you the black under your fingernails?'* (Case 739)
>
> *'Under the circumstances (poor pay, lack of health and safety, poor working hours, inadequate staffing ratios) - I'm not putting my life on the line'* (Case 108)
>
> *'Underpaid for years, humiliated as a urine waiter, forgotten by politics and rediscovered in the crisis. That is not motivation. Care is also a quality service, i.e. 'serve and earn.' Why should I be there for a society that has forgotten me for years!!!'* (Case 829)
>
> *'I would NEVER EVER work in nursing again!!!'* (Case 1590)

The participants in the focus groups showed great understanding for the decision not to return to nursing – be it temporarily or permanently. Some of them went so far as to suggest that some of the inactive nurses had experienced trauma, moral distress, or even moral injury during their active time and that this prevented them from returning. The participation of these persons in the online survey, apart from justifying their rejection of a (temporary) return to nursing, possibly also served to highlight perceived grievances and thus perhaps bring about an improvement for active nurses (Lücker et al., 2023).

Preparation for a deployment or actual deployment in nursing

Out of 100 respondents in the online survey, 23 said they had been deployed during the pandemic. A majority of 18 of them rated the experience as positive overall. With the option to give multiple answers, the deployments were perceived as meaningful and satisfying, but also as challenging, physically and mentally demanding and frustrating (Lücker et al., 2022).

The participants in the focus groups considered it crucial to have a say in the location of the deployment, working hours and responsibilities. There was uncertainty as to whether existing nursing knowledge and skills were still sufficient. In particular, a deployment in specialised areas in which they had not gained any experience during their active period was viewed

critically by inactive nurses. In the opinion of the focus group participants, a good induction and the assignment of a contact person/mentor should be guaranteed (Lücker et al., 2023).

The conditions of a deployment described above should be communicated even before registration so that it is clear to the inactive nurses from the beginning what is expected of them and what they can expect. According to the focus group participants, this could give them a certain sense of security (Lücker et al., 2023).

Discussion

To the best of our knowledge, this is the first study in Germany and one of the few international studies to investigate both quantitatively and qualitatively the willingness of inactive nurses to temporarily return to work in a crisis situation.

This decision depends on a variety of factors, not least the reasons for leaving the profession in the first place. For example, working conditions and remuneration in nursing are still considered generally poor.

An important prerequisite for registration is the perception of a crisis situation in which crisis communication plays a vital role (Hahm et al., 2019). The evaluation of a situation leads to a behavioural response. Various factors are included in this evaluation, e.g. the assessment of the situation as a stressor and the available possibilities to deal with it, as presented in Lazarus' stress model (Lazarus & Folkman, 1984) as well as threat perceptions, protective action perceptions, and stakeholder perceptions shown in the Protective Action Decision Model (PADM) which describes the response to environmental hazards and disasters (Figure 3) (Lindell & Perry, 2012).

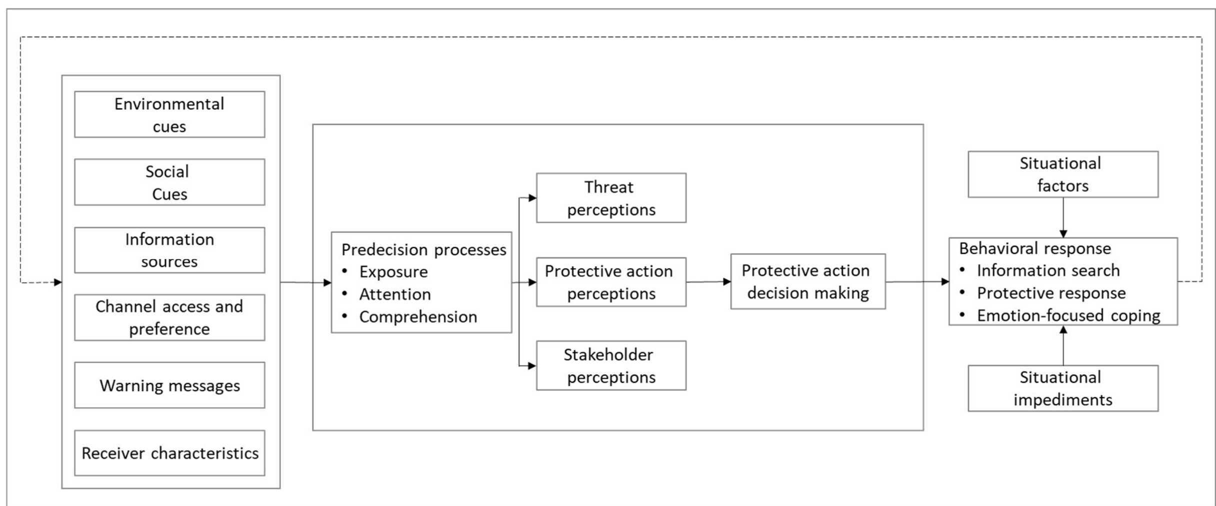

FIGURE 3 - Information flow in the PADM (Lindell & Perry, 2012)

There were no dramatic images in the media for Germany as there were for Italy or New York (Senni, 2020). The perception was that the German health system was functioning quite well. In this respect, there was apparently no stressor or triggering reason for some of the respondents to return to care and they at least wanted to wait.

Participants in the online survey and the focus groups (Lücker et al., 2022; Lücker et al., 2023) described the decision to return to nursing as a continuum, at one end of which is the knowledge of having the necessary qualifications to support former colleagues and care for patients. On

the other end are fears and anxieties about one's own interests, doubts about whether one's own skills would (still) be sufficient, and about working conditions during a pandemic (Tezcan-Güntekin et al., 2021).

The decision to return to care is likely to come from a mix of the abovementioned factors - perceptions of stress, threat and how the situation is handled in general, as well as the more personal aspects that lie on the continuum. The decision to return can thus probably be supported if the need for support due to the situation is clearly communicated.

Another major obstacle is the lack of possibilities to contact inactive nurses directly, e.g. via a professional register. Even if (email) addresses may change over time (McIntosh et al., 2006), at least a large proportion of inactive nurses could be reached in this way. More detailed and specific information about the situation in the health sector could be communicated and targeted requests for support could be made.

Commitment and identity

Commitment and identity play an important role in the decision to return to nursing in case of emergency.

Commitment and identity as a nurse

It was evident from both the online survey and the focus groups that belonging to the profession and feeling like a nurse were part of their identity for many participants. The same applied to a sense of duty or professional commitment associated with the qualification.

Another German study, very similar to ours, (Tezcan-Güntekin et al., 2021) supports these findings. In that study, interviews were conducted on the professional identity of inactive nurses in crisis situations like the COVID-19 pandemic, which also showed that 'being a nurse' is part of the identity of many inactive nurses and that there was often a strong feeling of professional commitment. However, it was emphasised that being a nurse was only one part of the identity and the offer to 'help out' during the pandemic was not seen as a 'return' (Tezcan-Güntekin et al., 2021).

Some of the respondents very clearly rejected the identity as a nurse and a professional commitment for themselves or considered it a closed part of their biography (Lücker et al., 2022; Lücker et al., 2023). Reasons for this rejection were often negative experiences during the time as an active nurse and a professional reorientation (Lücker et al., 2022; Lücker et al.,

2023). Therefore, both 'being a nurse' as part of one's identity and professional commitment can lead to or against the willingness to return to nursing in a crisis situation.

However, it might be that those who do not want to or cannot return at least try to improve the working conditions of active nurses in the context of their new job (e.g. as a nurse scientist) or even just by participating in the online survey and explaining their decision. For those, the online survey offered the opportunity to emphasise grievances and other reasons that prevent a return to nursing.

A literature review on employee commitment in care (Lauxen et al., 2018) shows that commitment is high among those who have autonomy, scope of action and opportunities for participation. These factors could also play a role in the decision to help out in a crisis situation in nursing and thus actively deal with this crisis situation.

'Heroes'

With the onset of the COVID-19 pandemic in Germany in spring 2020, a wider public became aware of the worsening problem of nursing staff shortages and less than optimal working conditions in nursing. All over the world, active nurses were celebrated as 'heroes' and people clapped on balconies to show their appreciation and thank the nurses (Der Spiegel, 2020). However, the 'hero' identity associated with the profession and created by the media, politicians and the public during the pandemic is largely rejected by nurses due to implications of invulnerability and self-sacrifice associated with it (Halberg et al., 2021). Some focus group participants were also critical of this. Additionally, they pointed out that while e. g., fire fighters regularly practice for emergencies, nurses seem to be expected to be deployable at a short notice at any time and in all medical settings (Lücker et al., 2023).

Looking at the language used in the context of the COVID-19 pandemic, it is noticeable that it is very warlike/military and the term 'hero' fits in very well: Expressions such as 'frontline', 'enemy', 'fight' or 'battle' were used (Dargiewicz, 2022). The English National Health Service was looking for a 'volunteer army' (National Health Service (NHS) England, 2020). The question arises to what extent these terms may influence the willingness to return to nursing during the pandemic.

Helping behaviour

Different theories of helping behaviour can be applied to inactive nurses' willingness to return to nursing in a crisis.

Their willingness can fall under both 'helping' and 'prosocial behaviour'. Helping refers to improving the situation of the recipient (Bierhoff, 2010). Recipients of help during the COVID-19 pandemic could be both the patients and the active nurses. Prosocial behaviour is more narrowly defined and refers to those helpers who do not become active because of professional obligations or membership of an organisation (Bierhoff, 2010). With regard to professional obligations, identity and commitment again play a role. Those who continue to identify themselves as nurses could accordingly also feel professional obligations, which would classify their willingness to return to nursing in a crisis situation under 'helping'.

In terms of the theory of social categorisation (Levine & Thompson, 2004), the identity as a nurse might have led a proportion of inactive nurses to want to support their former colleagues.

Another concept, 'reciprocity norm', refers to people helping because they expect to receive help when they are in need themselves (Gouldner, 1960). Since their own illness could not be ruled out, the nurses also wanted to be well cared for in such a situation.

Moral distress, moral injury

The concepts of moral distress and moral injury may also play a role in the decision not to return to direct patient care, even temporarily.

Moral distress arises from intrinsic conflict, committing, witnessing or failing to prevent an action that is contrary to one's moral values and beliefs (Larsson et al., 2018). This can be for internal (e.g. self-doubt, fear of conflict) or external reasons (e.g. hierarchy, lack of resources) (Moss et al., 2016; Rushton et al., 2017). Various factors, including staffing problems, outdated equipment and inadequate education, training and support can lead to poor quality of care (All-Party Parliamentary Group (APPG) on Global Health, 2016), which can cause moral distress for the nurses. During the pandemic, shortcomings were likely to occur or to increase (Rowlands, 2021). Previous experiences of moral distress and the knowledge of these conditions may have negatively influenced the willingness to return to nursing.

Larsson et al. (2018) reported long-term effects where negative memories and emotions can be reactivated. This may explain the strongly negative statements made by some participants in the online survey about working conditions in care and the refusal to return. In this context, the decision not to return might be seen as self-protection.

Current occupation

A return of inactive nurses to nursing during a crisis situation depends not only on the willingness but also on the possibility to do so (Fottler & Widra, 1995).

'Reserve' in the case of inactive nurses does not mean that, as in football, the reserve players sit idly on a bench waiting to be substituted. Current professional activity may argue against a return to nursing. Inactive nurses have often furthered their qualifications academically or otherwise which generally results in at least a higher salary. Furthermore, many nurses continue to work in the health or care sector after leaving the profession (Black et al., 2008) and are important for the functioning of the system in their new positions.

In general, it is not possible for them to simply pursue another professional activity without problems. A possible deployment as a nurse with another employer must be agreed with the current employer and contractual and legal issues need to be clarified and agreed upon (Vereinte Dienstleistungsgewerkschaft [Ver.di], 2022).

Among the circumstances that prevent a return are also family or caring responsibilities. For those who have e.g. very young children, are possibly still breastfeeding them, or for those who are responsible for the care of another person, the return may be difficult.

Facilitating the willingness of inactive nurses to return to nursing in crisis situations

In order to mobilise as many inactive nurses as possible in future crisis situations, for instance, the following points regarding deployment need to be considered and communicated:

- Specific area/medical field of deployment
- Sufficiency of current knowledge and skills, availability of training
- Scope of responsibility while working with patients
- Induction and mentoring or a permanent contact person
- Legal, organisational and financial regulations
- The narrative in relation to nurses and their work in a crisis situation, i.e. terms such as 'hero' are misleading and expressions associated with war and fight should be avoided

These points must be considered and communicated from the outset (even before registration) in order to encourage inactive nurses to return to nursing during a crisis, to offer them the greatest possible security and reliability (Lauxen et al., 2018) and to make the deployment as easy as possible for everyone involved. A contact person should be available by phone and

email for questions. At least for those inactive nurses who doubt that their competencies and knowledge are still sufficient, refresher courses could be offered before a deployment or at regular intervals in general. Disaster competencies would be important for both inactive and active nurses, e.g. in view of climate change and the expected (re-)emergence of known and novel infectious diseases (Skillman et al., 2010; Vogel & Schaub, 2021).

In addition, regulations (legal, organisational, financial) are needed that make it as straightforward as possible for inactive nurses to take up employment with another employer during a crisis situation (Lauxen et al., 2018). For example, a central office could offer support in concluding employment contracts and clarifying issues regarding deployments.

The language used in the context might be important: If terms such as 'heroes' are superimposed on the identity as a nurse, the commitment of inactive nurses might decrease and with it their willingness to step in in an emergency.

The silent reserve of nurses

The idea of bringing inactive and retired nurses back into nursing in times of crisis is not new:

For ‘retired nurses’ and ‘former nurses’, the first entries in Pubmed (search on 29.04.2022) in connection with a (temporary) return to work date from 1915 (n=205 entries altogether) and 1910 (n=56 entries altogether) respectively, for ‘inactive nurses’ from 1940 (n=49 entries altogether). During the First World War, in the USA, it was suggested to deploy retired nurses to supervise the care of less severe cases, so that active nurses could concentrate on the care of severe cases (“Hospital and Institutional News,” 1915, 27 March).

However, the results of this study suggest that the silent reserve of inactive nurses who could be deployed in crisis situations is probably not as large as hoped (Lücker et al., 2022; McIntosh et al., 2006). Among the approximately 864,000 inactive nurses, of whom up to 583,000 full-time equivalents could envisage a general return to nursing (Auffenberg et al., 2022), are many who remain employed in the health sector and take on important tasks in crisis situations that leave them unavailable for direct patient care tasks.

Others cannot or do not want to work in nursing again for a variety of reasons. In particular, attempts to deploy those with a fundamentally negative attitude must be viewed critically with regard to cooperation with and the effects on active nursing staff and, ultimately, with regard to patient safety. A compulsory obligation of inactive nurses - as briefly considered at the beginning of the pandemic - would probably not make sense in this respect.

Strengths and Limitations

This work has some limitations. Due to the nature of the recruitment (self-selection, snowball system), neither the sample of the online survey nor that of the focus groups might be representative. For example, many academically qualified inactive nurses participated in the online survey and the focus groups (though not the same people). This is due to the fact that in Germany there is presently no possibility to contact inactive nurses directly or in a more targeted way.

Those who were not registered but indicated that they would wait and see were assigned to the group of those who were not willing to return to nursing during the COVID-19 pandemic. However, a later registration or willingness to return to nursing in case of a worsening or a reassessment of the situation cannot be ruled out.

Especially in the focus groups, statements repeatedly referred to a permanent return of inactive nurses to nursing. Therefore, there may be an overlap between a temporary and a permanent return in the statements. Nevertheless, we assume that the reasons for or against a deployment in a crisis situation and the reasons for and particularly against a permanent return to nursing are equally valid.

One strength of this study is that we were able to recruit participants from all over Germany who had different previous experiences and were engaged in different jobs after leaving the profession. This was both the case for the survey and for the focus group discussions. We were also able to recruit people for the focus groups who had different views on a (temporary) return to nursing. We were able to conduct the survey relatively at the beginning of the pandemic, a time when there was a lot of uncertainty and little knowledge, so we believe that the results can be applied to other, similar crisis situations.

Conclusion

In summary, all of the abovementioned factors contribute to the decision to return to nursing in the event of a crisis. It can be assumed that the factors lie on the continuum of decision-making described by Tezcan-Güntekin et al. (Tezcan-Güntekin et al., 2021).

In the long term, the main aim should be to improve working conditions in nursing and thus the nursing experience, both to retain active nurses and to reduce the risk of moral distress or moral injury in nursing which could, in a crisis situation, prevent a temporary return of those who decided to change careers.

I would like to conclude this work with two quotations between which lie almost 90 years and apparently little change:

> *1927: 'The nurse is looking toward a time when she will have a job that will satisfy her energy, capability and ambition, and which will present satisfactory conditions for employment.'* (Ames, 1927)
>
> *2016: 'Nurses around the world, however, have shared concerns about staffing problems, poor facilities and inadequate education, training and support. This can result in poor quality care. Moreover, nurses report that they are frequently not permitted to practise to the full extent of their competence; are unable to share their learning; and have too few opportunities to develop leadership, occupy leadership roles and influence wider policy.'* (All-Party Parliamentary Group (APPG) on Global Health, 2016)

Summary

An already existing shortage of nurses was exacerbated by the COVID-19 pandemic. Inactive (former) nurses were regarded as a so-called silent reserve and were called upon by various agencies to volunteer for nursing. The question arose as to what factors might encourage or hinder such volunteering and facilitate deployment.

First, inactive nurses were asked via an online survey whether they had registered for deployment or not and what the reasons were for this decision. Further information on professional background was collected, including the reason for having left the profession in the first place. Based on the results of the online survey, focus group discussions were conducted with registered and unregistered inactive nurses, with nurses who had returned to the profession permanently, and with care home managers.

Only one third of the participants in the online survey said they had registered for a temporary assignment during the pandemic. The main reasons for registering were that inactive nurses 'wanted to do their bit' to manage the crisis, felt it was their duty and/or felt a sense of belonging to the nursing profession. The main reasons given for not having registered was that respondents 'could not see a reason at the moment', had health concerns, and 'other relevant job commitments'. The majority of respondents still had jobs related to health, care or nursing.

The topics covered in the focus group discussions included the following: perception of the pandemic as a crisis, identity as a nurse and sense of professional commitment, role of current occupation in the decision to register, winning over inactive nurses with a very negative attitude towards returning to care during a crisis situation, support measures and offers regarding a deployment in nursing.

Both in the online survey and in the focus group discussions, a sense of belonging to the nursing profession was evident among many participants. However, this identity does not necessarily lead to a willingness to return to nursing during a crisis situation. Weighing up the risk of deployment against the positive or negative experiences gained during the active period can influence willingness. However, the possibility of taking a break from current work and returning to nursing at short notice is not always given. Many inactive nurses continue to work in the health sector and fulfil equally important tasks during a crisis situation which render them unavailable for deployment.

Different kinds of support for those willing to return to nursing during a crisis situation and communication on conditions of deployments need to be implemented and continuously

improved to offer the inactive nurses the greatest possible security and to enable a largely unbureaucratic deployment.

References

All-Party Parliamentary Group (APPG) on Global Health (Ed.). (2016). *Triple Impact: How developing nursing will improve health, promote gender equality and support economic growth*. http://www.nnpbc.com/pdfs/policy-and-advocacy/misc/APPG-Triple-Impact-Report.pdf

Ames, M. (1927). Public Health Nursing. *American Journal of Public Health (New York, N.Y.: 1912)*, *17*(2), 196–198. https://doi.org/10.2105/ajph.17.2.196

Arnetz, J. E., Goetz, C. M., Arnetz, B. B., & Arble, E. (2020). Nurse Reports of Stressful Situations during the COVID-19 Pandemic: Qualitative Analysis of Survey Responses. *International Journal of Environmental Research and Public Health*, *17*(21). https://doi.org/10.3390/ijerph17218126

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

Bierhoff, H.-W. (2010). Prosocial Behaviour. In M. Hewstone, W. Stroebe, & K. Jonas (Eds.), *BPS textbooks in psychology. Introduction to social psychology: A European perspective* (4. ed. [Nachdr.], pp. 176–195). Blackwell. https://www.blackwellpublishing.com/content/hewstonesocialpsychology/chapters/cpt9.pdf

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

Breinbauer, M. (2020). *Arbeitsbedingungen und Arbeitsbelastungen in der Pflege*. Springer Fachmedien Wiesbaden. https://doi.org/10.1007/978-3-658-32021-8

Bundesministerium für Gesundheit, Bundesministerium für Familie, Senioren, Frauen und Jugend, & Bundesministerium für Arbeit und Soziales (Eds.). (2020). *Konzertierte Aktion Pflege: Erster Bericht zum Stand der Umsetzung der Vereinbarungen der Arbeitsgruppen 1 bis 5*. https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Pflege/Berichte/2020-12-09_Umsetzungsbericht_KAP_barrierefrei.pdf

Dargiewicz, A. (2022). Sprache im Kampf gegen Corona. Eine Analyse von Texten aus den deutschsprachigen Online-Medien. *Linguistische Treffen in Wrocław*(21), 47–73. https://doi.org/10.23817/lingtreff.21-3

Ellison, J. (2021). Why are experienced nurses leaving work? *Kai Tiaki: Nursing New Zealand*, *27*(4), 22–23. https://kaitiaki.org.nz/article/why-are-experienced-nurses-leaving-work/

Fottler, M. D., & Widra, L. S. (1995). Intention of inactive registered nurses to return to nursing. *Medical Care Research and Review: MCRR*, *52*(4), 492–516. https://doi.org/10.1177/107755879505200404

Golombek, J., & Fleßa, S. (2011). Einflussfaktoren auf die Verweildauer im Beruf und die Standortwahl des Arbeitsplatzes bei Gesundheits- und Krankenpflegern. *HeilberufeScience*, *2*(1), 3–10. https://doi.org/10.1007/s16024-011-0104-x

Gouldner, A. W. (1960). The Norm of Reciprocity: A Preliminary Statement. *American Sociological Review*, *25*(2), 161. https://doi.org/10.2307/2092623

Hahm, S., Kietzmann, D., Lemanski, S., Knuth, D., & Schmidt, S. (2019). Factors of perceived threat regarding severe storm events: Results of a vignette study in four European countries. *Safety Science*, *116*, 26–32. https://doi.org/10.1016/j.ssci.2019.02.026

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

Hospital and Institutional News: A plea for the mobilisation of hospitals and nurses (1915, 27 March). *The Hospital*, *57*(1501), 569–574. https://doi.org/News

Kennedy, A. (2021). The International Council of Nurses in the time of the COVID-19 pandemic. *International Nursing Review*(68), 144–164. https://onlinelibrary.wiley.com/doi/pdf/10.1111/inr.12681

Kerzman, H., van Dijk, D., Siman-Tov, M., Friedman, S., & Goldberg, S. (2020). Professional characteristics and work attitudes of hospital nurses who leave compared with those who stay. *Journal of Nursing Management*, *28*(6), 1364–1371. https://doi.org/10.1111/jonm.13090

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

Larsson, G., Nilsson, S., Hyllengren, P., Ohlsson, A., Waaler, G., & Kallenberg, K. (2018). Stress reactions following acute situations involving moral challenges among health care professionals. *Scandinavian Journal of Psychology*, *59*(2), 177–185. https://doi.org/10.1111/sjop.12425

Lauxen, O., Larsen, C., Schwarz, L., & Höhmann, U. (2018). Personal sichern: Wie können Arbeitgeber Einfluss nehmen? *Pflegezeitschrift*, *71*(4), 59–64. https://doi.org/10.1007/s41906-018-0465-1

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer Publishing Company.

Levine, M., & Thompson, K. (2004). Identity, place, and bystander intervention: Social categories and helping after natural disasters. *The Journal of Social Psychology*, *144*(3), 229–245. https://doi.org/10.3200/SOCP.144.3.229-245

Lindell, M. K., & Perry, R. W. (2012). The protective action decision model: Theoretical modifications and additional evidence. *Risk Analysis*, *32*(4), 616–632. https://doi.org/10.1111/j.1539-6924.2011.01647.x

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*, 3687–3695. https://doi.org/10.1111/jan.15268

Lücker, P., Henning, E., Kästner, A., & Hoffmann, W. (2023). Inactive Nurses' Willingness to Return to Active Nursing during the COVID 19 Pandemic: A Qualitative Study. *Journal of Advanced Nursing*, *00*, 1–15. https://doi.org/10.1111/jan.15881

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

McIntosh, B., Palumbo, M. V., & Rambur, B. (2006). Does a 'shadow workforce' of inactive nurses exist? *Nursing Economics*, *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

Moss, M., Good, V. S., Gozal, D., Kleinpell, R., & Sessler, C. N. (2016). A Critical Care Societies Collaborative Statement: Burnout Syndrome in Critical Care Health-care Professionals. A Call for Action. *American Journal of Respiratory and Critical Care Medicine*, *194*(1), 106–113. https://doi.org/10.1164/rccm.201604-0708ST

National Health Service (NHS) England. (2020). *'Your NHS Needs You' – NHS call for volunteer army*. https://www.england.nhs.uk/2020/03/your-nhs-needs-you-nhs-call-for-volunteer-army/

Paul Hartmann AG (Ed.). (2018). *#PflegeComeBack-Studie*. https://www.hartmann.info/de-de/wissen-und-news/2/2/pflegecomeback

Rowlands, S. L. (2021). Understanding and mitigating moral injury in nurses. *Nursing Standard (Royal College of Nursing (Great Britain): 1987)*, *36*(11), 40–44. https://doi.org/10.7748/ns.2021.e11703

Rushton, C. H., Schoonover-Shoffner, K., & Kennedy, M. S. (2017). Executive Summary: Transforming Moral Distress into Moral Resilience in Nursing. *The American Journal of Nursing*, *117*(2), 52–56. https://doi.org/10.1097/01.NAJ.0000512298.18641.31

Schreyögg, J., & Milstein, R. (2016). *Expertise zur Quantifizierung der Pflegezahlen in Deutschland sowie zum Überblick über die normative Bestimmung des Pflegebedarfs in ausgewählten OECD-Ländern: im Auftrag der Expertenkommission "Pflegepersonal im Krankenhaus" im Bundesministerium für Gesundheit (BMG).*

Die Senatorin für Gesundheit, Frauen und Verbraucherschutz Freie Hansestadt Bremen. (2022, August 4). *Gesundheitssenatorin ruft Pflege- und Hilfskräfte mit freien Kapazitäten zur Registrierung auf Plattform #pflegereserve auf* [Press release]. https://www.senatspressestelle.bremen.de/pressemitteilungen/gesundheitssenatorin-ruft-pflege-und-hilfskraefte-mit-freien-kapazitaeten-zur-registrierung-auf-plattform-pflegereserve-auf-375685?asl=bremen02.c.732.de

Senni, M. (2020). Covid-19 experience in Bergamo, Italy. *European Heart Journal*, *41*(19), 1783–1784. https://doi.org/10.1093/eurheartj/ehaa279

Simon, M. (2022). *Pflegenotstand auf Intensivstationen: Berechnungen zum Ausmaß der Unterbesetzung im Pflegedienst der Intensivstationen deutscher Krankenhäuser. Study*

/ Hans-Böckler-Stiftung: 474 (Juni 2022). Hans-Böckler-Stiftung. https://www.boeckler.de/fpdf/HBS-008331/p_study_hbs_474.pdf https://doi.org/259805

Skillman, S. M., Palazzo, L., Hart, L. G., & Keepnews, D. (2010). The characteristics of registered nurses whose licenses expire: why they leave nursing and implications for retention and re-entry. *Nursing Economics*, *28*(3).

Der Spiegel (Ed.). (2020). *Applaus für Helfer: Der Klang der Dankbarkeit*. https://www.spiegel.de/panorama/gesellschaft/coronavirus-applaus-fuer-helfer-aus-fenstern-und-balkonen-der-klang-der-dankbarkeit-a-d98cda75-610a-4a65-a70d-5e2c134fd6d9

Tezcan-Güntekin, H., Schmidt, J. M., & Özer-Erdogdu, I. (2021). Zurück in die Pflege: Zwischen 'Sollen', 'Wollen' und 'Können' – Berufsidentitäten von Pflegefachkräften in Krisensituationen am Beispiel der Sars-CoV-2-Pandemie. *Gesundheitswesen (Bundesverband der Ärzte des Öffentlichen Gesundheitsdienstes (Germany)).* Advance online publication. https://doi.org/10.1055/a-1531-5079

Thüringer Ministerium für Arbeit, Soziales, Gesundheit, Frauen und Familie, LIGA der Freien Wohlfahrtspflege in Thüringen e. V., & Landesarbeitsgemeinschaft der privaten Pflegeverbände in Thüringen (Eds.). (2020). *Aufruf zur Aktivierung der 'stillen Reserve'*. https://www.tmasgff.de/medienservice/artikel/aufruf-zur-aktivierung-der-stillen-reserve

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

Vogel, P. U. B., & Schaub, G. A. (2021). *Seuchen, alte und neue Gefahren: Von der Pest bis COVID-19*. *Springer eBook Collection*. Springer Spektrum. https://doi.org/10.1007/978-3-658-32953-2

Wolf-Ostermann, K., Rothgang, H., Domhoff, D., Fridrich, A.-C., Heinze, F., Preuß, B., Schmidt, A., Seibert, K., & Stolle, C. (Juni 2020). *Zur Situation der Langzeitpflege in Deutschland während der Corona-Pandemie: Ergebnisse einer Online-Befragung in Einrichtungen der (teil)stationären und ambulanten Langzeitpflege*. https://media.suub.uni-bremen.de/bitstream/elib/4331/4/Ergebnisbericht%20Coronabefragung%20Uni-Bremen.pdf

World Health Organization (Ed.). (2020). *State of the World's Nursing 2020, Executive Summary: Investing in education, jobs and leadership*. https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf

World Health Organization (Ed.). (2022). *Nursing and midwifery: Key facts*. https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery

Check for updates

Received: 21 November 2021 | Revised: 23 March 2022 | Accepted: 3 April 2022

DOI: 10.1111/jan.15268

ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - QUANTITATIVE

To come back or not to come back during the coronavirus crisis—A cross-sectional online survey of inactive nurses

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

Abstract

Aims: To examine whether inactive nurses are willing to return to nursing during the COVID-19 pandemic, the reasons for or against their decision and further, possibly relevant factors.

Design: Cross-sectional online survey.

Methods: We developed a questionnaire, addressing registration, professional experiences, anticipations, and internal and external factors that might affect the decision of inactive nurses to return to nursing during the pandemic. Between 27 April and 15 June 2020, we recruited participants in Germany via social networks, organizations and institutions and asked them to forward the link to wherever other inactive nurses might be reached.

Results: Three hundred and thirty-two participants (73% female) could be included in the analysis. The majority of the participants (n = 262, 79%) were general nurses. The main reason for registering was 'want to do my bit to manage the crisis' (n = 73, 22.8%). More than two thirds of the participants (n = 230, 69%) were not or not yet registered. One hundred and twelve (49%) out of 220 participants, who gave reasons why they did not register, selected they 'could not see a necessity at that time'. The few inactive nurses who were deployed reported a variety of experiences.

Conclusions: Different factors influence the nurses' decision to register or not. A critical factor for their decision was previous experiences that had made them leave the job and prevented a return—even for a limited time in a special situation.

Impact: From the responses of the participants in this study, it can be deduced that: negative experiences made while working in nursing influence the willingness to volunteer for a deployment; only one-third of the inactive nurses would be willing to return to the nursing profession to help manage the Corona pandemic; policymakers and nursing leaders should not rely on the availability of inactive nurses in a crisis.

KEYWORDS
care, COVID-19, deployment, inactive nurses, nursing, nursing shortage, nursing workforce, pandemic, register, return

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1 | INTRODUCTION

In March 2020, the World Health Organization (WHO) declared COVID-19 a pandemic and many countries faced challenges in responding. Particularly, a pre-existing shortage of nurses (WHO, 2020) became even more obvious. Nurses became a valuable resource, and different countries called on nurses who left the profession prior to retirement age (inactive nurses) to return to nursing (International Council of Nurses, 2021). In Germany, from an early stage of the pandemic in April 2020, various authorities and organizations began to call on this 'nursing reserve' to sign in to help manage the crisis (Williams et al., 2020). The bodies included university hospitals and clinics, health authorities, nursing councils ('Pflegekammern', Boards of Nursing), state governments, employment agencies and others. We conducted an online survey to find out which motives inactive nurses had to come back for a limited amount of time or what would prevent a return, as well as other factors which might play a role in their decision.

Summary

Policymakers or nurse leaders should not count on the availability of a reserve of inactive nurses in the event of a crisis.

2 | BACKGROUND

2.1 | Nurses in Germany

In Germany, there has been a nursing shortage for years (WHO, 2021). Especially, nurses, who had at least 3 years of training, either at university or through vocational training, are needed to ensure quality care for those who are sick or in need of care in hospitals and care homes (Blümel et al., 2020). In Germany, the majority of nurses are qualified through vocational training and are mainly divided into general, paediatric and geriatric nurses. In the following, nurses with at least 3 years of training are referred to as qualified nurses. In Germany, there is no professional register for nurses. Therefore, registration takes place only in the context of readiness to help out during the pandemic and this term is only used in this context.

To counter the shortage, hospitals as well as the German government have made efforts to motivate people for professional training and also to recruit nurses from abroad (Duell & Vetter, 2020). Additionally, the government developed a programme to win back inactive nurses. The authors of the #PflegeComeBack study (Paul Hartmann, 2018) assume that, in Germany, as many as 335,000 nurses may have left the profession over the past 25 years.

Nurses quitting their jobs is a well-known and widespread problem (Buchan et al., 2018). A study shows that a large proportion not only quit their job but also their profession (Sasso et al., 2019). Conditions leading to the exit of many nurses, relating to support, workload and professional development were reported in different studies over time (Ellison, 2021). The #PflegeComeBack study concluded that around 120,000–200,000 inactive nurses would consider returning to nursing, depending on circumstances, that is improved working conditions (Paul Hartmann, 2018). It has been shown that the pandemic is likely to make conditions even worse (Zipf et al., 2022).

In many countries, such as the UK or the USA, nurses can be easily reached, the profession is regulated and registration on a professional register is a pre-requisite for taking up work (International Council of Nurses, 2020). In Germany, such a register for nurses as part of a nursing council ('Pflegekammer') exists only in some federal states (Blümel et al., 2020), so the number of nurses as a potential reserve and their contact details are presently not known. This lack of comprehensive professional registration restricts the number of inactive nurses who can be contacted and approached personally in case of need.

Returning to an activity, to which one has turned one's back for various reasons, represents a particular challenge (Noorland et al., 2021), even if the return is voluntarily and temporarily. In this context, the question arises as to what motivates nursing professionals to make themselves available for a short-term return to the nursing profession in an emergency—or not.

Even if there is a basic willingness to support during the COVID-19 pandemic in the context of helping behaviour, which generally aims to improve the situation of the recipient of the aid (Bierhoff, 2010), for people, there may be reasons not to do so. Considering risk factors associated with severe COVID-19 (Mayo Clinic, 2022), there is one's own chronic illness or that of relatives, or very practically, a fear to contract an infection. These reasons were also given by healthcare workers about their willingness to work during an influenza pandemic (Aoyagi et al., 2015). Possibly, inactive nurses may have non-nursing work obligations that are equally important or no longer feel fit for practice (Fothergill et al., 2005). In addition, there are probably expectations and uncertainties about what it will be like to work again in nursing and especially during the COVID-19 pandemic. All these factors determine the decision about a voluntary registration and in those, who do, they will also affect the actual experience of working as a nurse again. To be able to draw on the nursing reserve, these factors should be known as precisely as possible. Our aim was to identify these conditions as well as others that might play a role.

3 | THE STUDY

3.1 | Aims

The study aims to identify if inactive nurses are prepared to return to the nursing workforce during a time of crisis, the reasons for or against their decision and related factors. For those who returned, it aims to gain an insight into their experiences.

3.2 | Design

Cross-sectional online survey.

3.3 | Participants

A convenience sample of inactive nurses was obtained using snowball techniques. A lack of a professional register meant that organizations such as universities or health insurance funds as well as social networks related to nursing were asked to recruit inactive nurses by disseminating the survey link, resulting in a self-selected sample.

Case number calculations for the one-sided *t* test using G*Power 3.1.9.6 with a power of 95% and a significance level α of 0.05 revealed a necessary minimum number of 176 (88 registered and 88 non-registered or academic versus non-academic inactive nurses). For the Wilcoxon–Mann–Whitney test, with the above power and significance level α, the total number of participants was calculated to be 184 (92 per group) at least.

The inclusion criteria were participants had to be qualified as a nurse and had to answer whether they were registered to return to the workforce or not. As older age is a known risk factor for a severe course of COVID-19 disease, only people up to 65 years of age were included. Those active nurses, who worked 75% or less were included because they might have increased their working hours to a relevant extent during the crisis. Excluded were participants not living in Germany.

3.4 | Data collection

To design the questionnaire, a review of the literature was conducted, searching the database PubMed for studies published between 2000 and 2020 that focused on nurses leaving the profession, and theories on helping behaviour in German and English languages. Publications screened mainly referred to the categories: health, family, job and organizational satisfaction, finance, autonomy and career options (e.g. McIntosh et al., 2006).

Based on this information and considering different aspects of the acute situation, for example the risk of contracting COVID-19, lack of protective equipment and unknown risks from a novel disease, we developed a questionnaire addressing the factors, which might influence the decision for a potential return to nursing.

A review of the literature related to reasons nurses leave the profession and theories on helping behaviour assisted in the development of a survey. The questionnaire consisted of 29 questions, broken into the following categories:

1. Sociodemographic information, including age, sex and qualifications.
2. Professional experiences, including additional qualifications, medical fields in which participants had experiences, reasons for leaving the profession, number of years being active in nursing, year and scope of last employment in nursing, current job (e.g. Ellison, 2021).
3. Helping behaviour includes returning to the workforce, the reasons for and against, expectations and preparations (e.g. Aoyagi et al., 2015; Bierhoff, 2010; Fothergill et al., 2005).
4. Experiences once deployed (e.g. Noorland et al., 2021).

A filter was used for the crucial question, whether people were willing to return to nursing during the crisis and then the reasons for or against their decision. Participants who were registered could give reasons for and those who had not registered, against registration. Those who chose ‘I am still waiting/still thinking’ or ‘other’ were able to give answers to both. Another filter was applied for those who were deployed to ask questions about their experiences. Participants were also asked where they registered and if and why a mandatory registration would make a difference for them.

The majority of the questions had a dichotomous answer format and included the option to provide more detailed information as free-text responses.The questionnaire was pre-tested by inactive nurses ($n = 4$) to evaluate its practicability, comprehensibility and completeness. The pre-test was carried out via a test version of the survey link. After the pre-test, the option to answer ‘does not apply’ and the opportunity to provide additional information for some questions (free-text) were added.

We used the web application SoSci Survey (Leiner, 2019). The survey was online between 27 April and 15 June 2020. The sample was obtained by initial dissemination of the survey link via social and professional networks, institutions that offer registration and other structures related to the nursing profession. While the survey was online, we continuously asked new people or institutions to publish and share the link, which led to a self-selected sample.

For analysis, the data collected via SoSci Survey were transferred to the software SPSS (IBM SPSS Statistics 28, 2021).

3.5 | Validity, reliability and rigour

The acceptability and validity of the questionnaire were assessed after receiving all questionnaires. The questionnaire had satisfactory acceptability as less than 3.9% of missing values occurred, except for the scope of activity (10.5%) and changed thinking about returning to nursing after a deployment (4.3%).

3.6 | Data analysis

The answers were analysed for inclusion criteria. Excluded were 72 people who did not give the answer whether they were registered, 28 who were not trained nurses or had a related degree. Furthermore, six participants were older than 65 years, one did not live in Germany,

15 currently worked more than 75% in nursing and nine reported they had been declared unfit for work. Therefore, out of 463 participants, we excluded 131 and could analyse 332 questionnaires. Since different numbers of participants answered the respective questions, the number of respondents to each question is given.

Categorical variables are presented with frequencies and percentages and univariate analysis was performed applying a chi-squared test. Effect sizes are given by Cramer's V. For Mann–Whitney *U* tests, median and interquartile ranges (IQR) were reported. A $p < .05$ was considered statistically significant.

In addition to predefined response options, further information from the open responses was categorized and coded by two researchers independently of each other according to the method of Kuckartz (2019). Where possible, the answers were assigned to the already existing response categories.

4 | RESULTS

Six hundred and eighteen people started the survey and 463 completed the questionnaire. Out of these, 332 questionnaires could be analysed.

4.1 | Sample characteristics

The sample can be described as follows (Table 1).

TABLE 1 Sample characteristics ($n = 332$)

Variable	*n* (%)
Demographic Information	
Gender ($n = 328$)	Female: 238 (72.6)
	Male: 89 (27.1)
	Diverse: 1 (0.3)
Age (years, $n = 327$)	$M = 45.4$
	SD 10.69
	Range 21–65; median = 46; mode = 42
Qualification ($n = 332$)	
General nurse	264 (76.7)
Paediatric nurse	21 (6.1)
Geriatric nurse	54 (15.7)
Professional experience (years)	$M = 15.0$
	SD 9.51
	Range 1–48; median = 13.5; mode = 15
Academic degree/title ($n = 117$, multi-response)	
Bachelor	62 (53.0)
Master	46 (39.3)
PhD and/or Professor	9 (7.7)
Degree/title awarded in health or care ($n = 48$)	43 (89.6)
Additional professional specialisation ($n = 279$, multi-response)	
ICU nurse	75 (19.4)
Quality management	51 (13.2)
Anaesthetic nurse	31 (8.0)
Teaching and training	26 (6.7)
Ward or area management	17 (4.4)
Hygiene expert	13 (3.4)

Note: M, mean; SD, standard deviation.

4.2 | Leaving the profession

On average, the nurses ($n = 330$) were 8.7 years out of nursing (*SD* 8.12, range 0–38) and some of them were still in the job, however, worked part-time. The nurse who had been out of the job the longest, last worked in nursing in 1982.

The participants were asked for the reasons why they had left work in nursing or care (Table 2). Multiple answers were possible.

Among the five leading reasons to leave the job, at least two are related to career: poor career options (8.8%) and the decision to study (8.0%). Professional re-orientation, which is the decision not to work in direct patient care anymore as the most chosen reason (11.1%), can have various triggers including career options.

4.3 | Current jobs (320 respondents)

Currently, participants are in different jobs or activities. Up to four answers were provided by the participants (Table 3).

Respondents were asked about their current jobs. The majority of respondents ($n = 196$, 61.1%) still had jobs related to health, care or nursing.

4.4 | Registration for deployment during the pandemic (332 respondents)

Only one-third of the respondents ($n = 102$, 30.7%) were former nurses who indicated that they were registered. One hundred and ninety (57.6%) were not registered and 39 (11.7%) watched the development of the situation or were still considering registration. These data were recoded into 'registered' or 'not registered'. One person would have registered but did not know where and 'nobody asked'.

4.4.1 | Reasons for registration (100 respondents)

Participants are registered for different reasons (Figure 1).

TABLE 2 Reasons why participants left the profession (319 respondents, multiple answers possible, 1301 answers)

Reasons why participants left the profession	%	n
Professional reorientation	11.1	145
Shift patterns and working hours	10.0	130
Poor or other career options	8.8	114
Time pressure, not enough time for patients	8.7	113
Decision to study	8.0	104
Compatibility of work and family	7.5	97
Financial reasons	7.0	91
Physical health issues	5.2	68
Lack of social recognition	5.2	68
Organisational issues	4.7	61
Other reasons	4.6	60
Lack of recognition by other professions	4.2	55
Work interruptions	3.6	47
Problems with colleagues and superiors	2.6	34
Insufficient occupational health & safety	2.5	33
Mental health issues	2.4	31
Too much administration	2.2	29
Working conditions, perception of role	1.0	13
Retirement	0.4	5
Introduction of Nursing Councils in Germany	0.2	3

TABLE 3 Current job or activity (319 respondents; multiple answers possible, 385 answers)

Current job or acitivity	%	n
Administration health sector	25.4	97
Other	17.5	67
Research, teaching, training, consulting	17.3	66
Job, not health-related	10.7	41
Medical Service of the Health Funds (MDK)	7.6	29
Studies, health related	7.3	28
Parental leave	3.7	14
Studies, not health related	3.4	13
Controlling, Quality Management, Business Consulting and Development	2.9	11
Health Insurance	1.8	7
Retirement	1.8	7
Medical practice (Doctor's surgery)	0.5	2

Among the five most given reasons are three which relate to the nursing profession: participants feel a sense of belonging, want to support former colleagues and use their skills (total $n = 143$ answers, 44.7%).

4.4.2 | Reasons against registration (219 respondents)

The main reason against registration (Figure 2) was that at the time they were asked, respondents could not see any necessity to register ($n = 108$, 35.9%). Working in a different relevant job ($n = 49$, 14.0%) or health concerns, such as existing diseases, pregnancy or the fear of contracting infection with SARS-CoV-2 ($n = 78$, 22.2%), were also reasons. Those, who chose 'other' ($n = 26$, 7.4%) and gave additional information, listed primarily compatibility with their current job or workload or other commitments, or that they do not want to return to a system they see as very negative.

By means of a cross-tabulation, it could be determined that 60 (27.1%) of the nurses without an academic qualification and 42 (37.8%) of the nurses with an academic qualification registered in the COVID-19 crisis. Chi-squared test showed a statistically significant difference between both (χ^2 (1, $N = 332$ 4.0, $p = .046$). However, the effect size was small (Cramer's $V = 0.11$). There is also a statistically significant positive association between being trained as a geriatric nurse and registration (χ^2 [1, $N = 332$] = 5.2, $p = .022$, Cramer's $V = 0.13$). Neither the time inactive nurses were out of the job (registered: 8.0, IQR 14; not registered: 5.0, IQR 11; $p = .121$; $U = 10{,}331$), nor a current job related to health and care (χ^2 [1 $N = 321$] = 1.9, $p = .169$) or the current number of working hours (registered: 100.0, IQR 25.0; not registered: 100.0, IQR 25.0; $p = .861$, $U = 9540$) are statistically associated with registration.

4.5 | Expectations (295 respondents)

When returning to nursing, the inactive nurses expected (multiple answers possible, 939 answers) to enjoy the interaction with patients ($n = 138$, 14.7%) and to work in their original profession ($n = 96$, 10.2%). Some feared that no consideration would be given to their personal situation ($n = 105$, 11.2%) or that they would face insufficient protection against an infection with the Coronavirus ($n = 93$, 9.9%). Time pressure at work was also something that raised concern ($n = 85$; 9.1%).

4.6 | Deployment

Out of 100 respondents, who answered the question, 23 had been deployed to work in care during the Coronavirus crisis before mid-June, 2020. Being able to give multiple answers, 18 nurses rated their experience overall as positive, one nurse as negative. Most of the deployed nurses worked in the care of elderly people ($n = 12$), six of them cared for Coronavirus-infected people, and also six were deployed in intensive care.

Four of the nurses deemed their fears about returning to care realistic, but the majority ($n = 18$) had positive experiences. For 10, the deployment was meaningful and for nine challenging. Four of

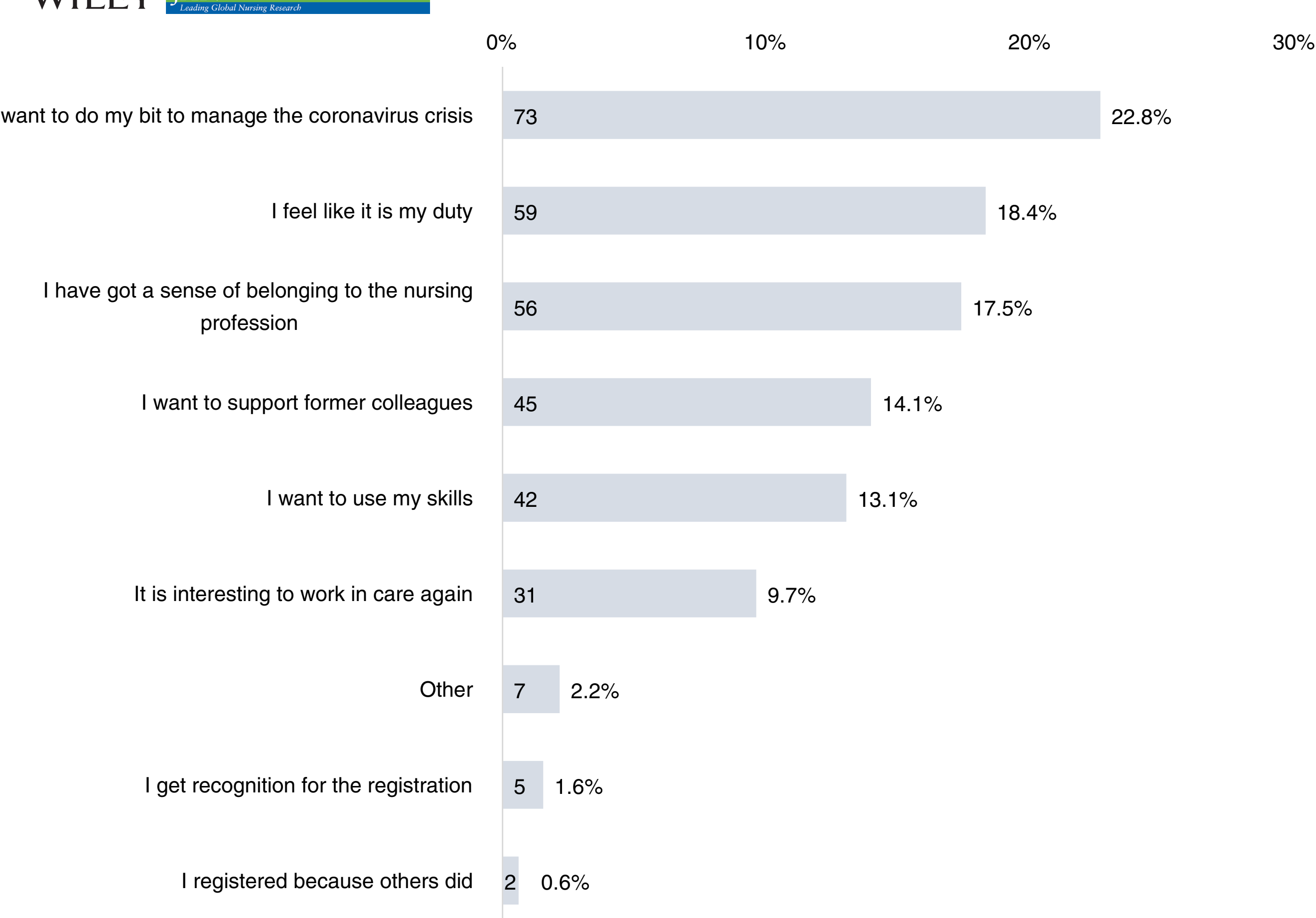

FIGURE 1 Reasons for registration (100 respondents, multiple answers possible, 320 answers; %, *n*)

the deployed found the experience satisfying, two frustrating. Four peoples experienced working in care again as physically, two as mentally demanding.

Volunteers reported that the main support they received was peer counselling ($n = 10$), childcare ($n = 2$), financial incentives ($n = 2$) and a Coronavirus hotline or similar ($n = 2$). If used, these offers were overall perceived as helpful ($n = 9$).

5 | DISCUSSION

Our study shows that different factors determine the decision for or against voluntary registration during a period of crisis such as the COVID-19 pandemic.

One of the main findings is that only 30% of participants were willing to return to nursing during the pandemic. Fothergill et al. (2005) reported almost the same figure (27%) for inactive nurses who would be available for disasters. One reason for this could be that, up until the time of the survey, a large proportion of respondents did not see the need to register for a possible deployment. This is comprehensible, compared with the conditions, for example in Bergamo in Italy (Senni, 2020), the infection rates in Germany had been low and the situation in hospitals and care facilities in most regions was relatively calm. Financial issues were also one of the reasons against registration, as a relevant number of inactive nurses were worried about adequate financial compensation and arrangements. There may be a link with leaving care: lack of career opportunities is among the reasons for leaving the profession (Ellison, 2021). A higher-skilled job comes with a higher salary, a return to nursing would reduce people's income. Nevertheless, in our study, an academic background was a statistically significant determinant for registration. A positive correlation between higher education and volunteering generally and during the pandemic was also found by Mak and Fancourt (2021). This suggests that arrangements about possible financial compensation and agreements with, for example main employers could facilitate registration (Noorland et al., 2021).

The majority of non-employed nurses in our study who were actually deployed and returned to work in nursing reported overall positive experiences but also mentioned negative components. Thus, the experience can be both satisfying and demanding. This is also reported by Zipf et al. (2022), in whose study nurses report stress and exhaustion, but also pride in what they have achieved so far.

Many of the inactive nurses expressed a sense of belonging to the nursing profession. Although challenging, there seems to be a

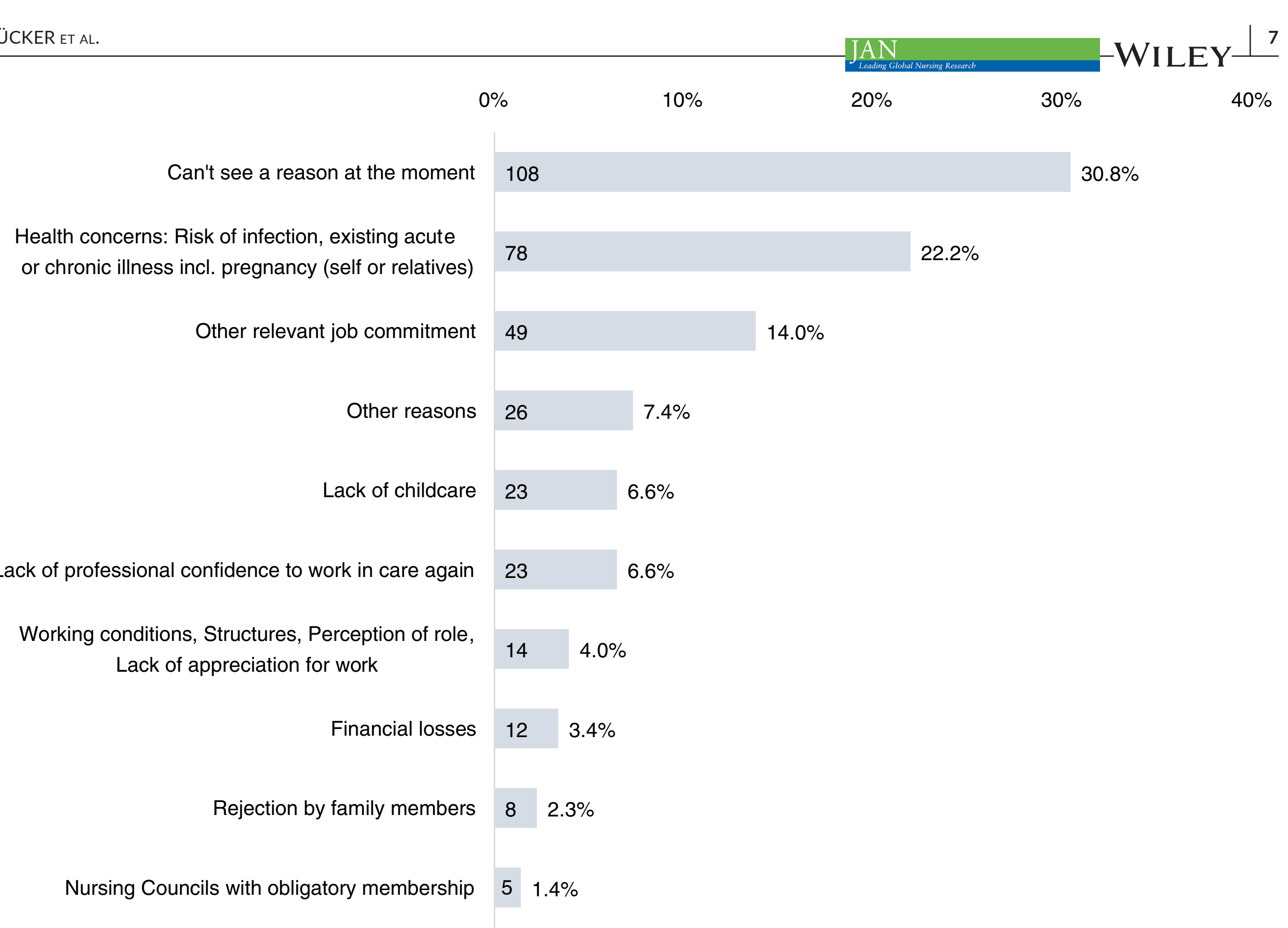

FIGURE 2 Reasons against registration (219 respondents, multiple answers possible, 351 answers; %, *n*)

professional identity that nurses all over the world refer themselves to (van der Cingel & Brouwer, 2021). A sense of belonging to the nursing workforce has been identified as a facilitating factor for volunteering (Fothergill et al., 2005). Participants in this study expressed this sense directly and indirectly as a reason for registration. Especially geriatric nurses showed a high willingness to help out. The knowledge of an already permanently tense situation in care homes (Devi et al., 2021) and the even higher workload for (former) colleagues due to COVID-19 might have contributed to the higher number of registrations in this subgroup.

It was striking that those inactive nurses, who had not registered, seemed to feel a need to explain their decision and the reasons that led to it. They often mentioned previous negative experiences in their everyday professional life as a reason for not having registered. A feeling of being demoralized and dissatisfied (Senek et al., 2020) seems to be persistent and can prevent the willingness to step in.

In other countries, nursing students at an advanced stage of their studies have been employed as additional nursing staff during the pandemic (Casafont et al., 2021; Nursing and Midwifery Council, 2020). In Singapore, for instance, it was also about a third (31%) of pre-registered nursing students who volunteered for frontline nursing (Seah et al., 2021). Due to the vocational training system in Germany, student nurses are already part of the staff involved in direct patient care and are not an additional resource.

Although the inactive nursing professionals basically have the skills and competence to care for the sick and those in need of care and could thus be deployed relatively quickly, there has been no coordinated, structured recording of the nursing reserve or a structured programme for re-entry so far. In their 2006 study, McIntosh et al. considered a register of non-employed nurses to be impractical, as the effort required to contact them due to relocation or death was estimated to be very high and timely implementation was considered unaffordable. Since a large part of the population can now be reached by email, this would pose a way to contact at least most inactive nurses. In this case, staff for the maintenance of the register and for queries would need to be considered.

In addition to winning back inactive nurses during crises of any kind, policymakers should also provide an incentive for nurses to pursue the profession outside pandemic periods and improve working conditions in the long term. Especially during crisis situations, the workload of nurses will increase rather than decrease, potentially making the profession less attractive and causing active nurses to

re-evaluate their careers. This trend was already evident in recent data: Between April and December 2020, the number of nurses in Germany and other countries considering leaving their profession increased (International Council of Nurses & CGFNS International Inc., 2021), indicating a decline in job satisfaction. This has implications not only for nursing in the current pandemic but also for future crisis situations.

5.1 | Limitations

One limitation is that the questionnaire was developed especially for this study and pre-tested by only four inactive nurses. However, since the main purpose was to test the comprehensibility of the questions, this number was considered sufficient. The results are not representative because they refer to a self-selected sample of inactive nurses as there is no central register of (inactive) nurses in Germany and their total number is not known. The link to the survey was disseminated in a snowball system through various channels to avoid systematic selection. Nevertheless, a large proportion of the participants indicate an academic background, whereas in Germany, the concept of nurses in direct patient care is still relatively young (Blümel et al., 2020) and these individuals thus represent a minority. The willingness to offer help might have been influenced by the timing of the survey, as it was generally high among the population, especially at the beginning of the pandemic. Of 618 participants who started the questionnaire, 208 dropped out at some point. One reason for ending the survey before starting and dropping out might be that participants were not inactive nurses, as the majority of them left the survey when they were asked questions about qualifications and professional experiences as a nurse.

6 | CONCLUSION

Regulations and agreements for deployments should be created for the inactive nurses who are willing to support the nursing workforce. This involves, for example, necessary financial compensation to the regular income and agreements to work for another employer including insurance issues as well as the opportunity for psychological support during and after deployments.

Although the number of nurses who are willing to support is currently small, a temporary return of inactive nurses to active nursing could be developed as one option to manage a crisis such as the COVID-19 pandemic. Yet, it can be assumed that the effect will be rather small.

Plans for pandemics, crises or even general nursing shortages should not focus too much on inactive nurses. To be prepared for further crisis situations and to meet the daily demands of patient care, it is important to counteract the general nursing shortage and thus improve working conditions. In the long term, this could both reduce the number of nurses leaving the profession and promote the willingness of those who have left to return and support in crisis situations.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

ETHICS STATEMENT

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

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15268.

DATA AVAILABILITY STATEMENT

Questionnaire available on request from the authors

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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

Bierhoff, H.-W. (2010). Prosocial behaviour. In M. Hewstone, W. Stroebe, & K. Jonas (Eds.), *BPS textbooks in psychology. Introduction to social psychology: A European perspective* (4th ed., pp. 176–195). Blackwell. https://www.blackwellpublishing.com/content/hewstonesocialpsychology/chapters/cpt9.pdf

Blümel, M., Spranger, A., Achstetter, K., Maresso, A., & Busse, R. (2020). Germany: Health system review. *Health Systems in Transition*, *22*(6), i-273. https://eurohealthobservatory.who.int/countries/germany/

Buchan, J., Shaffer, F. A., & Catton, H. (2018). Policy brief: Nurse retention. Philadelphia. https://www.icn.ch/sites/default/files/inline-files/ICNM%20Nurse%20retention%20FINAL.pdf

Casafont, C., Fabrellas, N., Rivera, P., Olivé-Ferrer, M. C., Querol, E., Venturas, M., Prats, J., Cuzco, C., Frías, C. E., Pérez-Ortega, S., & Zabalegui, A. (2021). Experiences of nursing students as healthcare aid during the COVID-19 pandemic in Spain: A phemonenological research study. *Nurse Education Today*, *97*, 104711. https://doi.org/10.1016/j.nedt.2020.104711

Devi, R., Goodman, C., Dalkin, S., Bate, A., Wright, J., Jones, L., & Spilsbury, K. (2021). Attracting, recruiting and retaining nurses and care workers working in care homes: The need for a nuanced understanding informed by evidence and theory. *Age and Ageing*, *50*(1), 65–67. https://doi.org/10.1093/ageing/afaa109

Duell, N., & Vetter, T. (2020). *The employment and social situation in Germany*. European Union. https://www.europarl.europa.eu/RegData/etudes/STUD/2020/648803/IPOL_STU(2020)648803_EN.pdf, https://doi.org/10.2861/579773

Ellison, J. (2021). Why are experienced nurses leaving work? *Kai Tiaki: Nursing New Zealand*, *27*(4), 22–23. 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*, *22*(5), 414–421. https://doi.org/10.1111/j.0737-1209.2005.220506.x

International Council of Nurses (Ed.). (2020). *List of regulatory bodies*. https://www.icn.ch/sites/default/files/inline-files/Database%20regulatory%20boards%20ICN_updated_18_03_2020_rev.pdf
International Council of Nurses (Ed.). (2021). International Council of Nurses Policy Brief: The Global Nursing shortage and Nurse Retention. https://www.icn.ch/sites/default/files/inline-files/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention_0.pdf
International Council of Nurses, & CGFNS International Inc. (Eds.). (2021). Annex: COVID-19 and the global nursing workforce: impacts on World Health Organization regions. https://www.icn.ch/system/files/documents/2022-01/Regional%20aspects_press%20release%20Sustain%20and%20Retain%20in%202022%20report_ENG.pdf
Kuckartz, U. (2019). Qualitative text analysis: A systematic approach. In G. Kaiser & N. Presmeg (Eds.), *Springer eBook collection. 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
Leiner, D. J. (2019). SoSci Survey (cloud-based survey tool, Version 3.2.00). Available at https://www.soscisurvey.de
Mak, H. W., & Fancourt, D. (2021). Predictors of engaging in voluntary work during the COVID-19 pandemic: Analyses of data from 31,890 adults in the UK. *Perspectives in Public Health*, 1757913921994146, https://doi.org/10.1177/1757913921994146
Mayo Clinic (Ed.). (2022). COVID-19: Who's at higher risk of serious symptoms? https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-who-is-at-risk/art-20483301#
McIntosh, B., Palumbo, M. V., & Rambur, B. (2006). Does a 'shadow workforce' of inactive nurses exist? *Nursing Economics*, *24*(5), 231-237, 227; quiz 238.
Noorland, S. A., Hoekstra, T., & Kok, M. O. (2021). The experiences and needs of re-entering nurses during the COVID-19 pandemic: A qualitative study. *International Journal of Nursing Studies Advances*, *3*, 100043. https://doi.org/10.1016/j.ijnsa.2021.100043
Nursing and Midwifery Council. (2020). Joint statement on expanding the nursing workforce in the Covid-19 outbreak. https://www.nmc.org.uk/news/news-and-updates/joint-statement-on-expanding-the-nursing-workforce/
Paul Hartmann AG (Ed.). (2018). #PflegeComeBack-Studie. https://www.hartmann.info/de-de/wissen-und-news/2/2/pflegecomeback
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). 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*, 88. https://doi.org/10.1186/s12912-020-00481-3
Senni, M. (2020). Covid-19 experience in Bergamo. *Italy. European Heart Journal*, *41*(19), 1783–1784. https://doi.org/10.1093/eurheartj/ehaa279
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*, *22*(2), e12343. https://doi.org/10.1111/nup.12343
WHO (Ed.). (2020). Shortage of personal protective equipment endangering health workers worldwide. https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide
WHO (Ed.). (2021). National Health Workforce Accounts Data Portal: State of the world's nursing 2020—country profiles. https://apps.who.int/nhwaportal/Sown/Index
Williams, G. A., Maier, C. B., Scarpetti, G., De Belvis, A. G., Fattore, G., Morsella, A., Pastorino, G., Poscia, A., Ricciardi, W., & Silenzi, A. (2020). What strategies are countries using to expand health workforce surge capacity during the COVID-19 pandemic. *Eurohealth*, *26*(2), 51–57. https://apps.who.int/iris/bitstream/handle/10665/336296/Eurohealth-26-2-51-57-eng.pdf
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

How to cite this article: 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*, *00*, 1–9. https://doi.org/10.1111/jan.15268

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

DOI: 10.1111/jan.15881

EMPIRICAL RESEARCH QUALITATIVE

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

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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.

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- 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

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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):

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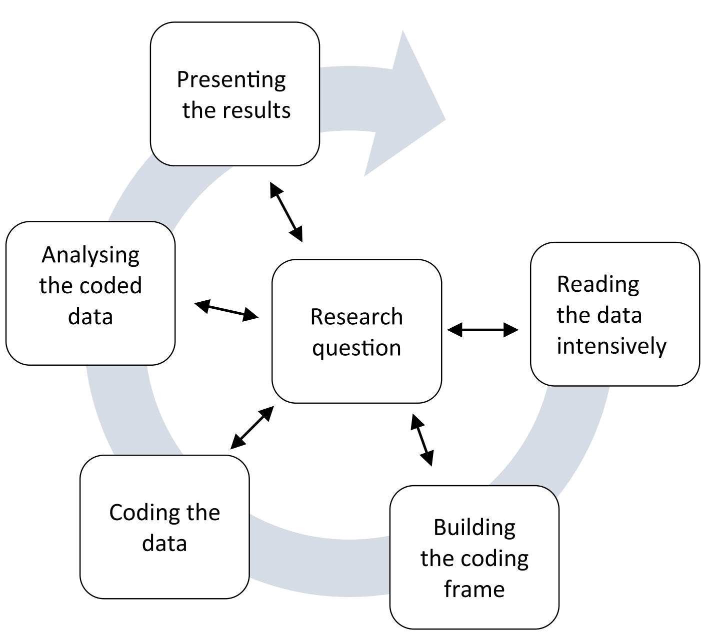

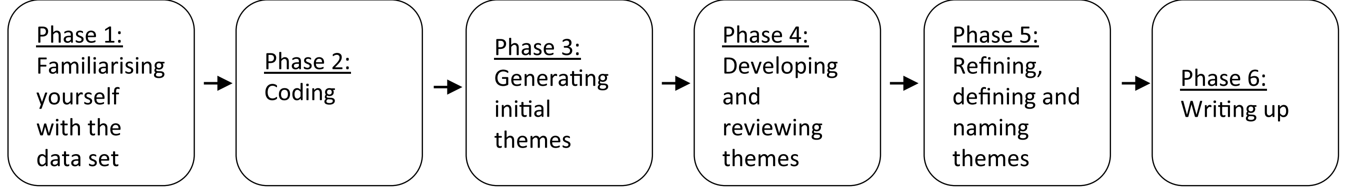

FIGURE 1 Comparison of qualitative content analysis (Kuckartz, 2019) and thematic analysis (Braun & Clarke, 2022).

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

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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.

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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.

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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.

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> 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).

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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)

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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).

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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.

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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.

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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

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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/10.1177/09697330211003217
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

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How to cite this article: Lücker, P., Henning, E., Kästner, A., & Hoffmann, W. (2023). Inactive nurses' willingness to return to active nursing during the COVID-19 pandemic: A qualitative study. *Journal of Advanced Nursing*, *00*, 1–15. https://doi.org/10.1111/jan.15881

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Liebe*r Gesundheits- und Krankenpfleger*in, liebe Gesundheits- und Kinderkrankenpfleger*in, liebe Altenpfleger*in,

das neue Coronavirus fordert uns alle und in besonderer Form auch diejenigen, die (wie wir auch) einen Pflegeberuf erlernt oder studiert haben.

Um personelle Engpässe bei einer weiteren Ausbreitung zu verhindern, wurden **ehemalige Pflegefachpersonen** dazu aufgerufen, sich für die Unterstützung in der Patient*innenversorgung freiwillig zu registrieren.

Wir möchten mehr über die Gründe erfahren, die zu einer freiwilligen Registrierung und damit einer möglichen, zeitlich begrenzten Rückkehr in die direkte Patientenversorung führen – aber auch über Gründe, die eine Registrierung verhindern. Hierfür führen wir die Studie RETURN (*Freiwillige Registrierung ehemaliger Pflegefachpersonen im Krisenfall*) durch. Wir wenden uns mittels einer Onlineumfrage an **alle ehemaligen, d. h. nicht mehr in der direkten Patientenversorgung tätigen Pflege-fachpersonen**, unabhängig davon, ob sie sich für einen möglichen Einsatz registriert haben, dagegen entschieden haben oder noch abwarten.

Die Erkenntnisse aus dieser Studie können dazu beitragen, Maßnahmen zu identifizieren, die eine freiwillige, zeitlich begrenzte Rückkehr in die Pflege in einem Krisenfall erleichtern.

Um mehr über die Gründe für oder gegen eine freiwillige Registrierung zu erfahren, bitten wir Sie, an unserer Umfrage teilzunehmen. Die Beantwortung der Fragen dauert ca. 10 Minuten.

Zur Erleichterung des Ausfüllens des Fragebogens bieten wir Ihnen jeweils eine Vielzahl von Antwortmöglichkeiten an. Nutzen Sie aber gerne auch die Möglichkeit, unter „Sonstiges" weitere Angaben zu machen. Die Umfrage ist anonym, freiwillig und kann jederzeit ohne Nachteile für Sie abgebrochen werden.

Vielen Dank für Ihre Unterstützung.

Esther Henning und Petra Lücker Wissenschaftliche Mitarbeiterinnen am Institut für Community Medicine der Universitätsmedizin Greifswald und ehemalige (Kinder-)Krankenschwestern

1. Geschlecht

- ○ weiblich
- ○ männlich
- ○ divers

2. Alter

[ ] Jahre

3. Die ersten 3 Ziffern Ihrer Postleitzahl (Beispiel: Postleitzahl 12345: 123)

[ ]

4. Welche(s) Ausbildung / Studium haben Sie abgeschlossen?

Bitte alles Zutreffende auswählen

- ☐ Gesundheits- und Krankenpfleger*in / Krankenschwester/-pfleger
- ☐ Gesundheits- und Kinderkrankenpfleger*in / Kinderkrankenschwester/-pfleger
- ☐ Altenpfleger*in
- ☐ Bachelor (gerne unter „Sonstiges“ genaue Bezeichnung)
- ☐ Master (gerne unter „Sonstiges“ genaue Bezeichnung)
- ☐ Dr. (gerne unter „Sonstiges“ genaue Bezeichnung)
- ☐ Prof. (gerne unter „Sonstiges“ genaue Bezeichnung)
- ☐ Sonstiges:

5. Welche pflegerische(n) Zusatzqualifikation(en) haben Sie?

Bitte alles Zutreffende auswählen

- ☐ Keine
- ☐ Intensivpflege
- ☐ Anästhesiepflege
- ☐ Hygienefachkraft
- ☐ Qualitätsmanagement
- ☐ Pflegedienstleitung
- ☐ Sonstiges:

6. In welchen Arbeits- und Fachgebieten konnten Sie bisher Berufserfahrung (nach Ausbildung/Studium) sammeln?

Bitte alles Zutreffende auswählen

- [ ] Erwachsenenkrankenpflege
- [ ] Kinderkrankenpflege
- [ ] Altenpflege
- [ ] ambulante Pflege
- [ ] stationäre Akutversorgung
- [ ] Rehabilitation
- [ ] Funktionsbereich
- [ ] OP
- [ ] Anästhesie
- [ ] Intensivstation
- [ ] Arztpraxis
- [ ] Innere Medizin
- [ ] Chirurgie
- [ ] Gynäkologie
- [ ] Psychiatrie
- [ ] Gesundheitsamt
- [ ] Forschung
- [ ] Sonstiges:

7. Wieviele Jahre waren Sie in der direkten pflegerischen Patientenversorgung tätig?

(Unabhängig vom Umfang der Tätigkeit)

Jahre

8. In welchem Jahr waren Sie zuletzt in der direkten, pflegerischen Patientenversorgung tätig? (z. B. 2003)

9. In welchem Umfang waren Sie zuletzt in der direkten pflegerischen Patientenversorgung tätig?

z. B. Vollzeitstelle = 100 %; ca. 20 Stunden = 50 %; bei 400/450 €-Basis bitte 4 eingeben

%

10. Aus welchen Gründen sind Sie nicht mehr in der direkten, pflegerischen Patientenversorgung tätig?
Bitte alles Zutreffende auswählen

- ☐ Vereinbarkeit Beruf und Familie
- ☐ Fehlende Karriereaussichten
- ☐ Berufliche Umorientierung
- ☐ Arbeitszeiten
- ☐ Körperliche Probleme
- ☐ Psychische Probleme
- ☐ Finanzielle Gründe
- ☐ Organisation im Unternehmen
- ☐ Zu hoher Zeitdruck; keine Zeit für Patienten
- ☐ Störende Unterbrechungen bei der Arbeit
- ☐ Zu viele administrative Tätigkeiten
- ☐ Mangelhafter Arbeitsschutz
- ☐ Mangelnde gesellschaftliche Anerkennung
- ☐ Probleme mit Kolleg*innen/Vorgesetzten
- ☐ Mangelnde Anerkennung durch andere Berufsgruppen (Gesundheitsbereich)
- ☐ Studium
- ☐ Sonstiges:

11. In welchem Bereich / in welcher Position sind Sie aktuell beschäftigt?
Bitte alles Zutreffende auswählen

- ☐ Elternzeit
- ☐ Rente
- ☐ Arbeitsunfähigkeit
- ☐ Administration Gesundheitswesen
- ☐ Krankenkasse
- ☐ MDK
- ☐ Arztpraxis
- ☐ Studium „Gesundheit“
- ☐ Studium „Anderes“
- ☐ Forschung
- ☐ Lehre/Ausbildung
- ☐ Außerhalb des Gesundheitswesens (gerne unter „Sonstiges“ genauere Angaben)
- ☐ Sonstiges:

12. Falls zutreffend: In welchem Umfang üben Sie Ihre reguläre Tätigkeit aus?

z. B. Vollzeitstelle = 100 %; ca. 20 Stunden = 50 %; bei 400/450 €-Basis bitte 4 eingeben

[ ] %

13. Haben Sie sich aufgrund der Covid-19-Krise für einen möglichen Einsatz in der Pflege registriert?

- ○ Ja
- ○ Nein
- ○ Ich warte noch ab / überlege noch
- ○ Sonstiges: [ ]

14. Mit wem haben Sie sich über eine mögliche Registrierung beraten?

Bitte alles Zutreffende auswählen

- ☐ Mit niemandem
- ☐ Partner*in
- ☐ Kinder
- ☐ Eltern
- ☐ Freund*innen / Bekannte
- ☐ Kolleg*innen
- ☐ Vorgesetzte*r
- ☐ Sonstige: [ ]

15. Was hat Sie dazu bewogen, sich zu registrieren?

Bitte alles Zutreffende auswählen

- ☐ Ich möchte meine Fähigkeiten anwenden
- ☐ Ich möchte ehemalige Kollegen unterstützen
- ☐ Ich finde es interessant, mal wieder in der Pflege zu arbeiten
- ☐ Ich möchte meinen Teil zur Bewältigung der Corona-Krise beitragen
- ☐ Ich fühle mich der Pflege zugehörig
- ☐ Ich habe mich registriert, weil andere es auch getan haben
- ☐ Ich bekomme durch die Registrierung Anerkennung
- ☐ Ich empfinde es als meine Pflicht
- ☐ Sonstiges: [ ]

16. Wo haben Sie sich registriert?

Bitte alles Zutreffende auswählen

- ☐ Bei der Pflegekammer meines Bundeslandes
- ☐ #pflegereserve (Bertelsmann-Stiftung)
- ☐ Wir wollen helfen
- ☐ Pflegepool Bayern
- ☐ Klinik / Krankenhaus / Alten- o. Pflegeheim / ambulanter Pflegedienst
- ☐ Sonstiges:

17. Welche Angebote gab oder gibt es, um Sie allgemein oder auch coronaspezifisch auf eine pflegerische Tätigkeit vorzubereiten?

Bitte alles Zutreffende auswählen

- ☐ Weiß ich (noch) nicht
- ☐ Keine
- ☐ Informationen zu Grundpflege
- ☐ Informationen zu Corona
- ☐ Informationen zur Anwendung von Schutzausrüstung
- ☐ Praktische Übungen
- ☐ Geräteeinweisung
- ☐ Umgang mit Medikamenten, Infusionen
- ☐ Sonstiges:

18. Was hat Sie davon abgehalten bzw. hält Sie davon ab, sich zu registrieren?

Bitte alles Zutreffende auswählen

- ☐ Ich sehe (momentan) keinen Grund für eine Registrierung
- ☐ Ich traue mir die Tätigkeit in der Pflege fachlich nicht mehr zu
- ☐ Angst vor Ansteckung mit dem Corona-Virus
- ☐ Eigene chronische Erkrankung
- ☐ Chronische Erkrankung bei Angehörigen
- ☐ Ablehnung durch meine Angehörigen
- ☐ Fehlende Kinderbetreuung
- ☐ Andere systemrelevante Tätigkeit
- ☐ Sonstiges:

19. Wie ging oder geht es Ihnen beim Gedanken, wieder in der direkten pflegerischen Patientenversorgung tätig zu sein?

Bitte alles Zutreffende auswählen

- ☐ Freude auf den Umgang mit Patient*innen
- ☐ Freude auf das Arbeiten in bekanntem Umfeld
- ☐ Freude, wieder im erlernten Beruf zu arbeiten
- ☐ Sorge vor hohen Erwartungen (z. B. Kollegen)
- ☐ Sorge vor Überforderung bei der Bedienung medizinischer Geräte
- ☐ Befürchtung, Pflege „verlernt" zu haben
- ☐ Befürchtung vor Zeitdruck beim Arbeiten
- ☐ Befürchtung vor nicht ausreichendem Schutz vor Ansteckung mit dem Corona-Virus
- ☐ Befürchtung, dass auf persönliche Umstände keine Rücksicht genommen wird
- ☐ Befürchtung, dass Abbruch bei Problemen nicht möglich ist
- ☐ Interesse daran, anderen Arbeitgeber kennenzulernen
- ☐ Interesse an aktuellen Arbeitsbedingungen (Corona-unabhängig)
- ☐ Interesse an Corona-bedingten Arbeitsbedingungen
- ☐ Sonstiges: ____________

20. Sind Sie bereits aufgrund der Covid-19-Krise in die Pflege zurückgekehrt?

- ○ Ja
- ○ Nein

21. In welcher Einrichtung / in welchem Bereich sind Sie eingesetzt?

Bitte alles Zutreffende auswählen

- ☐ Corona-infizierte Patient*innen
- ☐ Erwachsenenkrankenpflege
- ☐ Kinderkrankenpflege
- ☐ Altenpflege
- ☐ Ambulante Pflege
- ☐ Stationäre Akutversorgung
- ☐ Rehabilitationsklinik
- ☐ Funktionsbereich
- ☐ OP
- ☐ Anästhesie
- ☐ Intensivstation
- ☐ Arztpraxis
- ☐ Innere Medizin
- ☐ Chirurgie
- ☐ Gynäkologie
- ☐ Psychiatrie
- ☐ Sonstiges:

22. Wie war / ist es für Sie, wieder in der direkten pflegerischen Patientenversorgung tätig zu sein?

Bitte alles Zutreffende auswählen

- ☐ Positiv
- ☐ Negativ
- ☐ Befriedigend
- ☐ Frustrierend
- ☐ Sinngebend
- ☐ Körperlich belastend
- ☐ Psychisch belastend
- ☐ Herausfordernd
- ☐ Sonstiges:

23. Sind die Befürchtungen, die Sie hatten, eingetroffen?

(Bitte alles Zutreffende auswählen)

- ☐ Ja
- ☐ Nein
- ☐ Teilweise und zwar:
- ☐ Sonstiges:

24. Welche Unterstützungsangebote gab oder gibt es vom „neuen" Arbeitgeber?

Bitte alles Zutreffende auswählen

- ☐ Keine
- ☐ Kinderbetreuung
- ☐ Finanzielle Anreize
- ☐ Kollegiale Beratung
- ☐ Supervision
- ☐ Psychologische Gespräche
- ☐ Corona-Hotline o. ä.
- ☐ Sonstiges:

25. Wie hilfreich sind/waren die Angebote?

- ○ Habe ich (bisher) nicht in Anspruch genommen
- ○ Insgesamt sehr hilfreich
- ○ Insgesamt hilfreich
- ○ Insgesamt weniger hilfreich
- ○ Insgesamt nicht hilfreich

26. Würden Sie sich in einem erneuten Krisenfall (wieder) registrieren?

- ○ Ja
- ○ Nein
- ○ Nur unter bestimmten Bedingungen und zwar:

27. Denken Sie anders als vorher über eine mögliche Rückkehr in den Pflegeberuf?

- ○ Ja
- ○ Nein

28. Würde es für Sie einen Unterschied zur jetzigen freiwilligen Registrierung machen, wenn Sie als Pflegefachkraft in einem Krisenfall zur Mitarbeit in der Pflege verpflichtet werden könnten?

- ○ Ja
- ○ Nein

29. Warum würde eine Verpflichtung für Sie einen Unterschied machen?

Bitte alles Zutreffende auswählen

- ☐ Keine Rücksichtnahme auf persönliche Umstände
- ☐ Möchte das selbst entscheiden können
- ☐ Arbeitsmotivation ist bei Freiwilligkeit größer
- ☐ Sonstiges:

Wir bedanken uns ganz herzlich für Ihre Teilnahme an dieser Umfrage.

Bitte leiten Sie den Umfragelink gerne an andere "Ehemalige" weiter, wir freuen uns über jeden Teilnehmer.

Bei Rückfragen wenden Sie sich gerne an: petra.luecker@med.uni-greifswald.de

Wir würden zusätzlich gerne einige vertiefende Diskussionen führen (voraussichtlich als Webkonferenz mit 5-6 Teilnehmern). Wenn Sie sich vorstellen können, uns hierfür zur Verfügung zu stehen, senden Sie bitte eine Email an petra.luecker@uni-greifswald.de. Teilen Sie uns bitte mit, ob Sie sich registriert haben oder nicht und in welchem Bundesland Sie wohnen. Die Beteiligung kann aller Voraussicht nach weiterhin anonym erfolgen.

Ihre Antworten wurden gespeichert, Sie können das Browser-Fenster nun schließen.

Petra Lücker, Esther Henning, Institut für Community Medicine, Universitätsmedizin Greifswald

Leitfaden für die qualitative Fokusdiskussionen – RETURN

Registrierte/nicht Registrierte

A. Begrüßung
   a. Dank (**Folie 1** Projekt-Name)
   b. Vorstellung Ziel (**Folien 2 & 3**)

B. Vorstellung der Anwesenden
C. Erst Moderatoren dann Teilnehmer (Name, berufliche Qualifikation, aktuelle Tätigkeit)

D. Erläuterung der Gesprächsregeln (**Folie 4**)

E. Fragen?

F. Hinweise Aufnahme startet

G. Fragen (jeweils Folien mit den Zahlen zeigen, grau = Backup-Fragen)

1. Insgesamt konnten 332 Fragebögen ausgewertet werden. Von diesen 332 Personen waren 103 registriert und damit bereit, in der Pflege „auszuhelfen“.

Was glauben Sie, warum deutlich mehr Personen, die nicht registriert waren, an der Umfrage teilgenommen haben?

2. In der RETURN-Studie gaben 27 % der nicht akademisch qualifizierten Pflegefachpersonen (PFP) an, sich registriert zu haben, während dies bei den akademisch qualifizierten PFP 38 % waren.

Was sind oder könnten aus Ihrer Sicht die Hintergründe für diesen Unterschied sein?

3. Als Hauptgründe für eine Registrierung wurde angegeben **(Folie 5)**:

In welcher Form fühlen Sie sich dem Pflegeberuf bzw. den ehemaligen Kolleg:innen (noch) verbunden?

4. **Die Pandemie war zum Zeitpunkt der Befragung sehr real und in einigen Ländern z. B. Italien kam es zu Engpässen in der Versorgung. Der meistgenannte Grund gegen eine Registrierung war, dass keine Notwendigkeit dafür wahrgenommen wurde. Haben Sie eine Erklärung hierfür? (Folie 6)**:

5. Weitere Gründe gegen eine Registrierung wurden in Form von Freitexten angegeben. Beispiele sind **(Folie 7)**:
   - „Ich würde NIE WIEDER in der Pflege arbeiten!!!“
   - „Warum? Für die Menschen die einen für die Tätigkeit verachten und nicht einmal das schwarze unter den Fingernägeln gönnen?“
   - „Jahrelang unterbezahlt, als Urinkellner gedemütigt, von der Politik vergessen und in der Krise wiederentdeckt. Das ist keine Motivation. Auch Pflege ist eine hochwertige Dienstleistung, d.h. "Dienen und verdienen." Warum sollte ich für eine Gesellschaft da sein, die mich jahrelang vergessen hat!?“

Was kann aus Ihrer Sicht unternommen werden, um die genannten Hindernisse für eine Registrierung zu überwinden? Sehen Sie eine Chance, die Ablehnenden irgendwie zu erreichen und sie dazu zu bewegen, im Notfall zur Verfügung zu stehen?

6. **Folie 8**: Auf die Frage, „Wie ging oder geht es Ihnen bei dem Gedanken, wieder in der direkten Patientenversorgung tätig zu sein?“ wurden als offene Antworten angegeben:
   - „Flaues Gefühl bei dem Gedanken, den Job, den man froh ist hinter sich gelassen zu haben, wieder ausführen zu müssen“
   - „Befürchtung eigenen Anspruch aufgrund der Rahmenbedingungen nicht gerecht werden zu können.“

   Genannt wurde aber auch
   - „Abenteuerlust“
   - Wenn ich gebraucht werde, bin ich da.“

   Was denken Sie zu diesen Aussagen? Warum wird dies so unterschiedlich gesehen? Welche Schlüsse sollten die Einrichtungen bzw. die Politik aus diesen Aussagen ziehen?

7. **Folie 9:** Bei Mehrfachantwortmöglichkeit: Von 24 der eingesetzten inaktiven PFP gaben 18 an, dass die Erfahrungen des Einsatzes positiv waren, 1 gab an, dass diese negativ waren. 4 gaben an, dass sich die Angst bzgl. der Rückkehr bestätigt hat, 2 gaben an das der Einsatz frustrierend war. Für 4 war die Arbeit physisch und für 2 psychisch anstrengend. Dagegen gaben 10 an, dass für sie die Arbeit bedeutungsvoll, für 9 herausfordernd und für 4 zufriedenstellend war.
   Wie interpretieren Sie die Ergebnisse?

8. **Welche Vorbereitung/Unterstützung der Rückkehr wäre aus Ihrer Sicht notwendig/gewünscht/sinnvoll?**

9. **Gibt es weitere Punkte, die Sie als wichtig im Zusammenhang mit dem Einsatz von inaktiven Pflegefachpersonen in Krisensituationen erachten?**

10. **a) Glauben Sie, dass es eine relevante sogenannte „stille Reserve“ an Pflegefachpersonen gibt, die im Krisenfall zur Verfügung stünde?**

    b) Inwieweit könnten diese inaktiven Pflegefachpersonen dann unterstützen?

11. PFP mit einer allgemeinen Pflegeausbildung haben sich häufiger registriert als Altenpflegefachpersonen.

Was könnten aus Ihrer Sicht Gründe hierfür sein?

12. Ungefähr die Hälfte der befragten Personen gaben an, dass es für Sie keinen Unterschied macht, ob eine Registrierung verpflichtend ist oder nicht. Die andere Hälfte sah dies anders.

Was sind aus Ihrer Sicht Gründe, die für oder Gründe die gegen eine verpflichtende Registrierung sprechen?

c) Dank und Verabschiedung

Fokusgruppendiskussion

RETURN

Registrierung ehemaliger Pflegefachpersonen im Krisenfall

16.11.2021

Vorstellungsrunde

1. Name
2. beruflicher Hintergrund (Qualifikation, aktuelle Tätigkeit)
3. Warum sind Sie aus der Pflege „ausgestiegen“?

2

Fokusgruppendiskussion

Diskussion über Fragestellungen zu:

- Ergebnisse der Umfrage RETURN
- Registrierung inaktiver Nurses
- ...

Ziel:

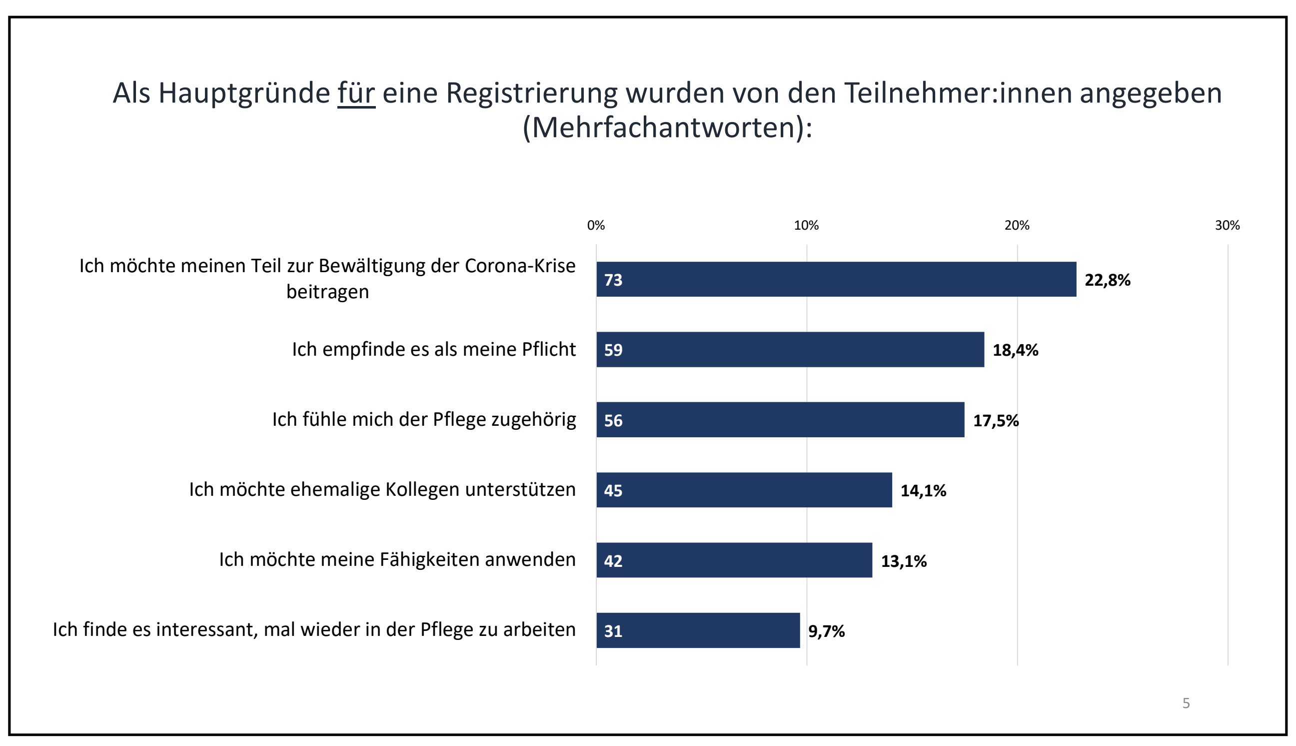
- Vertiefung von Befragungsergebnissen
- Wahrnehmung und Bewertung aus verschiedenen Perspektiven

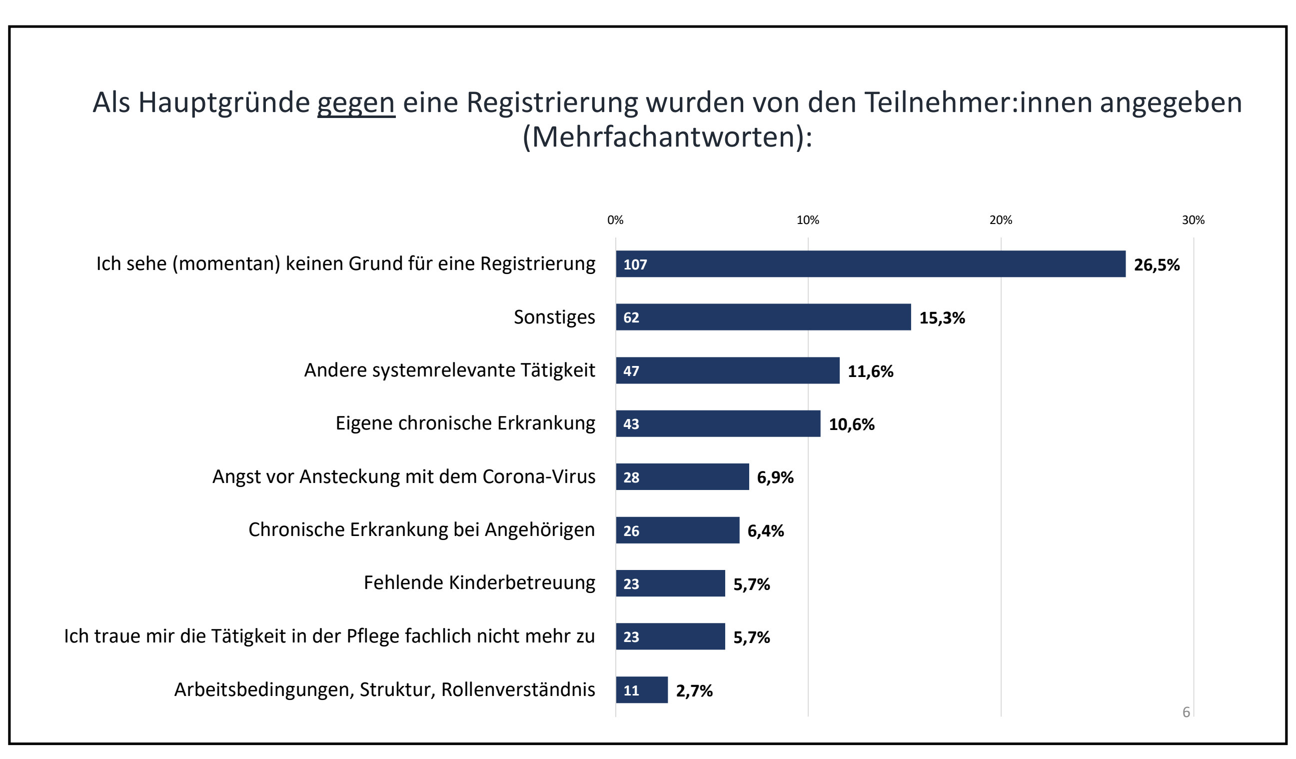
3

Gesprächsregeln

- Einfach sprechen, falls jemand das Gefühl hat, er/sie kommt nicht zu Wort, bitte Hand heben
- Ausreden lassen
- Jede Meinung ist okay und wertvoll und sollte gehört werden – nicht bewerten
- Bei Fragen: fragen!

4


Als Hauptgründe für eine Registrierung wurden von den Teilnehmer:innen angegeben (Mehrfachantworten):
0%
10%
20%
30%
Ich möchte meinen Teil zur Bewältigung der Corona-Krise beitragen
73
22,8%
Ich empfinde es als meine Pflicht
59
18,4%
Ich fühle mich der Pflege zugehörig
56
17,5%
Ich möchte ehemalige Kollegen unterstützen
45
14,1%
Ich möchte meine Fähigkeiten anwenden
42
13,1%
Ich finde es interessant, mal wieder in der Pflege zu arbeiten
31
9,7%
5


Als Hauptgründe gegen eine Registrierung wurden von den Teilnehmer:innen angegeben (Mehrfachantworten):
0%
10%
20%
30%
Ich sehe (momentan) keinen Grund für eine Registrierung
107
26,5%
Sonstiges
62
15,3%
Andere systemrelevante Tätigkeit
47
11,6%
Eigene chronische Erkrankung
43
10,6%
Angst vor Ansteckung mit dem Corona-Virus
28
6,9%
Chronische Erkrankung bei Angehörigen
26
6,4%
Fehlende Kinderbetreuung
23
5,7%
Ich traue mir die Tätigkeit in der Pflege fachlich nicht mehr zu
23
5,7%
Arbeitsbedingungen, Struktur, Rollenverständnis
11
2,7%
6

„Was hat Sie davon abgehalten bzw. hält Sie davon ab, sich zu registrieren?“
Sonstiges:

„Ich würde NIE WIEDER in der Pflege arbeiten!!!“

„Warum? Für die Menschen die einen für die Tätigkeit verachten und nicht einmal das schwarze unter den Fingernägeln gönnen?“

„Jahrelang unterbezahlt, als Urinkellner gedemütigt, von der Politik vergessen und in der Krise wiederentdeckt. Das ist keine Motivation. Auch Pflege ist eine hochwertige Dienstleistung, d.h. "Dienen und verdienen." Warum sollte ich für eine Gesellschaft da sein, die mich jahrelang vergessen hat!?“

Als Pflegefachkraft verheizt zu werden, also nicht eingesetzt zu werden um Coronaerkrankte zu versorgen sondern generelle Personalknappheit auszugleichen

7

„Wie ging oder geht es Ihnen bei dem Gedanken, wieder in der direkten Patientenversorgung tätig zu sein?“

Flaues Gefühl bei dem Gedanken, den Job, den man froh ist hinter sich gelassen zu haben, wieder ausführen zu müssen

Wenn ich gebraucht werde, bin ich da.

Abenteuerlust

Befürchtung eigenen Anspruch aufgrund der Rahmenbedingungen nicht gerecht werden zu können.

8

Erleben eines Einsatzes (*N* = 24, Mehrfachantworten möglich)

+		-	
Positiv	18	Negativ	1
Bedeutungsvoll	10	Ängste haben sich bestätigt	4
Zufriedenstellend	4	Frustrierend	2
		Physisch anstrengend	4
		Psychisch anstrengend	2
Herausfordernd 9			

9

Leitfaden für die qualitative Fokusdiskussionen – RETURN

Rückkehrer

A. Begrüßung
    a. Dank (**Folie 1** Projekt-Name)
    b. Vorstellung Ziel (**Folie 2 & 3**)

B. Vorstellung der Anwesenden
Erst Moderatoren dann Teilnehmer: Name, Woher (Ort), Qualifikation, In welchem pflegerischen Bereich waren Sie bis zu Ihrem Ausstieg zuletzt oder überwiegend tätig und was waren Ihre Gründe für den Ausstieg aus der direkten Patient:innenversorgung?

C. Erläuterung der Gesprächsregeln

D. Fragen?

E. Hinweis Aufnahme startet

F. Fragen (jeweils Folien mit den Zahlen zeigen, grau = Backup-Fragen)

1. **Wie lange waren Sie beim ersten Mal in der Pflege, wie lange dann raus aus der Pflege und wie lange jetzt wieder drinnen?**

2. **Welcher Tätigkeit sind Sie nach dem Ausstieg aus der Pflege nachgegangen?**

3. **Was waren Ihre Gründe**
    a) für das Aufgeben der neuen Tätigkeit und
    b) den Wiedereinstieg in die Pflege?

4. **In welchem Bereich sind Sie jetzt tätig?**

5. **Hat sich Ihr Einkommen geändert? Wenn ja, höher, niedriger, gleich?**

6. **Wie ging es Ihnen beim Wiedereinstieg? Welche Erwartungen, Gefühle, Ängste hatten Sie?**

7. **Wie haben Ihr Umfeld, Ihre alten und neuen Kolleg:innen reagiert?**

8. **Haben Sie sich auf die Rückkehr vorbereitet? Welche Vorbereitung/Unterstützung der Rückkehr ist aus Ihrer Sicht notwendig/gewünscht/sinnvoll (besonders für Rückkehrer im Rahmen einer Krisensituation)?**

9. **Haben Sie den Eindruck, dass sich die Situation in der Pflege zwischen Ihrer ersten und jetzigen Tätigkeit verändert hat? Wenn ja, inwiefern?**

Kurze Erläuterung zur RETURN-Studie *(Befragung inaktiver Pflegefachpersonen zwischen April und Juni 2020. Frage, ob registriert, warum oder warum nicht, Gründe für Pflegeausstieg, momentane Tätigkeit u. a.)* **(Folie 5 & 6)**

10. **Folie 7 & 8**: In der RETURN-Studie wurden Gründe gegen eine Registrierung auch in Form von Freitexten angegeben. Beispiele sind:
    - „Ich würde NIE WIEDER in der Pflege arbeiten!!!“
    - „Warum? Für die Menschen die einen für die Tätigkeit verachten und nicht einmal das schwarze unter den Fingernägeln gönnen?“
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    Was kann aus Ihrer Sicht unternommen werden, um die genannten Hindernisse für eine Registrierung für den Krisenfall zu überwinden? Sehen Sie eine Chance, die Ablehnenden irgendwie zu erreichen und sie dazu zu bewegen, im Notfall zur Verfügung zu stehen?

11. **Gibt es weitere Punkte, die Sie als wichtig im Zusammenhang mit dem Einsatz von inaktiven Pflegefachpersonen in Krisensituationen erachten?**

12. **Wenn Sie den oder die Gesundheitsminister:in beraten würden: Wie sollte das Problem des Fachkräftemangels in der Pflege angegangen werden? Was wären Ihre Vorschläge?**

13. **Glauben Sie, dass es eine relevante sogenannte „stille Reserve“ an Pflegefachpersonen gibt, die im Krisenfall zur Verfügung stünde?**
    Inwieweit könnten diese inaktiven Pflegefachpersonen dann unterstützen? (bestimmte Bereiche/Aufgaben).

G. Dank und Verabschiedung

Fokusgruppendiskussion

RETURN

Registrierung ehemaliger Pflegefachpersonen
im Krisenfall

08.11.2021

Fokusgruppendiskussion

Diskussion über Fragestellungen zu:
- Ergebnisse der Umfrage RETURN
- Registrierung inaktiver Nurses
- ...

Ziel:
- Vertiefung von Befragungsergebnissen
- Wahrnehmung und Bewertung aus verschiedenen Perspektiven

2

Vorstellungsrunde

1. Name
2. beruflicher Hintergrund (Qualifikation, aktuelle Tätigkeit)
3.
   a. In welchem pflegerischen Bereich bis zum Ausstieg zuletzt oder überwiegend tätig
   b. Gründe für den Ausstieg aus der direkten Patient:innenversorgung

3

Gesprächsregeln

- Einfach sprechen, falls jemand das Gefühl hat, er/sie kommt nicht zu Wort, bitte Hand heben
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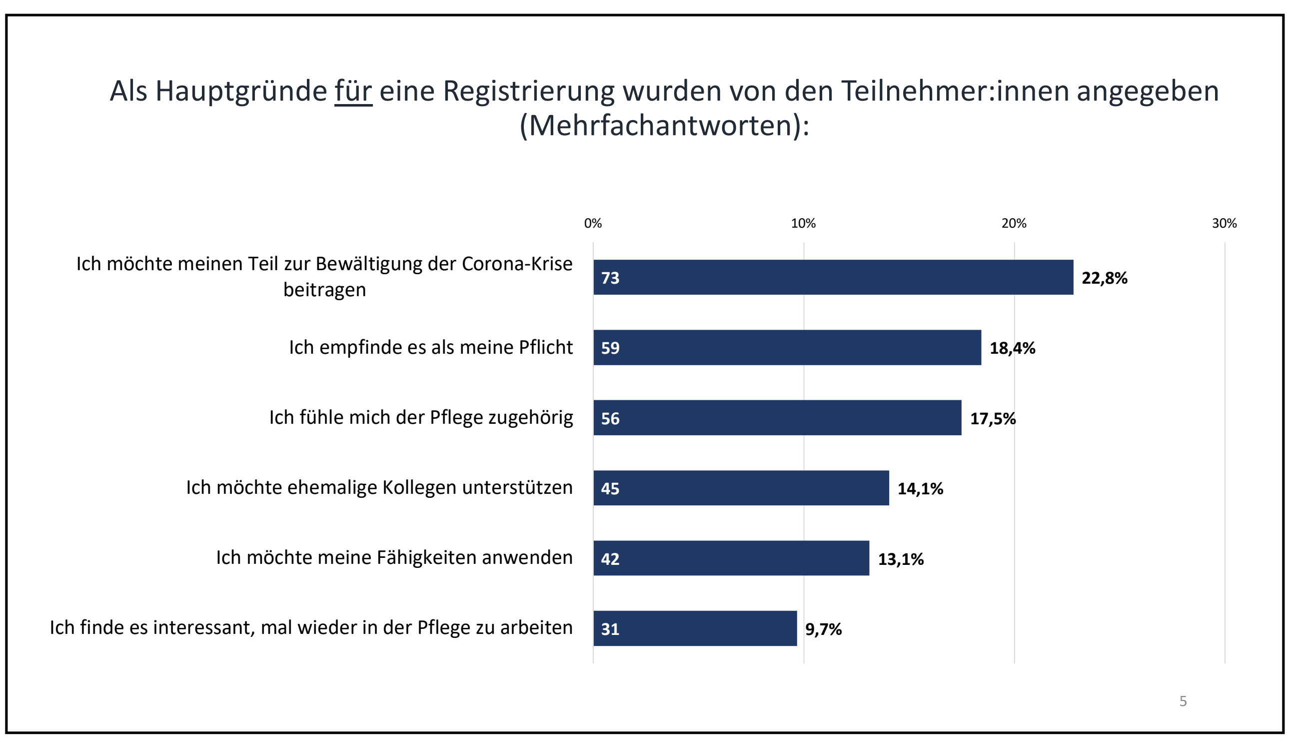
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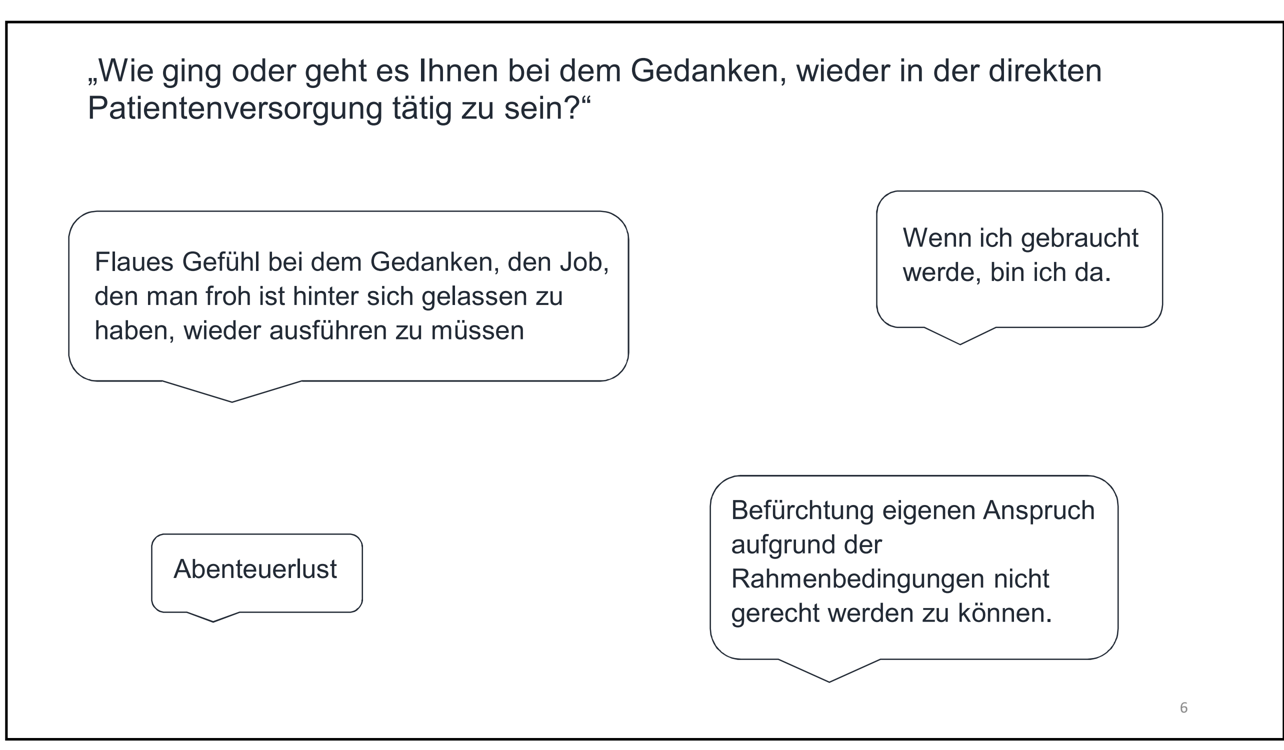
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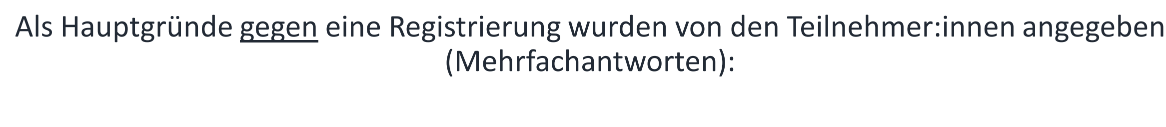
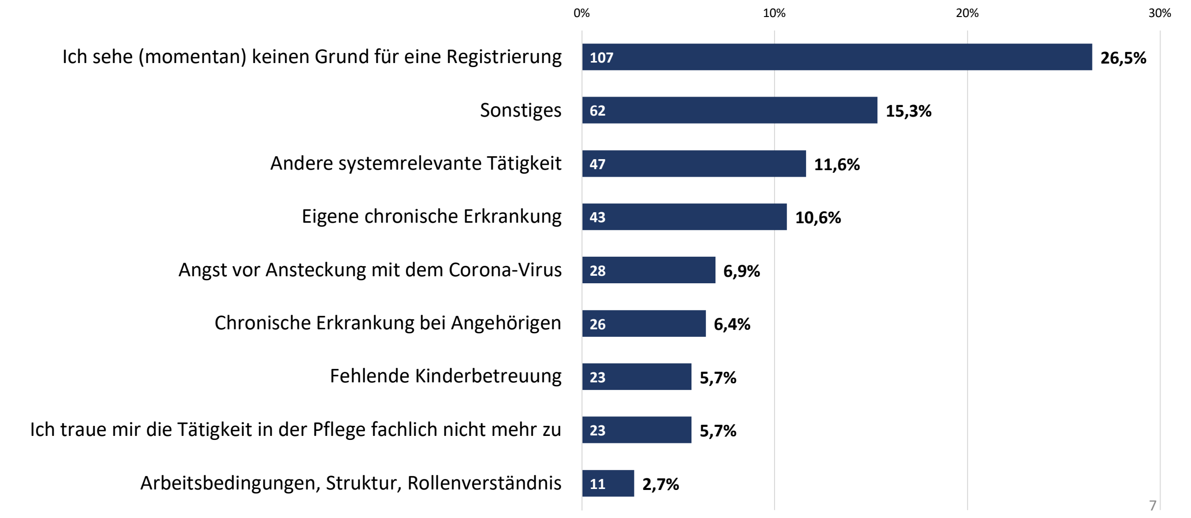
Abenteuerlust
Befürchtung eigenen Anspruch aufgrund der Rahmenbedingungen nicht gerecht werden zu können.
6





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8