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Araştırma Makalesi

Being A Nurse in the COVID-19 Pandemic: A Qualitative Study with A Communication Dimension

COVID-19 Pandemisinde Hemşire Olmak: İletişim Boyutuyla Nitel Bir Çalışma

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ABSTRACT

Objective: In the COVID-19 pandemic, the critical role of nurses became more visible. The COVID-19 pandemic increased staff psychological stress and has put enormous pressure on healthcare systems across the World. The purpose of this study was to investigate communication challenges that come from nurses' COVID-19 experiences.
Methods: Qualitative study with a phenomenological approach using in-depth interviews was conducted to obtain data about the experiences of 16 nurses who actively participated in COVID-19 patient care. Data were analysed using content analysis.
Results: In this study, the effect of the COVID-19 pandemic on the communication of nurses with their families, healthcare personnel, patients and their relatives was focused. As a consequence of the analysis, three main themes emerged: (1) keep away, (2) conflict, (3) strengths.
Conclusion: Nurses faced many communication challenges. The vast majority of them appear to be caused by fear of infection. These communication struggles can reduce a peaceful and safe work environment for a nurse and jeopardize patient care. It can also lead to psychological effects for nurses. Strategies that nursing managers could use are; being fair in patient sharing and distribution of materials, such as protective equipment, and making them feel that their feelings and thoughts are important by listening to nurses.
Keywords: Colleagues, Communication, COVID-19, Nurses, Qualitative.

ÖZ
Amaç: COVID-19 salgınında hemşirelerin kritik rolü daha görünür hale geldi. COVID-19 salgını, personelin psikolojik stresini artırdı ve dünya genelinde sağlık sistemleri üzerinde büyük bir baskı oluşturdu. Bu çalışmanın amacı hemşirelerin COVID-19 deneyimlerinden kaynaklanan iletişim zorluklarını incelemektir.
Yöntem: COVID -19'lu hasta bakımına aktif olarak katılan 16 hemşirenin deneyimlerini incelemek amacıyla derinlemesine görüşmeler kullanılarak fenomenolojik yaklaşımla nitel bir çalışma yapılmıştır. Veriler içerik analizi kullanılarak analiz edilmiştir.
Bulgular: Bu çalışmada COVID -19 pandemisinin hemşirelerin aileleri, sağlık personeli, hasta ve yakınlarıyla iletişimine etkisine odaklanılmıştır. Analiz sonucunda üç ana tema ortaya çıkmıştır: (1) uzak durma, (2) çatışma, (3) güçlü yönler.
Sonuç: Hemşireler birçok iletişim zorluğuyla karşı karşıya kalmıştır. Bunların büyük çoğunluğu enfeksiyon korkusundan kaynaklanıyor gibi görünmektedir. Bu iletişim mücadeleleri hemşirenin huzurlu ve güvenli çalışma ortamını azaltabilir ve hasta bakımını tehlikeye atabilir. Ayrıca hemşireler için psikolojik sorunlara da yol açabilmektedir. Hemşire yöneticilerinin kullanabileceği stratejiler; hasta paylaşımı koruyucu ekipman gibi malzemelerin dağıtımında adil olmak, hemşireleri dinleyerek duygu ve düşüncelerinin önemli olduğunu onlara hissettirmektir.
Anahtar Kelimeler: COVID-19, Hemşireler, İletişim, Meslektaşlar, Nitel.

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INTRODUCTION

As the number of patients affected by COVID-19 increased in Türkiye, the critical role of nurses became more visible. Nurses' responsibility extends beyond patient care; they are seen as the secure hook that connects all interprofessional teams and communities from many professions and sectors to enable effective communication and risk mitigation in the wake of the global coronavirus pandemic (Buheji & Buhaid, 2020).

The COVID-19 pandemic increased staff psychological stress and has put enormous pressure on healthcare systems across the World (Jun et al., 2020). In order to minimize these psychological challenges, staff need support from their institutions and team members (Digby et al., 2021).

Effective communication is the underpinning of everything that happens in a hospital (Collins, 2021). In high-stress situations such as a pandemic, communication with the patient, institution, team members, and family may be obstructed. The communication difficulties increase when nurses are in critical areas, putting on heavy personal protective equipment, and monitoring more than one patient (Buheji & Buhaid, 2020). The use of a face mask and personal protective equipment can affect the provision of nursing care and have an impact on empathetic communication, which is crucial for optimal therapeutic involvement (Andersson et al., 2022; McCarthy et al., 2021). The lack of personal contact and the inability to physically examine patients cause limitations on the accuracy of patient assessment and create a barrier to communication (Digby et al., 2021). Additionally, communication between frontline nurses and managers is key to ensuring efficient care management in times of crisis (Lake et al., 2022). A lack of communication among team members at work will not only hinder patient care but will also induce anxiety and depression among staff (Zhang et al., 2021).

One of the largest problems, according to research performed with nurse leaders during the pandemic, was communicating and implementing policy change (Lake et al., 2022). Communication has an effect on nurses' feelings of certainty and their comfort level at work (Nelson et al., 2021). Additionally, Lake and colleagues (2022) found poor leadership communication may lead nurses to feel unsupported amid a crisis. Effective communication between nurses goes a long way toward resolving misunderstandings and conflict in the moment (Jennings & Yeager, 2020). To reduce stress and foster trust in times of unforeseen circumstances, hospital management should be responsive by offering transparent information and procedures (Spalluto et al., 2020).

As frontline employees, nurses have been particularly affected, attempting to build and maintain good nurse-patient communication. Therefore, it is of great clinical significance to understand the impact of COVID-19 on communication, which can provide a theoretical basis for patient and staff safety and psychology. Furthermore, perceptions of nurses may be useful to nursing managers and policymakers in the future as the next global threat from an infectious illness occurs. To address this knowledge gap, our investigation of the communication challenges that come from nurses' COVID-19 experiences contributes to that learning.

METHODS

Research Design and Setting

A descriptive qualitative approach was adopted. A qualitative approach was chosen as most appropriate for the determination of an individual's feelings, interactions, perceptions and behaviours (Grove et al., 2013). We used social media (Facebook) to create recruitment messages that briefly described the study and invited potential volunteers. Those who were interested in participating in the study emailed the researchers. The Standards for Reporting Qualitative Research (SRQR) checklist was consulted (O'Brien et al., 2014).

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Participants

Using a purposive technique, recruited participants included 16 nurses, one male and 15 females, without dropouts. The study's inclusion criteria were active participation in care with COVID-19 positive patients.

In this study, the average age of participants was 24.43 (23–42) years, and work experience was 61.28 months (4.5 months-19 years). Nine of the participants had a bachelor's degree, five had a master's degree, one had a degree from a health vocational high school, and one had an associate degree. All participants actively participated in COVID-19 patient care before the interviews. Their mean working time in COVID-19 wards before their interview was 10.38 (2-28) weeks, and three of them had previously been diagnosed with COVID-19. Eight of the 16 participants were currently working in pandemic wards (COVID-19 services/ICUs).

Data Collection

A semi-structured, in-depth interview technique was used to obtain data about the experiences of nurses, with the same open-ended questions asked of all nurses and in the same sequence. The primary research question was, "What do you think about the effects of the COVID-19 pandemic on your communication with your surroundings?" The descriptive characteristics of the participants were collected using the socio-demographic form, which consisted of 10 questions. During the interviews, prompts and questions eliciting more information were utilized when necessary, such as "What did you think of it? or "What else came to your mind?" Interviewers allowed retrieval of in-depth information hidden in each participant's statements (Cohen et al., 2011).

Interviews were conducted between November 2020-January 2021 during the second wave of the pandemic in Türkiye. Interviews were conducted by the second researcher via Zoom or telephone. Both authors communicated with the participants and determined the time and method of the interview. Each interview was recorded using a voice recorder. The interviews lasted 40-60 minutes, and none of the participants refused to be recorded during the interviews. While reporting, nurses' comments remained anonymous and the participants were represented using numbers to maintain confidentiality.

Data collection continued until data saturation was reached. After 10 interviews, no new information emerged. Using Francis and colleagues (2010) methodologies, data collection continued for a further three interviews. The last three interviewers in particular, verified previous statements and did not provide any new information; at that point, data saturation was considered to have been achieved by two members of the research team after 13 interviews. There were no repeated interviews with the same participant. Each interviewer participated in the interviews in their homes with their personal devices, in other words, in an independent, quiet, and safe environment. After the interviews were completed, the recordings were immediately transcribed verbatim.

Data Analysis

The data were manually analyzed using inductive content analysis (Elo and Kyngäs, 2008; Graneheim & Lundman, 2004). During the analysis, the researcher began by sorting the coded manifest content into categories and continued to search for the latent content (Graneheim et al., 2017).

The inductive content analysis process consisted of three main phases: preparing, organizing, and reporting. The preparation phase began with reading and re-reading transcripts in order to become familiar with the data as a whole (Elo & Kyngäs, 2008) and determining a meaning unit (Graneheim & Lundman, 2004). The meaning units are words, sentences, or paragraphs related to the same context and contents (Graneheim & Lundman, 2004). The researchers looked for similarities and differences in the data and moved from the concrete and specific to the abstract and general (Graneheim et al., 2017).

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The next step, organizing the qualitative data, included open coding, creating categories, and abstraction. The transcripts were read several times by two researchers, and keywords and phrases were identified during open coding. After open coding, the lists of codes were compared and grouped together based on shared similarities, and the associated codes were combined by categorizing them to capture nurses' perceptions and experiences. During the abstraction, each category was named by its content, and categories and themes were identified. Both of the authors analyzed data separately and checked multiple times. Next, in order to perform triangulation, the analysis was discussed with an expert in qualitative studies. The research team and the expert discussed the coding discrepancies until consensus was reached and an agreement was made on the themes that best described the findings.

In the last phase of the analysis, quotes from the interviews were chosen and the analysis and findings were reported (Elo & Kyngäs, 2008).

Research Team and Reflexivity

This study was analyzed by two female (HB and PS) nurses who had PhDs in Nursing. Therefore, they could provide the nursing perspective on the study question at hand. The authors and an individual expert were well-trained in qualitative courses, had experience with qualitative studies, and had published qualitative studies in international journals. The second author conducted the interviews with nurses, and there was no prior relationship between the interviewees and the interviewer.

Rigor

We ensured the trustworthiness of the study results with the four criteria described by Lincoln and Guba (1985); credibility, dependability, confirmability, and transferability. Credibility was assured by iterative questioning and peer debriefing. Peer debriefing was carried out by discussion with an expert experienced in qualitative research to evaluate the overall results in order to check the credibility of the findings. All participant responses were recorded, and field notes were taken during or after interviews to enhance data reliability. Throughout the interview process, the researcher allowed participants to speak freely and discuss any ideas or thoughts. The recordings were listened to and transcripts were read several times for prolonged engagement. All statements within each theme were cross-checked for accuracy after content analysis, which also strengthened the credibility of the data.

Regarding dependability, investigator triangulation was carried out. To increase the reliability of the data analysis, two researchers analyzed the transcripts independently, reached a view on the perceptions of the nurses, and determined themes and subthemes. These conclusions were discussed with the individual expert, and final themes were determined. Additionally, the use of the same interview form in each interview, the use of a voice recorder, and the fact that all interviews were conducted by the same researcher ensured dependability.

The confirmability of the data was ensured by maintaining an audit trail of all documents and decisions and allowing for examination of data collection throughout the study. This was accomplished by using a voice recorder to record all the interviews and reporting themes and subthemes in detail, including the methods and processes employed, the study's goal and objectives, open-ended questions used in the interviews, and study results.

Regarding transferability, to maximize information regarding the participants' experiences and provide rich descriptions of the phenomenon, purposive sampling was employed until data saturation was achieved. Transferability was further increased by thick description, selection and characteristics of the participant, data collection, process of analysis, and many representative quotations from the transcripts. The results of the study can be replicated in similar contexts in further studies.

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Ethical Considerations

Approval for the study was obtained from the Turkish Ministry of Health COVID-19 Scientific Research Evaluation Commission (Confirmation code: 05-30T12-05-15), and ethics committee approval was obtained from University's Noninvasive Research Ethics Board (ethical approval number: 60116787-020/45891). The participants were informed about the aim of the study, and that interviews were to be recorded. Participation in the study was voluntary, and participants could withdraw from the study at any time. As written consent could not be obtained, verbal informed consent for participation was obtained and demographic information was collected prior to data collection. All recordings and transcripts were stored on a password-protected computer.

RESULTS

As a consequence of the analysis, three main themes emerged: (1) keep away, (2) conflict (3) strengths.

Theme 1: Keep Away

Fears of being infected and spreading the virus have caused nurses to communicate less with their families, health care providers, patients, and relatives. As some of the participants stayed away from their families for fear of infecting them with the virus, they began to live separately from their families, which reduced family communication, raised stress, and had a negative psychological effect.

> *"My sister asks me, 'brother can I hug you?' I haven't hugged my sister for months. This hurts a lot; it has frayed me." (P5)*

A decrease in the nurses' communication with health personnel, especially with colleagues, caused nurses to experience negative emotions such as sadness, disappointment, and loneliness.

> *"We only communicated with the physicians via WhatsApp. Doctors did not enter the patient's room unless there was a risky situation. They talked over the phone to settle the problems." (P16)*

The participants stated that they could not meet the care needs of the patients adequately. Sadness, regret, and remorse accompanied this situation. Some nurses said that some patients knowingly transmitted the COVID-19 virus to them and other people; thus, they avoided communicating with these patients.

> *"I actually feel it is cruel. Because those patients are alone, terrified, and dealing with an illness they don't understand. We leave them alone. I feel guilty about it afterwards." (P7)*

Nurses indicated that the protective equipment they were wearing acted as a barrier to communicate with their patients (visors, double masks, etc.).

> *"We cannot make our voices heard from the protective equipment. Therefore, our communication level is minimal." (P13)*

Theme 2: Conflict

Reluctance to care for COVID-positive patients, non-compliance with pandemic rules, the intense work pace, the change of clinic, the lack of sufficient equipment (N95 masks, etc.), working under stress, and lack of communication caused conflicts in the workplace. Nurses stated that they were not understood, felt lonely, sad, furious, worthless, and used, and they did not receive enough support, especially from managers and physicians.

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"Sometimes, lots are drawn to see who will take care of the COVID *patient. If there is no one who does not want to care, there is an argument. It's teamwork after all." (P3)*

"We want enough personal protective equipment, we want more nurses. The answer given to us by the managers is that your psychology is broken, you should go to a psychiatrist. While we were waiting for more equipment and appreciation from them… we felt humiliated." (P11)

Nurses stated that the doctors put the work they had to do on the nurses in order not to come into contact with the patient, and that is why there were arguments.

"...they always entered the room with us. They didn't want to enter and they were trying to put their work on us." (P7)

Asking nurses to look after patients with COVID-19 who have just started working, have no children, live alone, or have had the disease before has caused serious tensions among nurses:

"I am scared too. Is my life more worthless? It makes me feel pure. I'm very offended. After a while, our communication will get worse as the resentments build up. It's slowly accumulating now." (P14)

Situations due to the pandemic, such as visitor restrictions and illness of family members, have decreased communication with patients' relatives and increased conflicts. All of these have caused nurses to work in a more tense and stressful environment.

"For a while, we supported the communication between the patient and the patient's relatives with notes, letters. However, the restriction of visitors to a large extent caused conflict..." (P7)

Theme 3: Strengths

Although the pandemic has caused challenges in communication for many nurses, it has also strengthened the bonds and communication between nurses and their families and colleagues.

"It makes our family proud that we take care of patients with COVID *at the hospital. Like a soldier on the front line…" (P5)*

"Everyone helps each other more in this process. Our friendship has deepened (with colleagues)." (P15)

DISCUSSION

In this study, nearly all of the interviewed nurses avoided communicating with their families. Similar to research by Ness and colleagues (2021), the nurses in this study were voluntarily isolated from their family members while giving care to COVID -19 patients. Planning an effective communication strategy that includes sufficient resources and guidance on how to protect themselves could help relieve fears about COVID-19 transmission to family members (Lord et al., 2021). Additionally, providing the possibility of communication with family members through digital communication technologies can minimize the emotional burden of this condition in nurses (Nogueira Galeno Rodrigues et al., 2020).

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Nurses in this study thought they reduced their communication due to the fear of infecting the patient and wearing personal protective equipment diminished patient interactions. These situations may cause their communication and quality of care they provide to their patients to remain the same (Andersson et al., 2022; Ness et al., 2021) or diminish as in our sample. Wearing personal protective equipment forces nurses to care for patients without the use of touch (Ness et al., 2021), which is a component of therapeutic communication (McCarthy et al., 2021). Nurses may experience ethical dilemmas and moral distress as a result of not being at the patient's bedside at the time of need, and not being able to provide spiritual, empathetic, compassion-focused, and holistic care (Andersson et al., 2022; Melnikov et al., 2022). Nurses were often the only professionals willing to enter patient rooms, which increased their risk for infection and left them emotionally vulnerable in their added role as the sole supporter for their patients (Ness et al., 2021). Some nurses said that some patients knowingly transmitted the COVID-19 virus to others; thus, they avoided communicating with these patients. This situation may have developed due to psychological difficulties as a result of stigma, as seen in HIV or sexually transmitted (or transmissible) infections (Holt et al., 2004). However, informing the public about COVID-19 is critical in order to prevent the spread of disinformation about the disease. These problems could make it more difficult to identify patients' communication requirements and offer them the effective help they require. Credibility in personal safety can be improved by using sufficient personal protective equipment and open communication with nursing leaders. This enables nurses to provide more time for patient care and communication interventions.

Changes in clinical practice due to COVID-19 included visitation restrictions. Communication with patients' families and primary caregivers occurred online (Kagan et al., 2021; Maaskant et al., 2021). Although the importance of the presence of the patient's relatives in the clinic in terms of maintaining nurse-patient communication cannot be ignored, nurses in this study reported they had communication problems with them. Nurses supported the communication between the patient and the patient's relatives with notes, letters, etc. However, some visitors wanted to see the patients, were angry with the nurses because of the restrictions, got into arguments, and behaved in hostile ways. The nurse's role in sustaining communication between the patient and the family was weakened as a result of these conflicts.

This study revealed that nurses who worked with COVID-19 patients faced negative reactions, were exposed to discrimination, and were stigmatized by their colleagues. The nurses felt frustrated, neglected, demoralized (Kwaghe et al., 2021), lonely, and worthless. According to colleagues, nurses who have survived the disease, don't have children, and live alone should take care of COVID-19 patients. As far as it is known, this is new information. The main reason for stigma is the fear of being infected (Kwaghe et al., 2021), and it is possible that this is the reason for the discrimination. This situation may cause nurses conscientiously forced (Dal & Akpınar, 2023). As one nurse put it, this environment makes nurses feel worthless, which leads to resentment, and resentment worsens communication with colleagues. Communication is a crucial element for maintaining interprofessional connections, resulting in team collaboration (Nogueira Galeno Rodrigues et al., 2020). It is necessary to pay close attention to the relationships among medical team members and increase their communication (Zhang et al., 2021).

Nurses participating in this study stated that they were not understood and did not receive enough support, especially from managers and physicians. Communication became a challenge for nurses who were paired with a different nurse partner every day (Cadge et al., 2021), working outside of their usual area, patient care volume, and personal protective equipment workarounds (Fernandez et al., 2020; Lake et al., 2022; White et al., 2021). Kagan and colleagues (2021) reported that emotional distress results from a lack of guidance from hospital managers. At times of high stress, as with the COVID-19 pandemic, transparent, timely, and effective leadership communication, less difficulty accessing personal protective

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equipment/supplies, and providing information, support, and training will improve nurses' morale and effectiveness (Cadge et al., 2021; Dal & Akpınar, 2023; Jennings & Yeager, 2020; Lake et al., 2022).

Despite the fact that nurses suffered communication difficulties during the pandemic, they believed it strengthened their bonds with their families and colleagues. During pandemic, healthcare professionals frequently maintained communication with their families by telephone, which not only provided comfort to the workers themselves but also alleviated the worries of their loved ones (Billings et al., 2021). Feelings of closeness bloom as families strengthen their bonds as a unit to better withstand the pandemic, adjust to its demands, and safeguard themselves and their loved ones (da Silva Barreto et al., 2022; Sheen et al., 2022). Being together in a stressful situation might have a positive outcome, such as colleagues supporting one another and the creation of close friendships (Blake, 2021). Nurses feel comfortable sharing feelings and anxieties and getting advice and support from colleagues at a time when not much else is known (Cadge et al., 2021; McCarthy et al., 2021).

Limitations

One of the limitations of this study is that the majority of the participants were female and from the western part of Türkiye. In addition, due to the nature of qualitative studies, the findings cannot be generalized to all nurses in the country.

Conclusions

In this study, it was found that during the second wave of the pandemic, nurses faced many communication challenges. The vast majority of them appeared to be caused by fear of infection. Communication struggles can reduce nurses' peaceful and safe work environment and jeopardize patient care. It can also lead to psychological effects on nurses. The findings of this study could be used to identify nursing needs and create and implement programs to prevent conflicts caused by a lack of communication.

Many of the communication problems were caused by fear of infection, increasing workload demands, and poor communication with management, according to the nurses' descriptions of the specific communication challenges they encountered during the pandemic. Nurses must devise plans of action to solve these issues. It is unrealistic to anticipate effective collaboration between colleagues during a crisis like a pandemic. Nevertheless, based on our research, we can state that strategies that nursing managers could use are; being fair in patient sharing and distribution of materials, such as protective equipment, and making them feel that their feelings and thoughts are important by listening to nurses. When managers encourage nurses to receive psychological support while working in stressful conditions, communication among colleagues can improve. Nurses feel valued and secure in this way. In order to support and empower nurses for pandemic management, nursing managers need to have proper training in communication skills. Transparent and consistent communication training should be supported by nursing schools, and nursing managers should organize such training as part of in-service training.

We recommend that nursing managers be prepared for the next pandemic, including personnel and equipment planning and sharing their knowledge and experiences about communication. They can create institutional or regional strategies or an action plan on how to maintain communication or solve communication-related problems during the pandemic. A relationship between nurses and managers may be cultivated through the implementation of a strategy, improving the possibility of more honest and efficient communication when a crisis arises.

Ethics Comittee Approval: Approval for the study was obtained from the Turkish Ministry of Health COVID-19 Scientific Research Evaluation Commission (Confirmation Code: 05-30T12-05-15), and ethics committee approval was obtained from University's Noninvasive Research Ethics Board (Ethical Approval Number: 60116787-020/45891).
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REFERENCES

Andersson M, Nordin A, Engström Å. (2022). Critical care nurses' experiences of working during the first phase of the COVID-19 pandemic – Applying the Person-centred Practice Framework. *Intensive and Critical Care Nursing, 69,* 103179. doi: 10.1016/j.iccn.2021.103179

Billings J, Ching BCF, Gkofa V, Greene T, Bloomfield M. (2021). Experiences of frontline healthcare workers and their views about support during COVID-19 and previous pandemics: a systematic review and qualitative meta-synthesis. *BMC Health Services Research, 21,* 923. doi: 10.1186/s12913-021-06917-z

Blake N. (2021). Building a new, better normal after COVID-19. *Nursing Management, 52*(6), 20-23. doi: 10.1097/01.NUMA.0000752780.68152.46

Buheji M, Buhaid N. (2020). Nursing human factor during COVID-19 pandemic. *International Journal of Nursing Science, 10*(1), 12-24. doi: 10.5923/j. nursing.20201001.02

Cadge W, Lewis M, Bandini J, Shostak S, Donahue V, Trachtenberg S, et al. (2021). Intensive care unit nurses living through COVID-19: A qualitative study. *Journal of Nursing Management, 29,* 1965–1973. doi: 10.1111/jonm.13353

Cohen L, Manion L, Morrison K. (2011). *Research methods in education.* New York: Routledge.

Collins R. (2021). Protect the nurse, protect the practice: Effective communication is the foundation for keeping nurses safe. *Healthcare Management Forum, 34*(4), 200-204. doi: 10.1177/08404704211022144

Dal HE, Akpınar H. (2023). The effect of the COVID-19 pandemic on nurses' conscientious perception levels. *Black Sea Journal of Health Science, 6*(4), 667-674. doi: 10.19127/bshealthscience.1339762

da Silva Barreto, M., Leite, A. C. A. B., García-Vivar, C., Nascimento, L. C., & Marcon, S. S. (2022). The experience of coronaphobia among health professionals and their family members during COVID-19 pandemic: A qualitative study. *Collegian, 29*(3), 288-295. doi:10.1016/j.colegn.2022.03.006

Digby R, Winton-Brown T, Finlayson F, Dobson, H, Bucknall T. (2021). Hospital staff well-being during the first wave of COVID-19: StafF perspectives. *International Journal of Mental Health Nursing, 30,* 440–450. doi: 10.1111/inm.12804

Elo S, Kyngäs H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107–115. doi: 10.1111/j.1365-2648.2007.04569.x.

Fernandez R, Lord H, Halcomb E, Moxham L, Middleton R, Alananzeh I, et al. (2020). Implications for COVID-19: A systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic. *International Journal of Nursing Studies, 111,* 103637. doi: 10.1016/j.ijnurstu.2020.103637.

Francis JJ, Johnston M, Robertson C, Glidewell L, Entwistle V, Eccles MP, et al. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health, 25*(10), 1229-1245. doi: 10.1080/08870440903194015

Graneheim UH, Lindgren B-M, Lundman B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today, 56,* 29-34. doi: 10.1016/j.nedt.2017.06.002

Graneheim UH, Lundman B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24,* 105-112. doi: 10.1016/j.nedt.2003.10.001

Grove SK, Burns N, Gray JR. (2013). *The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence*. (7th edition). China: Elsevier Inc.

Holt M, Jin F, Grulich A, Murphy D, Smith G. (2004). Syphilis, STIs and Men Who Have Sex with Men in Sydney: Understanding and Managing Risk. Australia: National Centre in HIV Social Research. Monograph 7/2004.

Jennings BM, Yeager KA. (2020). From fear to fortitude: Using the power within the nursing profession to fight COVID-19. *Nursing Outlook, 68*(4), 391-392. doi: 10.1016/j.outlo ok.2020.04.008

Jun J, Tucker S, Melnyk BM. (2020) Clinician mental health and well-being during global healthcare crises: evidence learned from prior epidemics for COVID-19 pandemic. *Worldviews on Evidence-Based Nursing, 17*(3), 182-184. doi: 10.1111/wvn.12439

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2024, 7 (3), 337-346
Doi: 10.54189/hbd.1452084

Kagan I, Shor R, Ben Aharon I, Yerushalmi S, Kigli-Shemesh R., Gelman S, et al. (2021). A Mixed-Methods study of nurse managers' managerial and clinical challenges in mental health centers during the COVID-19 pandemic. *Journal of Nursing Scholarship, 53*(6), 663-670. doi:10.1111/jnu.12685

Kwaghe AV, Ilesanmi OS, Amede PO, Okediran JO, Utulu R, Balogun MS. (2021). Stigmatization, psychological and emotional trauma among frontline health care workers treated for COVID-19 in Lagos State, Nigeria: A qualitative study. *BMC Health Services Research, 21,* 855.doi:10.1186/s12913-021-06835-0

Lake ET, Narva AM, Holland S, Smith JG, Cramer E, Rosenbaum KEF, et al. (2022). Hospital nurses' moral distress and mental health during COVID-19. *Journal of Advanced Nursing, 78,* 799-809. doi: 10.1111/jan.15013

Lincoln SY, Guba EG. (1985). Naturalistic Inquiry. CA: Sage. In Elo S, Kääriäinen M, Kanste O, Pölkki T, Utriainen K, Kyngäs H. (2014). Qualitative content analysis: a focus on trustworthiness, *SAGE Open, 4*(1), doi:10.1177/2158244014522633

Lord H, Loveday C, Moxham L, Fernandez R. (2021). Effective communication is key to intensive care nurses' willingness to provide nursing care amidst the COVID-19 pandemic. *Intensive & Critical Care Nursing, 62,* 102946. doi: 10.1016/j.iccn.2020.102946

Maaskant JM, Jongerden IP, Bik J, Joosten M, Musters S, Storm-Versloot MN, et al. (2021). Strict isolation requires a different approach to the family of hospitalised patients with COVID-19. A rapid qualitative study. *International Journal of Nursing Studies, 117,* 103858. doi: 10.1016/j.ijnurstu.2020.103858.

McCarthy B, O'Donovan M, Trace A. (2021). A new therapeutic communication model "TAGEET" to help nurses engage therapeutically with patients suspected of or confirmed with COVID-19. *Journal of Clinical Nursing, 30,* 1184-1191. doi: 10.1111/jocn.15609

Melnikov S, Kagan I, Felizardo H, Lynch M, Jakab-Hall C, Langan L, et al. (2022). Practices and experiences of European frontline nurses under the shadow of COVID-19. *Nursing & Health Sciences, 24,* 405–413. doi: 10.1111/nhs.12936

Nelson H, Hubbard Murdoch N, Norman K. (2021). The role of uncertainty in the experiences of nurses during the Covid-19 pandemic: A phenomenological study. *Canadian Journal of Nursing Research, 53*(2), 124-133. doi: 10.1177/0844562121992202

Ness MM, Saylor J, Di Fusco LA, Evans K. (2021) Healthcare providers' challenges during the coronavirus disease (COVID-19) pandemic: A qualitative approach. *Nursing & Health Sciences, 23,* 389-397. doi: 10.1111/nhs.12820

Nogueira Galeno Rodrigues ME, Belarmino ADC, Lopes Custódio L, Lima Verde Gomes, I, Ferreira Júnior, AR. (2020). Communication in health work during the COVID-19 pandemic. *Investigación y educación en enfermería, 38,* e09. doi: 10.17533/udea.iee.v38n3e09.

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. (2014). Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine, 89,* 1245-1251. doi: 10.1097/ACM.0000000000000388.

Spalluto LB, Planz VB, Stokes LS, Pierce R, Aronoff DM, McPheeters ML., et al. (2020). Transparency and trust during the coronavirus disease 2019 (COVID-19) pandemic. *Journal of the American College of Radiology, 17,* 909–912. doi: 10.1016/j.jacr.2020.04.026.

White EM, Wetle TF, Reddy A, RR Baier. (2021). Front-line nursing home staff experiences during the COVID-19 pandemic. J*ournal of the American Medical Directors Association, 22,* 199-203. doi: 10.1016/j.jamda.2020.11.022

Zhang J, Fang Y, Lu Z, Chen X, Hong N, Wang C. (2021). Lacking communication would increase General Symptom Index scores of medical team members during COVID-19 pandemic in China: A retrospective cohort study. *INQUIRY: The Journal of Health Care* Organization, *Provision, and Financing, 58,* 1-8. doi: 10.1177/0046958021997344