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Lived experience of nurses at two covid-19 designated hospitals: a phenomenological study

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ABSTRACT

Introduction: The COVID-19 pandemic has fundamentally altered how society functions, including the conditions under which health professionals work. Nurses, who are at the forefront of providing care to COVID-19 patients, spend extended periods in close contact with infected patients. These stressful conditions may increase nurses' risk of developing depression and other mental health problems. This study aimed to explore the experiences of Indonesian nurses working in two COVID-19-designated hospitals that provide direct patient care.

Methods: The qualitative phenomenological design was used in this study. Between June and December 2020, 15 nurses at two COVID-19-designated hospitals participated in in-depth telephone interviews, and four nurses were selected to participate in a focus group discussion for data triangulation. Following that, data were analyzed according to Colizzi's phenomenological method.

Results: The data were categorized into four themes: 1) Responsibility to maintain nursing professionalism; 2) Challenges in caring for COVID-19 patients; 3) Support in caring for COVID-19 patients; 4) Increase insights while caring for COVID-19 patients. These themes indicate that, while nurses felt supported by hospital administration and close family members, they were also affected by the high workload, which resulted in behavioral changes associated with mental illness.

Conclusion: These findings shed light on the benefits and drawbacks of nurses caring for COVID-19 patients. These findings can serve as a starting point for hospital administration in developing policies and systems that promote nursing staff well-being.

Keywords: COVID-19; Nurse; Nursing Care; Pandemic; Qualitative.
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INTRODUCTION

The coronavirus disease (COVID-19) is a global health threat caused by the SARS-COV2 virus. It is spread between humans via aerosolized respiratory tract particles and direct contact.[1] The World Health Organization (WHO) declared it a global pandemic on March 11, 2020,[2] and Indonesia subsequently declared it a national disaster under Presidential Regulation Number 12 (*Peraturan Presiden Nomor* 12) on non-natural disasters.[3] COVID-19 transmission occurred rapidly in Indonesia, spreading to regions such as Tangerang and Banten, resulting in a high mortality rate in a short period.[4] COVID-19 cases were reported in 215 countries in early May 2020, with 3,356,205 confirmed cases and 238,730 deaths worldwide,[2] while Indonesia reported 11,192 confirmed cases and 845 deaths.[4] In the same month, Tangerang Regency confirmed 143 cases of COVID-19 positivity, 399 patients were placed under observation (*Pasien Dalam Pengawasan*/PDP), and up to 749 persons were placed under surveillance (*Orang Dalam Pemantauan*/ODP).[5]

COVID-19 patient management requires adherence to specific protocols, including admitting patients, providing patient care, preventing transmission, and handling deceased patients.6 COVID-related care is distinguished from general patient care by the extensive measures required prevent COVID-19 transmission during intervention implementation.[6] Additionally, the health status of COVID-19 patients varies significantly, ranging from asymptomatic to severe disease.[7,8] Healthcare professionals, particularly nurses, are on the front lines of care for COVID-19 patients from admission to discharge. However, nurses face numerous obstacles, including a lack of manpower and appropriate personal protective equipment (PPE), patients concealing their medical histories, and a negative stigma toward healthcare workers in the community.[9]

Nurses must receive specialized training and education before caring for COVID-19 patients, including intensive education and training, a rational work schedule, infection control team monitoring, and psychological counseling. They must also avoid unnecessary contact to minimize cross contamination.[6] Additionally, healthcare workers are at risk of infection while caring for COVID-19 patients.[7]

Hospital nurses are impacted psychologically, physically, and socially by the COVID-19 pandemic. According to a study conducted in Austrian urban and rural hospitals,[10] the pandemic had a

psychological effect on nurses, including fear of infecting someone at home, insomnia, and depression. Headaches, diarrhea, muscle tension, skin redness, and increased sweating frequently reported physical consequences. All nurses mentioned social isolation and increased media use in terms of social impact. During the pandemic's early stages, nurses in China reported experiencing dominant negative emotions such as fatigue, discomfort, and helplessness.[9] These negative emotions were induced by high-intensity work, fear and anxiety, and concern for patients and family members, but with adequate psychological support, positive emotions eventually emerged.[9] Furthermore, nurses caring for COVID-19 patients in a designated-hospital China reported experiencing negative emotions such as anxiety and fatigue and positive emotions such as increased self-awareness and feelings of happiness.[7] Similarly, South Korean nurses caring for patients infected with MERS-CoV (Middle East Respiratory Syndrome-Coronavirus), a virus similar to COVID-19, expressed fear and anxiety.[11] In Belitung, Indonesia, a previous study confirmed that nurses experienced fear, stress, sadness, and nervousness for caring for COVID-19 patients.[12] Given the potential for detrimental effects on the well-being of nurses caring for COVID-19 patients, this study examined the lived experiences of nurses managing COVID patients at two hospitals in Western Indonesia.

METHODS

Study Design

This study employed a qualitative method using a phenomenological approach[13] to understand nurses' experience in providing care for COVID-19 patients, to obtain first-hand information from the respondents while adhering to scientific standards.

Sample selection

This study was conducted between June and December 2020 at two designated hospitals in Western Indonesia. Due to the nature of qualitative research, no randomization was used to select the sample. The study enrolled fifteen nurses who provide direct care to COVID-19 patients, fifteen recruited via purposive sampling to accomplish the study objective. The inclusion criteria were as follows: (1) nurses who provide care to COVID-19 patients, (2) nurses who hold a bachelor's degree in nursing, (3) nurses who agreed to participate in the study, and (4) nurses who can communicate in Bahasa Indonesia. Inability to participate in an interview and FGD/Focus Group Discussion during the study period was an exclusion criterion. The study was conducted on nurses who provided care to COVID-19 patients based on the inclusion criteria until the data saturation point was reached, and no new topics emerged.[13]

Assessment

After conducting an extensive literature review, the researcher developed the interview guide and FGD (Focus Group Discussion) guide to ensure that interview questions and research objectives were consistent. Six structured interview questions were included. (1) How do you feel about caring for COVID-19 patients? (2) What difficulties do clinicians face when caring for COVID-19 patients? (3) How much assistance did you receive while caring for COVID-19 patients? (4) What is your strategy for overcoming obstacles? (5) What new insights have you gained from your experience with the COVID-19 epidemic? (6) How has your life changed because of your role in providing care to COVID-19 patients? FGD was used in this study to elucidate the participants' responses during the interview.

The MRIN/Mochtar Riady Institute for Nanotechnology Ethics Committee approved this study and two hospitals granted permission. The researcher scheduled interviews with participants based on their availability after obtaining permission from each hospital. The researcher, who had extensive experience conducting qualitative research, used caring and therapeutic communication to establish rapport with the nurses, ensuring that their perceptions and experiences were communicated effectively.

The study enrolled a total of fifteen nurses. The data collection process included participant interviews and focus group discussions, while enforcing COVID-19 infection control measures throughout, one of which was virtual interviewing via Zoom. The researcher informed the participants of the research objectives by verbally explaining all the study consent information. Each participant's interview lasted between 60 and 120 minutes. The researcher reflected the participants' experiences and thoughts during the interviews without distorting their opinions or imposing assumptions to avoid affecting the outcomes. Subsequently, the researcher scheduled a focus group discussion with four participants in December 2020 to confirm their interview findings and avoid bias.[13] The interview and FGD recordings were stored in a password-protected file accessible only to the researcher. Additionally, the researcher examined secondary non-verbal data from the participants, such as intonation, laughter, silence, and sighs. Additionally, the researcher established a space for participants to seek counseling if they exhibit symptoms of psychological trauma because of caring for COVID-19 patients.

Data Analysis

The Colaizzi seven-step method was used to analyze the data until saturation, which included the following steps: (1) obtaining descriptions of participants' lived experiences, (2) reading through the descriptions, (3) selecting significant statements, (4) articulating significant meanings from each question, (5) categorizing meanings under themes, (6) writing an in-depth description by returning to the participants, and (7) incorporating new information discovered during data validation into a final in-depth description.[14]

Trustworthiness

The study's trustworthiness was determined using Lincoln and Guba's framework, which considers factors such as credibility, confirmability, dependability, and transferability.[13] The study's credibility was bolstered by rapport-building with participants, data analysis, and member examination. The participants' trust was earned to provide a thorough understanding of the data's details. The researchers analyzed the interviews independently, compared and contrasted concepts, categories, and themes, and

discussed areas of disagreement to reach an agreement. Additionally, a member check was performed to ensure the data's credibility. After analyzing each interview, the researchers invited participants to participate in a focus group discussion, which was agreed upon by four participants. The purpose of the FGD was to ascertain whether the study's findings corroborated respondents' experiences or beliefs. The analysis included the respondents' comments and suggestions during the FGD. Additionally, to ensure the findings' validity, the preliminary results and analysis of the findings were discussed and revised among the researchers' team members.

The term "dependability or reliability" refers to the fact that the data were collected accurately and were not influenced by the researchers' interests. The current study clearly stated the data collection procedure, interview process, coding, data analysis, and content identification. The transferability of the findings indicates that they applied to other contexts. The transferability of this study was established by providing sufficient context descriptions and presenting the necessary explanations for the participants' perceptions.

RESULTS

The study's participants (Table 1) worked at two hospitals: eight at Hospital I and seven at Hospital II. All participants were graduates of a Bachelor of Nursing program and registered nurses, with three males and twelve females, the majority of whom were between the ages of 17 and 25, and 12 of whom were single. Additionally, participants identified with various religions and ethnic groups, with three identifying as Muslims and twelve as Protestants. Eight participants worked on an inpatient ward, two in the intensive care unit/NICU, three in the emergency department, and two on other wards. The duration of time spent caring for COVID-19 patients also varied between participants, with the majority having spent between three and five months at the time of the interview (Table 2).

Additionally, this phenomenological study's exploration of nurses' lived experiences caring for COVID-19 patients revealed four themes, as illustrated in Table 3.

Table 1. Demographic Characteristics of Participants (n = 15).

Characteristics	N (%)
Gender	
Female	12 (80%)
Male	3 (20%)
Age	
17-25 years	10 (66.7%)
26-35 years	4 (26.7%)
36-45 years	1 (6.6%)
Religion	
Protestant	12 (80%)
Moslem	3 (20%)
Marital Status	
Single	12 (80%)
Married	3 (20%)
Ethnicity	
Java	3 (20.5%)
Batak	2 (13.3%)
Maluku	2 (13.3%)
Ambon	2 (13.3%)
Alor	1 (6.6%)
Buton	1 (6.6%)
Toraja	1 (6.6%)
Minahasa	1 (6.6%)
Nias	1 (6.6%)
Toraja	1 (6.6%)
Duty Location/Ward for COVID-19 Patients	
Inpatient	8 (53.3%)
Emergency Department	3 20.1%)
ICU/NICU	2 (13.3%)
Others	2 (13.3%)
Work Experience	
1-3 year	7 (46.66%)
< 1 year	4 (26.67%)
> 3 year	4 (26.67%)
Duration caring for COVID-19 Patients	
3-5 months	8 (53.3%)
< 3 months	5 (33.4%)
> 5 months	2 (13.3%)

Theme 1: Responsibility to maintain nursing professionalism

The first theme reflects nurses' professional responsibilities when caring for COVID-19 patients. It is subdivided into three subthemes: decision-making when caring for COVID-19 patients, holistic care, and infection prevention management. Some nurses decided to care the COVID-19 patients by stating:

> *"… I finally felt slapped and began to consider who would provide care if we did not. If all nurses withdraw from COVID-19 patient care, who will care for these patients? I am prepared to provide care to COVID-19 patients..."* **(P2)**

> *"...if I leave and am not able to provide care for COVID-19 patients, who will fill in for me?" Nurses, not other employees, are those who understand how to care..."* **(P5).**

When the pandemic first affected Indonesia, there was a general lack of preparedness among the healthcare workforce regarding equipment and personal protective equipment (PPE) availability and information. On the contrary, nurses reported a sense of readiness and willingness to care for COVID-19 patients at both hospitals.

Table 2. **Participant Characteristics (n = 15).**

Participant	Age	Gender	Religion	Marital Status	Ethnicity	Educational Background
P1	24	F	Protestant	Single	Maluku	Bachelor's + Registered Nurse
P2	23	F	Protestant	Single	Toraja	Bachelor's + Registered Nurse
P3	23	F	Protestant	Married	Nias	Bachelor's + Registered Nurse
P4	26	F	Protestant	Single	Batak	Bachelor's + Registered Nurse
P5	24	F	Protestant	Single	Ambon	Bachelor's + Registered Nurse
P6	25	F	Protestant	Single	Batak	Bachelor's + Registered Nurse
P7	28	F	Protestant	Single	Ambon	Bachelor's + Registered Nurse
P8	25	M	Protestant	Single	Batak	Bachelor's + Registered Nurse
P9	24	F	Protestant	Single	Minahasa	Bachelor's + Registered Nurse
P10	35	M	Moslem	Single	Buton	Bachelor's + Registered Nurse
P11	27	M	Protestant	Single	Alor	Bachelor's + Registered Nurse
P12	37	F	Moslem	Married	Java	Bachelor's + Registered Nurse
P13	29	F	Protestant	Single	Ambon	Bachelor's + Registered Nurse
P14	23	F	Protestant	Single	Maluku	Bachelor's + Registered Nurse
P15	30	F	Moslem	Married	Java	Bachelor's + Registered Nurse

Table 3. **Nurses' Experiences in Caring for COVID-19 Patients.**

Themes	Subthemes
1. Responsibility to maintain nursing professionalism	a) Decision-making in caring for COVID-19 patients b) Providing holistic care c) Infection prevention management
2. Challenges in caring for COVID-19 patients	a) Using PPE b) Overwhelming workload c) Changes in mental condition d) Concerns from closest people
3. Support in caring for COVID-19 patients	a) Self-management b) Support from closest people c) Support from healthcare services
4. Increase insights while caring for COVID-19 patients	a) Prevention and management of infections b) Differences in responses, signs and symptoms on each patient c) Management of different patient responses

Additionally, participants indicated that they provided holistic care to their patients, meeting their physiological needs and their psychological and spiritual needs.

"...although they are patients with COVID-19, we will minimize contact with patients who do not require special attention, such as those who have difficulty breathing; however, for patients who require total care, such as those who have difficulty breathing, we cannot simply go to the patient's room and observe them via CCTV or monitor; we must touch our patients, bathe them, assist them with ADL's, and administer medications; we must pay attention; if they are unable to eat, we will feed them." **(P10)**

"...I touch the patient, Madame, you must maintain your spirit; this is a new situation, but we will fight it together here; you are not alone in your dilemma; I am as well, but we must fight together, we must do it together; we cannot be stressed, so that the antibody does not deteriorate, so that we maintain our health, and so that we do our best as healthcare workers..." **(P3)**

As frontline workers, nurses were able to halt and control viral transmission, particularly in patient care areas, as indicated by the subtheme, which implies that nurses are responsible for infection control even after leaving the hospital, for example, at home or in the community setting.

"...I follow the procedure; if a bath is recommended, I will take one; I eat before going to work; and if I am given vitamins, I will take them. The point is to maintain personal hygiene, and I will never return home without washing my hands, face, and changing my clothes. When I am playing with children, I never have to shower again prior to returning home." **(P10)**

"...as soon as we exit the patient's room, we must bathe using the available

facilities. We were assigned a dorm and numerous others. The hospital's support staff genuinely cared about us. We were not truly abandoned. It is not the nurse's responsibility; it is your responsibility, not the nurse's. We were closely monitored in terms of vitamin consumption, given supplements, and provided with dorms for nurses who were unable to return home." **(P2)**

Theme 2: Challenges in caring for COVID-19 patients

The second theme is the difficulties inherent in caring for COVID-19 patients, given that the pandemic inevitably altered the way the healthcare system, particularly hospitals, operates. As expected, participants disclosed their initial lack of knowledge regarding donning and doffing PPE and their discomfort from prolonged use of N-95 face masks, hazmat suits, boots, and gloves. The inability of healthcare services to respond to COVID-19 patients was hampered by a lack of preparedness on the part of healthcare workers, insufficient facilities, and even hospitals with insufficient PPE supplies. Due to the virus's ability to spread via improper donning and doffing of PPE, nurses must adhere to standard PPE procedures when caring for COVID-19 patients.

"...the feeling was truly suffocating the first time; I was unable to wear the N-95 mask; if we wear the N-95 mask for an extended period, we just want to quickly exit and remove the N-95 mask..." **(P10)**

"...during my 12-hour night shift, I was thinking about the sensation of wearing PPE for 12 hours and being unable to hold my pee, so I wore diapers. I was uncomfortable, but I needed to provide the best care possible for my patients, and thus couldn't think about myself..." **(P4)**

"In our first month as nurses, we were the most [health]disciplined. Because the virus is invisible, we are more aware of it; however, how can we avoid becoming infected and infecting others? Thus, our discipline is equivalent to hand washing and wearing masks. Therefore, discipline before and after the corona is very different." **(P12)**

There was a severe shortage of personal protective equipment (PPE) throughout Indonesia, including these two hospitals. Fortunately, the hospital system that oversees both hospitals could replenish PPE supplies in time for the shortage to last only 1-2 months.

"...regarding our initial PPE, it was only a gown; thus, our PPE was not standard hazmat; additionally, for 2-3 weeks, we were still wearing regular shoes and clothing that exposed our necks due to the gowns; however, after discussions with hospital personnel, one nurse was finally able to obtain one pair of boots and PPE in accordance with standard. As a result, it could not be shared; PPE was complete; N-95 and surgical masks were sufficient for us; in fact, we had an excess of surgical masks." **(P2)**

"For the first 2-3 weeks, we disliked the PPE. Because the PPE was limited to a surgical gown, we wear the complete outfit, including boots, in comparison to what we have now. We initially complained to the head nurse, "Why is the PPE in that condition?" **(P3)**

"...and then there was a lack of standardization in the initial PPE" **(P10)**

The second subtheme was an overwhelming workload. Several nurses stated that they felt stressed because there were more patients but fewer nurses.

*"Compared to the initial phase when I was appointed to be a COVID nurse, I feel a bit more stressed in the final phase, where there are still a large number of patients and the workforce has begun to decrease. Initially, I did not feel stressed because there were plenty of nurses, but recently there have been fewer and fewer personnel."(***P7)**

"...the number of patients remains high, while the number of nurses has decreased and been withdrawn..." **(P13)**

The third and fourth subtheme that contributed to difficulties in providing care was the change in nurses' mental health and the lack of support from their families, exacerbated by anxiety and fear during the pandemic's initial stages. Disruptions in the nurses' mental health led to disruptions in care delivery, particularly during the first two months. Nurses reported fear, concern, and anxiety because of the novel pandemic, citing that "*wearing full PPE with boots, it was hot, tiring*" **(P2).**

"...but, those COVID-19 patients faced greater difficulties; they were unable to breathe. The fact that patients were given a high dose of antibiotics or were suddenly admitted to the intensive care unit in the middle of the night was the most concerning..." **(P10)**

"...I was required to work overtime in surgery from 5 a.m. to 10 a.m. because I was a member of the surgical team; consequently, I was required to continue until 10 a.m. and I felt extremely exhausted..." **(P8)**

Theme 3: Support received while providing care for COVID-19 patients

In both hospitals, nurses can manage themselves and receive assistance from family members, hospital administration, and close friends. Because nurses were able to communicate with their families and educate them about their roles as COVID-19 nurses, the nurses at both hospitals believed they reaped these benefits. Nurses felt proud and appreciated their journey despite facing numerous obstacles, as described below.

*"When treating a COVID patient, I feel a sense of pride because I have witnessed the patient's transformation,"****(P3)***

"I'm beginning to feel congested due to the excessive use of masks; I'm also afraid, but I've taken it easy after enjoying the journey to join the COVID team. As comfortable as we are, we already know how to learn how to use personal protective equipment (PPE) that is comfortable for us." **(P11)**

Nurses' respondents also mentioned that they received assistance from family members, hospital administration, and close friends:

"...yes, my husband is supportive; fortunately, my husband works from home, so I was always encouraged; he drives me to work, picks me up from work, and is always waiting for me because I needed to bathe and eat beforehand. Throughout this time, my husband has been understanding..." **(P10)**

"...from my experience in my environment, even though they are aware I am caring for COVID-19 patients, they always greet me..." **(P2)**

"...support from hospital management; we were facilitated for swab testing; we were provided with complete PPE and amenities; and we were rewarded and compensated. These became a source of encouragement as we cared for COVID-19 patients..." **(P6)**

Theme 4: Increased insights while caring for COVID-19 patients

The fourth theme is subdivided into three subthemes: infection prevention and control, distinguishing the signs and symptoms of each patient, and managing diverse patient responses. Caring for COVID-19 patients exposed nurses at both hospitals to novel situations, particularly during the first two months. Nurses must exercise caution with infection control, beginning with donning and removing personal protective equipment (PPE), preventing cross infection between patients, and preventing infection when patients return home. Self-protection measures, such as complying with PPE standards, were a novel concept that nurses believed had to be implemented each time they provided care.

"...because the nurse interacts directly with the COVID patient, this is my recommendation regarding the APD. If the APD meets the standard, a sense of calm prevails..."(**P9)**

"...all PPE requirements are always met, and masks are never lacking. If there is an issue with housing, the hospital has a dormitory. Once every few weeks, we are tested by PCR; sometimes, rapid tests are also incredibly helpful; therefore, it's incredibly useful; if there's a problem in the team, the team members are fine; we work together to serve patients..." **(P14)**

"...I'm more concerned with self-protection; if we're in the clinic, the APD is minimal, but we don't know whether the patients who come have been exposed to Covid or are positive or negative. Even though the symptoms are identical to coughs, colds, and fever..." (P15).

Each patient diagnosed with COVID-19 who was hospitalized exhibited distinctive signs and symptoms. Similarly, the psychological response of each patient was unique. Nurses must be aware of these additional resources and utilize them as additional references when providing nursing care. Due to their separation from their families and their fear of dying, patients were under extreme stress. Nurses believed that they not only needed to provide nursing care for their patients' recovery from COVID-19, but also psychological care for their patients and their families.

"...previously, I cared for patients with regular illnesses, and most patients recovered; however, with COVID-19 patients, we have no way of knowing whether they will recover or deteriorate at any point, because several our patients who tested negative were discharged but were re-admitted after testing positive again. As a result, this became a new experience in the care of COVID-19..." **(P2)**

"...patients present with a variety of symptoms; there are a few patients whose symptoms appear to be normal on the surface; their vital signs are normal; however, their ability to smell has been lost, and they are also unable to taste. I once cared for a patient who could not taste their food or smell it. As a result, I believe that there is additional knowledge beyond what has previously been published in journals, such as the occurrence of these symptoms..." **(P1)**

"...It is difficult for me to work in a facility that provides Total Care with extensive therapy. In the emergency room, there are many, but not as many as in the intensive care unit, and we must be extremely cautious about everything..." **(P14)**

DISCUSSION

This qualitative study of nurses caring for COVID-19 patients demonstrates nurses' critical role in comprehensively responding to the pandemic. However, being on the frontlines will invariably affect nurses' psychological well-being. Nurses reported fear of death, anxiety while managing COVID-19, anxiety during the deceased's burial, fear of infecting family members, prolonged periods of stress, emotional strain when bearing difficult news, fear of contamination, feelings of discomfort while wearing PPE, and fear in the lack of public awareness regarding prevention measures.[15] Fortunately, nurses reported receiving assistance from healthcare providers, as evidenced by efforts to address equipment shortages during the pandemic's early stages.[16]

This study indicated that they chose to care for COVID-19 patients despite knowing how difficult it would be to be on the frontlines during the pandemic. This finding is consistent with another study in which nurses chose to care for MERS-CoV patients because they were unable to decline the responsibility knowing they could assist during times of hospital staff shortages.[17]

Additionally, this study demonstrated that nurses experienced psychological consequences because of fatigue, discomfort, and feelings of powerlessness associated with working at a high level of intensity, fear, and anxiety toward family members and other patients.[18] Despite this, nurses play a critical role in providing intensive care and assisting patients with daily activities,[11] as evidenced by the efforts made to provide the best care possible for COVID-19 patients, not only in monitoring disease progression but also in monitoring patients' mental and psychological well-being.

Caring for COVID-19 patients may result in psychological distress, such as anxiety and stress. Three major factors contributed to fatigue in healthcare practice by healthcare providers caring for COVID-19 patients, including work-related stress, insufficient staffing while caring for COVID-19 patients, and fear of infection with COVID-19.[19] Additionally, nurses experienced emotional strain when they were required to empathize with the suffering and difficulties of patients undergoing care, such as when they encountered patients who were admitted alone, isolated, and quarantined.[20] This is supported by this current finding indicating that nurses experience distress when witnessing their patients' suffering and, in some cases, death and the excessive workloads that place them under increased mental strain. Furthermore, other studies indicate that nurses fear becoming infected with the virus while caring for COVID-19 patients and transmitting it to others.[21] All these outcomes contribute to increased psychological distress among nurses.[15]

Nurses working during the pandemic initially encountered it as an unfamiliar situation, which they eventually normalized and adapted to. Doctors, nurses, pharmacists, laboratory personnel, and other healthcare providers undergo personal changes and mental health disruptions. Individualized assistance and support must be provided to hospital staff. Nurses will benefit from supportive interventions that are consistent with participants' perceptions of hospital support, such as adequate equipment and personal protective equipment, as well as providing individual incentives and rewards to nurses caring for COVID-19 patients.[16]

To effectively manage the COVID-19 pandemic, the healthcare system must provide competent care and be equipped with standard personal protective equipment (PPE). By ensuring that adequate human resources in the form of competent healthcare workers are available and that demand for equipment and supplies is met, healthcare workers will be prepared to treat and manage COVID-19 patients.[22] As both hospitals' participants indicated, they encountered significant challenges during the first month of the pandemic, including a shortage of PPE, a lack of manpower, and an excessive workload.

Nurses require support from the service provider, such as hospital administration, and their families, close friends, such as their husbands or children, and their community. This study demonstrates how strong family and community support can serve as a source of encouragement for nurses who are fearful of infection, both for themselves and their families and neighbors. The study established that healthcare workers in hospitals can contact COVID-19 because of a history of risk factors associated with COVID-19 patient contact, insufficient medical protection, such as inadequate handwashing before and after patient contact, and improper use of PPE.[7]

These findings further demonstrate that nurses gained new perspectives while caring for COVID-19 patients. Nurses supported patients physiologically and psychologically throughout their hospitalization and quarantine stay by motivating and encouraging them, assuming the role of the family and facilitating communication with family members. Due to the fact that patients with COVID-19 will have disrupted sleeping, eating, and behavioral patterns as a result of the stress caused by fear of the disease,[18] nurse's participants perceive they are responsible for resolving issues encountered by patients, which is consistent with the literature review, which demonstrates that nurses are critical in managing the COVID-19 pandemic, preventing further transmission, and managing patients' psychological recovery during their hospitalization.[23]

This study added to prior research on nurses' experiences caring for COVID-19-infected patients in two designated hospitals. It decided to take a phenomenological design in describing nurses' thoughts, health situations, emotions, and behaviors during an infectious outbreak. However, because the sample population for this study was limited to nurses working in urban areas, the findings may not be applicable to all regions of Indonesia.

CONCLUSION

This study provided a comprehensive and in-depth understanding of nurses' experiences caring for COVID-19 patients by revealing four major themes using a phenomenological methodology. The themes were the responsibility to maintain nursing professionalism, difficulties in caring for COVID-19 patients, assistance in caring for COVID-19 patients, and gaining new insights while caring for COVID-19 patients. This study's findings can serve as a starting point for hospital administration to develop policies and systems that promote the well-being of nursing staff. However, due to the qualitative nature of this study, care should be taken when generalizing its findings. It is recommended to conduct additional quantitative research with a larger sample size.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

FUNDING

Center for Research and Community Development/LPPM Universitas Pelita Harapan have funded this study (P-006-K/FoN/VI/2020).

ETHIC APPROVAL

Mochtar Riady Institute for Nanotechnology/MRIN Ethical Committee have approved this study (011/MRIN-EC/ECL/VI/2020). The researchers assured the accuracy in presenting the participants' experience in providing care to COVID-19 patients.

AUTHOR CONTRIBUTION

Ni Gusti Ayu Eka (NE) conceived of the presented idea. Lina Berliana Togatorop (LBT) and NE designed research framework and research questions. NE analysed the data and continued with LBT, Ester and Alberta composed the theme. NE took a lead in writing the manuscript. All authors had contributed equally to the writing of the original draft, provided critical feedback, and agreed for final version.

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