






RESEARCH ARTICLE

Hospital nurses' experiences of and perspectives on the impact COVID-19 had on their professional and everyday life—A qualitative interview study

Lars Thrysoe^{1,2}  | Charlotte Dyrehave^{1,3}  | Helle Marie Christensen^{2,4}  |
Nanette B. Jensen⁵  | Dorthe S. Nielsen^{5,6,7} 

¹Department of Cardiology, Odense University Hospital, Odense, Denmark

²Department of Clinical Research, University of Southern Denmark, Odense, Denmark

³Department of Clinical Medicine, Aarhus University, Aarhus, Denmark

⁴Odense Respiratory Research Unit (ODIN), Department of Respiratory Medicine, Odense University Hospital, Odense, Denmark

⁵Department of Infectious Diseases, Odense University Hospital, Odense, Denmark

⁶Migrant Health Clinic, Odense University Hospital, Odense, Denmark

⁷Department of Geriatric Medicine, Odense University Hospital, Odense, Denmark

Correspondence

Dorthe Susanne Nielsen, Department of Infectious Diseases, Odense University Hospital, Odense, Denmark.
Email: dorthe.nielsen@rsyd.dk

Funding information

Østifterne

Abstract

Aim: To explore how hospital nurses experienced their work situation during the COVID-19 pandemic and how this affected the conduct of their professional and their everyday life.

Methods: Interviews using critical psychology. A total of 24 nurses participated, representing departments of both medicine and surgical specialties. All nurses worked either in the department where they are usually stationed or were recruited from other departments to the COVID-19 department.

Results: Five themes were identified: (1) COVID-19 had importance to nurses' sense of self as a nurse; (2) a new solidarity developed; (3) professional reflections—caring for patients; (4) the importance of recognition and humiliation and (5) COVID-19 had consequences for the nurses' conduct of everyday life.

Conclusion: The findings showed that some nurses caring for patients with COVID-19 experienced a new solidarity with their colleagues. Other nurses found it to have a negative impact on their conduct of their professional life.

KEYWORDS

COVID-19, Nurses perspectives, Nursing, Qualitative study

1 | INTRODUCTION

According to the International Council of Nurses, ICN more than 90,000 healthcare workers (HCWs) were infected with COVID-19 at the beginning of May 2020. Furthermore, HCWs dealing with COVID-19 were at risk of moral injury, and by June 2020, more than 600 nurses had died due to COVID-19. It is evident that the pandemic is taking a toll on nurses all over the world who take care of patients with COVID-19 (ICN, 2020). Because nurses are in the frontline and under pressure globally during COVID-19, in this study, we aimed to

uncover nurses' experiences, reactions and perspectives on being assigned to work in a newly developed COVID-19 department.

2 | BACKGROUND

A cross-sectional survey-based study among 1,257 HCWs in China showed an association between frontline HCW engagement in the direct diagnosis, treatment and care of patients with COVID-19 and a higher risk of symptoms of depression and psychological

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2021 The Authors. *Nursing Open* published by John Wiley & Sons Ltd.

burden, especially nurses. The ever-increasing number of patients with confirmed and suspected COVID-19, too much workload, lack of personal protection equipment and specific drugs, widespread media coverage and feelings of being inadequately supported seem to contribute to the mental burden (Lai et al., 2020). Another study from China revealed that 1,357 (85%) of the included HCWs in a non-epidemic but still critically affected area of China were afraid of becoming infected at work. The results also indicated that certain risk factors, including work experience and job category, influenced HCWs' attitudes and practice concerning COVID-19. The more knowledge the HCWs' had about COVID-19, the more confident they became in defeating the virus (Zhang et al., 2020). Confidence has been proven an important personal quality when taking care of COVID-19 patients, that is confidence makes nurses feel more positive, hopeful and self-assured during their work with the pandemic. Nurses' confidence has shown to be influenced by factors at work like having adequate supplies, clear guidance, leadership, good collaboration between HCWs and sufficient staffing (Nowell et al., 2021).

A study from South Korea revealed that HCWs taking care of COVID-19 patients and at the same time living with people suffering from long-term illnesses had a significantly higher incidence of depression and anxiety due to the risk of transmission of COVID-19 to their families (Yang et al., 2020). Moreover, a review on mental health care among HCW, including six articles, indicates increasing evidence on how COVID-19 can be an independent risk factor for stress. The review shows how HCWs encounter a considerable degree of anxiety, depression and insomnia due to the COVID-19 pandemic. These risks seem to be associated with gender, profession, age, place of work, department of work and psychological variables like poor social support and self-efficacy, making nurses more vulnerable (Spoorthy et al., 2020).

The recommendations of the World Health Organization, the United Nations and the International Red Cross Society jointly emphasize how the normalization of strong emotions and stress, the fulfilment of basic needs, social support, clear communication and task distribution may decrease the risk of stress and psychological load among HCWs working during the COVID-19 pandemic. Moreover, flexible working hours and the use of psychosocial and psychological help without stigmatization proved vital to HCWs' ability to cope with the COVID-19 situation (Petzold et al., 2020).

Summarizing, the knowledge above indicates that HCWs taking care of patients with COVID-19 are at risk of stress and other psychological distresses. Most of the included studies above used quantitative methods, and there seems to be a lack of qualitative knowledge on the impact, importance and consequences of the various reactions of nurses towards the care of patients with COVID-19, on nurses' professional lives and their private lives. To address this gap, the aim of this study was to explore how hospital nurses experienced their work situation during the first wave of the COVID-19 pandemic and how this affected the conduct of their professional and their everyday life.

3 | METHODS

3.1 | Design

The project was conducted as a qualitative interview study using critical psychology as an analytical tool (Moerck & Huniche, 2006).

3.2 | Interviews and interview guide

We conducted 13 explorative individual interviews and two focus group interviews with three nurses in each group in the period April to August 2021. The interviews lasted from 45 to 80 min. We chose to integrate both individual interviews and focus groups to guarantee data completeness. We expected the different types of data collection to be complementary and to contribute to a more comprehensive understanding of the nurses' working conditions (Lambert & Loisel, 2008). The focus was on the impact that working in COVID-19 units had on nurses' conduct of their everyday and working life. Our goal was to get in-depth knowledge on the meaning behind the nurses' reactions and feelings as well as the reasons for their choices and actions in practice. We expected the focus groups to accentuate a range of similarities and differences on the topics discussed and to get information about how their perspectives differed. Small groups of three to four people were chosen to keep a trustful and intimate environment during the interview (Wibeck et al., 2007). A thematic semi-structured interview guide (Holstein & Gubrium, 1995) was used in all interviews consisting of five main themes. We were working with the following themes in the interview guide: (1) Working conditions before COVID-19, (2) Private life before COVID-19, (3) Working conditions during COVID-19; impact on patients, care and treatment, colleagues, head of department and family life, (4) Ethical considerations and (5) The future—thoughts, wishes and worries. Four members of the research group conducted the interviews. To maintain close collaboration with the rest of the research team, the content of the interviews and the interview guide were continually discussed and developed as an iterative process. Interviews were taped on a Dictaphone and transcribed verbatim.

3.3 | Setting

The study took place at a large university hospital in Denmark. Here, the management handled the first wave of the COVID-19 pandemic by establishing COVID-19 units. These units were staffed with HCWs (physicians and nurses) trained to take care of patients with COVID-19, including to use safety equipment.

3.4 | Participants

The sampling strategy was conducted using a purposive approach (Maxwell, 2005) aimed at including diversity in terms of seniority,

age and gender. The inclusion criteria were nurses recruited to be working with patients diagnosed with COVID-19 in a specialized COVID-19 department. In total, 24 nurses agreed to participate in the study, representing departments of medicine and surgical specialties. Thus, some of the participating nurses were specialized in caring for patients with infectious diseases, and others were experienced in caring for patients with other (non-infectious) diseases. All participating nurses cared for patients with COVID-19, either in the department where they usually worked or as recruits from other departments (Table 1).

3.5 | Data analysis

All members of the author group worked together to discuss and analyse the material of both the individual and the focus group interviews. The preliminary thematic analyses of interview transcripts were theoretically informed by critical psychology (Moerck & Huniche, 2006) and carried out with inspiration from Malterud's text condensation (Malterud, 2012). First, all authors conducted a pre-analysis of their own interviews, reading the transcripts and listening to the interviews several times in a search for meaning units. The meaning units were identified in the material from both the individual interviews and the focus groups, drawing on critical psychological concepts such as first-person perspectives, conduct of everyday life, meaning, agency, possibilities and constraints (Dreier, 2008; Gildberg & Hounsgaard, 2018; Schraube &

Osterkamp, 2013). Meaning units were discussed and further analysed in the author group in order to qualify insights on participants' experiences of conditions, possibilities and constraints in relation to the impacts that COVID-19 had on the nurses' professional and private life (Table 2).

Critical psychology is based on historical and dialectical materialism and views participants as dialectically interacting with social structures in concrete action contexts. Not only does a participant live under certain societal conditions, he or she also influences and produces conditions. We are historically and socially embedded as human beings; history and society have a bearing on how possibilities and constraints in the conduct of everyday life and through life trajectories come about and how they are experienced and acted upon. Insight into personal strategies along with social conditions and meanings from a first-person perspective are necessary to understanding the specific ways people think, act and relate to possibilities and constraints (Dreier, 2008; Schraube & Osterkamp, 2013). This approach supports the nurses' exchange of experiences about concerns, conditions and their meanings, along with perceived possibilities and constraints of action. Analysis of these perspectives aimed to highlight what the nurses experienced as conditions and their meanings, along with the possibilities and constraints for acting in particular circumstances.

3.6 | Ethical considerations

All data are stored in a safe SharePoint room at the University Hospital. The study was approved by the Data Protection Agency in Region of Southern Denmark (Journal no. 20/17130). Sensitive personal data were changed to prevent any participating nurses from being recognized by others, and also between the authors personal data were altered.

The participating nurses received verbal and written information about the project and were informed that participation in the study was voluntary. The included participants provided informed consent in writing to participate and to have the interview audio recorded.

TABLE 1 Overview of participants

	Number of years working as a nurse	Age	Gender
IT1 - DSN	2	27	F
IT2 - DSN	19	49	F
IT3 - DSN	16	45	F
IT4 - DSN	13	38	F
IT5 - DSN	20	52	F
IT6 - LT	4	27	F
IT7 - LT	11	33	F
IT8 - LT	8	34	M
IT9 - LT	0.5	29	F
IT10 - LT	0.5	26	F
IT11 - CD	3	28	F
IT12 - CD	7	45	F
IT13 - CD	19	44	F
FG1-a - NBJ	12	42	F
FG2-a - NBJ	11	59	F
FG3-a - NBJ	10	36	F
FG4-b - NBJ	1	26	F
FG5-b - NBJ	16	44	F
FG6-b - NBJ	12	50	F

4 | FINDINGS

One of the most important factors for all the participating nurses (hereafter referred to as *the nurses*) was their ability choose whether they worked in the COVID-19 department and how this was experienced and acted upon. We identified a clear pattern between those who volunteered to work at the department and those who were transferred to the department against their will. With this in mind, we identified the following five themes during the analysis: (1) COVID-19 had importance to nurses' sense of self as a nurse; (2) a new solidarity developed; (3) professional reflections—caring for patients; (4) the importance of recognition and humiliation; and (5) COVID-19 had consequences for the nurses' conduct of everyday life.

TABLE 2 Example of the analysing process

Conditions	The solidarity among the nurses entailed an openness in the team, which for some was experienced as 'giving more energy,' 'a special fellowship,' feelings of 'being lost together.'
Meanings	<ul style="list-style-type: none"> • Clinical experience became a condition of importance to how the nurses experienced their abilities for taking action and control. • Had an impact on the unison experience depending on each other's different competences, skills and knowledge. • Expressed that all were somehow in 'the same boat'
Reasoning	<ul style="list-style-type: none"> • Special solidarity emerged and was experienced in feelings being shared • Nurses experienced being dependent on each other's competencies • Some nurses experienced how trust was built in the new field, and this new working culture entailed an openness and willingness to share feelings and vulnerability.

4.1 | COVID-19 had importance to nurses' sense of self as a nurse

The nurses who volunteered described their job as a vocation; they wanted to make a difference to patients and society. These nurses used various metaphors to describe their situation, which they described as: 'going into the battle of war,' 'having a leg in different camps,' 'being at the front fighting' and 'act of heroism.' These metaphors illustrate that some of the nurses experienced their new working conditions as a calling, and they felt devoted and were ready to 'fight' the COVID-19. The nurses who felt they had been assigned to work in the COVID-19 department against their will used different kinds of metaphors that reflected feelings of being lost, betrayed and abandoned: 'There was an outcry when we got told to go to the COVID-19 department,' 'there was moping in the ward,' 'standing with your back against the wall,' 'being picked out,' 'I got my sentence,' 'I got the hat on,' 'I felt expelled.' Most of the non-volunteering nurses described being at the COVID-19 department to be a challenge in many ways. Being picked out made some of the nurses feel vulnerable, and some began doubting their own skills and competences.

It made me nervous not knowing if I would be able to do the same as the other nurses who had worked at the department for many years. During the whole time, I lacked further clinical experiences. I felt inadequate.

IT13

The 'selected' nurses emphasized in the interviews that not having a choice and feeling forced to work in the COVID-19 department with very little preparation had affected their sense of self, and several nurses expressed that they developed stress and symptoms of depression over time.

The most important thing I have mentioned [during the interview] was about the external pressure. The experience of being forced to do something you do not have passion for – I don't want to do this and nevertheless, I am being forced...

IT11

4.2 | A new solidarity developed

Regardless of how the nurses had been appointed to the new COVID-19 department, they all described experiencing a new solidarity among their colleagues. This new solidarity among the nurses was experienced and argued by most of the nurses as being unique.

... I experienced a closer collaboration; we were united and were reflecting together, we met in "room 5" and discussed the patients and shared our private lives. In that way, we became closely attached to one another.

IT9

Having years of experience was argued to be an important condition for the nurses' sense of self as a nurse. Clinical experience became an important factor in how the nurses experienced their ability to take action and control. In the COVID-19 department, being inexperienced along with colleagues became a condition where it was legal to be open and vulnerable about one's own feelings and competences, and it created a new kind of solidarity. This solidarity emerged and was experienced in the feelings being shared such as 'fear of making mistakes,' 'fear of not being able to handle the situation professionally and with compassion,' 'fear of being infected with COVID-19 virus or being the one to infect family and friends' and 'fear of not being with the patient if his or her condition worsened.' Working in unison with colleagues who were also inexperienced in COVID-19 treatment and care, prognosis and symptoms had importance to all the nurses' sense of self as nurses and their sense of togetherness.

Some nurses expressed that they were all somehow in 'the same boat.' They experienced being dependent on one another's different experiences and competencies as an important condition which had an impact on the experienced solidarity. Furthermore, along with the solidarity, the nurses expressed that an openness developed within the team, which for some was experienced as 'giving more energy,' 'a special fellowship' and feelings of 'being lost together.' One nurse emphasized that she perceived her new colleagues to be more open-minded towards new ways of doing things and that they all 'threw away the rulebook.'

We formed quite a different solidarity because many of us had isolated ourselves in our private lives - many of my colleagues were not meeting either their parents or family, so we had each other, and we were more or less like a little family. We shared the same frustrations and we shared the same feelings and talked about it.

IT6

Some nurses experienced a building of trust in the new field, and this new working culture entailed an openness and willingness to share feelings and vulnerability.

You could show if you were sad and afraid of going in to see a [COVID-19] patient. It resulted in an openness - it was no longer risky to say if there was something, you were sad about or thought was frustrating.

IT7

4.3 | Professional reflections—Caring for patients

Caring for patients was described as being less physically demanding than expected. However, most nurses expressed that patients in the COVID-19 department needed special psychological nursing and care. Being isolated entailed feelings of loneliness, depression and guilt among the patients.

I have learned how to build up a relationship to the [patient] in a very short time, and at a distance, and build up trust and confidence. I am also much more aware of the consequences of isolation and how much it matters that relatives can come (to visit) when they [patients] are hospitalized.

IT10

The isolation regime for patients caused some of the nurses to experience fear about not being able to observe the patients if either their conditions worsened or they suddenly had respiratory problems behind closed doors. This was described as being stressful, especially for the newly qualified nurses. For some of the nurses, having patients in isolation meant that the nurses could exercise authority, power and control over the patient's life and autonomy, which they did not want to possess. Some of the nurses found that being the one to decide whether a patient was dying and therefore entitled to have close relatives nearby was extremely stressful and intimidating.

We were all very busy, and we knew the patient was dying. The patient's situation changed so fast ... and his relatives never made it, and they never got a chance to say goodbye. That really was the worst experience we all had.

IT1

The isolation regime required special tasks and a great deal of interaction with the relatives, who were making frequent calls to the nurses and the department. Some patients were using FaceTime and WhatsApp to communicate with their relatives, which in some cases was argued to be a help and relief for the nurses. The special role the nurses had in relation to patients' families and networks had consequences for some of the nurses after the COVID-19 restrictions had been lightened. The position of having had the power to determine the relatives' actions in the hospital affected the way some of the nurses' later approached family members. One nurse likened her role to that of a 'policeman':

There was no introduction when returning to usual practice. You felt as though you should act like a police officer to the relatives. At that moment, I was in a risk zone again because I did not know if the relatives had COVID-19 or the patient had COVID-19. I felt unsafe...

IT6

4.4 | The importance of recognition and humiliation

At the beginning of the pandemic, most nurses described the conditions and resources in the department as unlimited. The staff got the resources they needed and received recognition from their heads of department and from hospital management. Furthermore, healthcare workers were being applauded for being heroes in the press. The attention from the society had significant importance to all nurses. In particular, getting support and recognition from the charge nurse and the nurse specialists was highlighted as being significant to how the nurses handled being at the COVID-19 departments.

The charge nurses' commitment to supporting the individual nurse in handling her/his professional and private challenges, wishes and needs was experienced by all the nurses with gratitude and admiration.

The charge nurse was there 100%, all the time - day and night. We were never understaffed, and at the same time, she always considered whether it was necessary for you to come to work - she considered whether we could stay at home and be called in if necessarily - in order to protect our private life. The charge nurses were present - we owe them a lot of credit.

IT7

In contrast, some of the nurses experienced 'being left behind and alone' or 'not getting any support or contact' from their own head of department or colleagues. One nurse described it as being in 'a kind of a limbo' and being moved around like a 'chess piece.'

I felt like we were chess pieces. There was no one listening to us. I think we are generally ready to embrace changes and compromise on different working conditions as nurses.... Therefore, I lost confidence in my department head; the ones close to us should have supported us and visited us in the COVID-19 department.

IT12

Several nurses experienced that they were not being heard, understood or supported by their own department head when they had addressed their concerns and symptoms of being stressed and vulnerable at the COVID-19 department. Some nurses felt ignored, which only worsened their situation.

I expressed my concern to my head nurse and to my charge nurse and was told that I shouldn't look on the dark side. I should adopt a positive attitude and see how matters would turn out in the future.

IT12

Some nurses expressed that the experience of coming back to one's own department after the first wave of COVID-19 was a relief, whereas others experienced it to be very hard and stressful. Some came back as heroes and were 'applauded'; others experienced their coming back was related to experiences of humiliation and disrespect from their own colleagues.

Experiences of being marginalized and bullied were expressed with metaphors such as 'I felt like a bug or a parasite,' and others explained they were treated as though they had 'a pest or cholera.'

We were suddenly "the ones," and some colleagues felt it was dangerous to visit us in the COVID-19 department. This was so different from our normal way of working together... it felt so unpleasant.

IT10

The humiliation affected the nurses' capacity to take action and made the individual nurse even more vulnerable, and their own situation more difficult to handle. A few nurses expressed that they were not the same nurse or person after returning to their own department. They found that they no longer had the same energy and felt that they did not belong.

There is a reason why I am so tired – that it is so exhausting for me. I can only manage to be engaged in one department and one specialty – then I am doing well.... Previously, I was the kind of a person who was good at helping colleagues and asked everybody if I could be of any help. I have changed – now I can't do that anymore.

IT12

4.5 | COVID-19 had consequences for the nurses' conduct of everyday life

The pandemic had an existential impact on some of the nurses' conduct of everyday life, affecting their priorities and choices in their everyday life and their close relations. A few nurses expressed the various ways that the situation had turned their life upside down.

The COVID-19 made me think about my whole life, the values I have, my boyfriend, my childhood... somehow, I am grateful to COVID-19 for giving me a new chance to do things differently and better... I am starting to believe in myself.

(IT2)

Some nurses experienced consequences related to their relationship with a partner. Their being on the COVID-19 team made some of the nurses' partners fear getting infected and made them keep an emotional distance from the nurse. This caused increased feelings of loneliness:

I have a boyfriend but we do not live together. My boyfriend did not want to see me. There were many of his friends and family who did not want to see me – because they were afraid of COVID-19 ... it makes me very lonely.

IT6

Others described how they chose to move away from their family. They decided to move into a hospital apartment away from the family to ensure that no family members would contract COVID-19. Living in isolation from family and children was one of the prices some of the nurses paid to work at the COVID-19 department and take care of the family at the same time.

I decided to move into a duty room. The first two or three weeks I lived there, I was not at home to see my husband or my children. It was first at Easter that I went home, because the number of hospitalized patients was decreasing at that time.

IT13

The nurses who lived away from their children shared stories about the toll it took on the children to have their mother at a COVID-19 department. Being isolated away from their mother left the children feeling unsafe and insecure about what was happening to their mother, and some did not understand why she did not come home. Some nurses talked about how their children believed their mother had been caught by COVID-19; others were confused and unable to understand the situation. Living as a single mother also caused worries and extra stress, and not all of the nurses had close relatives who could take over, which entailed fear of coming home and infecting their children with the virus.

Most of the nurses revealed the impact that working in the COVID-19 department had on their social life. The nurses who had no close relatives nearby felt so isolated that they appreciated being at work as opposed to having time off. Others were isolated because their friends did not dare see or come in close contact with them.

5 | DISCUSSION

The main finding of our study is how important voluntariness becomes in extreme situations with new challenges and responsibilities like the COVID-19 pandemic. Some nurses became particularly vulnerable in a very complex way paying the price in both their social, private and working lives. The way the nurses were recruited to the COVID-19 department played an important role in not only how they experienced their sense of self as a nurse but also in relation to their conduct of everyday life. Furthermore, working with patients infected with COVID-19 had an impact on the private life of nurses and their close relations regardless of how the nurses were selected to work in the COVID-19 department.

Our study revealed that a special solidarity developed among the health professionals in the COVID-19 department. Peer support is essential when nurses are handling stressful situations such as taking care of patients with COVID-19, and this includes colleagues from their own team and new members coming from other departments. Other studies have also demonstrated the importance of caring for each other by providing peer support and helping new members feel safe, valued and welcome as quickly as possible as elements of team support. To insure, a welcoming and open working culture is also an essential task for managers and leaders (Maben & Bridges, 2020). A review on mental health care among healthcare professionals revealed that taking care of patients with COVID-19 increases the risk of stress, depressive symptoms and insomnia. Moreover, safety of family, corrective guidance, effective safeguards and positive attitude from their colleagues were highlighted as being crucial to reducing stress (Spoorthy et al., 2020). Previous experiences from the severe acute respiratory syndrome (SARS) outbreak highlight the importance of taking care of the mental health of frontline staff to prevent post-traumatic stress syndrome over time. There is a need to provide timely psychological support and specialized care for those affected, psychiatric treatments and appropriate mental health services (Smith et al., 2020).

Our results showed that working with patients with COVID-19 had an impact on the social life of nurses who were isolated from friends and family due to fear of transmission and moreover that the participants' colleagues from other departments were also found in some cases to act with fear and social distancing. The literature similarly describes that healthcare professionals caring for patients with COVID-19 feared the risk of being infected and passing COVID-19 onto their friends and family. Furthermore, did the health professionals increasingly worry about their children being home alone because of school closures without appropriate care and support? The staff were afraid of being stigmatized as those working with

COVID-19 (Inter-Agency Standing Committee, 2020). In general, nurses working with infectious diseases are highly concerned about personal or family health in the face of coming into direct contact with a potentially deadly virus. This stresses the challenge of balancing the ethical obligations of continuing to provide care on the one hand and on the other hand, taking care of oneself and one's own family (Cai et al., 2020; Khalid et al., 2016). One study recommended that nurses with family obligations be given the opportunity to rest and spend time with their loved ones (Coskun Simsek & Gunay, 2021).

The nurses pointed out that special psychological nursing became challenging and very important when taking care of patients with COVID-19. How to build up trust and relations, and how to incorporate and work with relatives, during isolation. Our study emphasizes that when preparing isolation training in addition to the isolation regimes themselves, training must be provided to nurses on how to build relations with the patient in isolation, how to collaborate and involve relatives and how to establish communication tools when the presence of relatives is not possible. A study from Toronto in 2003 after the outbreak of SARS described the psychological and occupational impact of SARS within a large hospital and concluded that the response from health professionals required clear communication, sensitivity to individual person's responses to stress, collaboration between disciplines, authoritative leadership and provision of relevant support. The emotional and behavioural reactions of patients and staff were understood to be a normal, adaptive response to stress in the face of an overwhelming event (Maunder et al., 2021).

The importance of recognition and humiliation in our study was particularly significant. Particularly vulnerable were those coming from another department, the newly educated and the nurses who had several concerns. These nurses felt alone and ignored, which worsened their situations. An Australian study identified how nurses had experienced community members spitting on them and verbally assaulting them because of fear of COVID-19 transmission, and nurses were being directed not to wear their uniform outside the hospital (Nurses abused over COVID-19 fears, 2020). Another study from India showed that positive motivational factors such as having a supportive family and colleagues, positive and strong role models, validation and appreciation, positive caretaking approaches, knowledge and acceptance became significant. The negative factors were associated with stigma, the complicated needs of the patients and the need for clear management plans. One solution provided by the authors to overcome the negatives included setting up multidisciplinary teams and screening questionnaires to the involved healthcare professionals (Mohindra et al., 2020). This supports the notion that department heads share the responsibility and must be aware of the ethical dilemmas occurring during a pandemic such as COVID-19 (Galehdar et al., 2021; Morley et al., 2020) and that psychosocial support is needed (Kalateh Sadati et al., 2020).

The sensitivity and vulnerability among the nurses in our study could be linked to and understood in relation to the individual nurse's personality and ways of handling routines and stressful situations. A

Danish study (Nielsen & Dieperink, 2020) has described three archetypes among nurses' reactions to the COVID-19 pandemic. The authors describe the *Devoted Ones*. This category covers nurses who are devoted to the idea of compassionate nursing and making changes through action. They are strongly motivated to make a difference by caring for vulnerable and severely ill patients. The *Concerned Ones* covers the group of nurses reacting with fear. They are extremely fearful of getting sick themselves and transmitting COVID-19 to family and relatives. Some nurses in this subgroup develop stress symptoms of fear. The third group is the *Noise Makers*. This category of nurses is dominated by nurses who 'make noise'; they speak up in departments, in their private life and on social media. They discuss working conditions, salary, nurses' rights, the problems with lack of testing or lack of protective equipment and the need for visible and responsible leadership (Nielsen & Dieperink, 2020). Our findings highlight that the most vulnerable nurses were the *concerned nurses*, compared to the ones who had volunteered to the COVID-19 department and could be characterized as the *devoted ones*.

5.1 | Ethical reflections

It became apparent during the interviews and the analytical process that the participants became very vulnerable in their open and trustful sharing of perspectives, feelings and experiences. Thus, it became extremely important to obscure participants' identity and characteristics to prevent that head of departments and other colleagues would recognize any of the participants. We therefore decided not to reveal participants' identification between authors and kept all participants anonymous during the analytical processes.

5.2 | Strengths and limitations

The analytical work in the researcher group was a systematic joint analysis based on the nurses' perspectives. The joint analysis ensured a balanced interpretation of the data, and the shared data analysis involving all participants ensured consistency of the results.

The advantage of using critical psychology as an analytical approach is that it resulted in a rigorous and systematic analysis of the collected material, and it revealed how nurses experienced working during the COVID-19 pandemic in the broader context of their conduct of everyday life. Furthermore, this approach ensured a persistent focus on first-person perspectives, namely, that of the nurses.

As demonstrated in the present study, drawing on data from four different settings increased and verified findings on nurses' experiences working in COVID-19 departments, which was identified during the joint analysis of the patient interviews.

During the analytical iterative process including all authors, it became evident that the main themes appeared in all authors' material, deriving from individual and focus group interviews, and no new themes came up. However, it is always difficult to claim that data saturation has been achieved (Ness, 2015).

We aimed for diversity in terms of seniority, age and gender. This was only partly achieved, as we only included one senior nurse at the age of 59, and no nurses above 60 years of age were included. Thus, our data lack a senior perspective on the COVID-19 situation. Furthermore, our study included only one male nurse, and therefore, the gender perspective is very limited. However, as only 3% of all nurses in Denmark are men, one out of 24 nurses seems to be representative for the population of nurses in DK.

Another limitation of our study is that all authors have professional backgrounds as nurses and are formed by their preunderstanding as nurses. This could have influenced both the data collection and the analytical process, but to overcome this, we decided to do the analytical process all authors together, discussing blind spots and tacit knowledge (Asher & Popper, 2019).

Using both focus group interviews and individual interviews, we aimed at getting enriched data and understanding of the nurses' perspectives. However, it is difficult to conclude that the combination of methods added value to the data generation in other words, we might have achieved the same results using individual interviews only (Lambert & Loiselle, 2008).

6 | CONCLUSION AND IMPLICATIONS FOR PRACTICE

The findings showed that some nurses found their work with patients with COVID-19 to be inspiring and that they experienced a new solidarity with their colleagues. Other nurses found that it was stressful and had a negative impact on their conduct of everyday and professional life. Some of the consequences were exclusion and distance from colleagues, family and friends, isolation and, in the worst case, some of the nurses lost their sense of self and professional self-confidence. Close contact and support from the nurses' leaders were emphasized by all the nurses as being significant to how the conditions were experienced.

The current study highlights the importance of a regular screening of nurses involved in the care of patients with COVID-19 to evaluate stress, depression and anxiety combined with a setup consisting of supervisors and leaders who are willing to support and listen to the individual nurse's personal experiences, problems and stress related to the working conditions.

ACKNOWLEDGEMENT

We warmly thank the participating nurses for sharing their personal stories. We also thank Østifterne for financial support.

CONFLICT OF INTEREST

No authors have any conflicts of interests to declare.

AUTHOR CONTRIBUTIONS

DSN: Conceived and designed the study; collected the data, (five interviews); performed the analysis; wrote the paper. CD: Collected the

data; contributed data, (three interviews), performed the analysis; wrote the paper. LT: collected the data, (five interview); performed the analysis; wrote the paper. NBJ: Collected the data, (conducted two focus group interviews, 6 nurses); performed the analysis; wrote the paper. HMC: Contributed analysis tools; performed the analysis; wrote the paper. All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (<http://www.icmje.org/recomendations/>)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

DATA AVAILABILITY STATEMENT

The data set generated and analysed during the current study are not publicly available due to ethical reasons and protection of the participants' identity.

ORCID

Lars Thysoee  <https://orcid.org/0000-0003-0577-848X>

Charlotte Dyrehave  <https://orcid.org/0000-0003-3310-2997>

Helle Marie Christensen  <https://orcid.org/0000-0001-6783-4112>

[org/0000-0001-6783-4112](https://orcid.org/0000-0001-6783-4112)

Nanette B. Jensen  <https://orcid.org/0000-0002-7582-9919>

Dorthe S. Nielsen  <https://orcid.org/0000-0002-3954-7551>

REFERENCES

- Asher, D., & Popper, M. (2019). Tacit knowledge as a multilayer phenomenon: The "onion" model. *The Learning Organization*, 26(3), 264–275. <https://doi.org/10.1108/TLO-06-2018-0105>
- Cai, H., Tu, B., Ma, J., Chen, L., Fu, L., Jiang, Y., & Zhuang, Q. (2020). Psychological impact and coping strategies of frontline medical staff in hunan between january and march 2020 during the outbreak of Coronavirus Disease 2019 (COVID-19) in Hubei, China. *Medical Science Monitor*, 26, e924171. <https://doi.org/10.12659/MSM.924171>
- Coskun Simsek, D., & Gunay, U. (2021). Experiences of nurses who have children when caring for COVID-19 patients. *International Nursing Review*, 68(2), 219–227. <https://doi.org/10.1111/inr.12651>
- Dreier. (2008). *Psychotherapy in everyday life*. Cambridge University Press.
- Galehdar, N., Toulabi, T., Kamran, A., & Heydari, H. (2021). Exploring nurses' perception of taking care of patients with coronavirus disease (COVID-19): A qualitative study. *Nursing Open*, 8(1), 171–179. <https://doi.org/10.1002/nop2.616>
- Gilberg, F. A., & Hounsgaard, L. (2018). *Kvalitative analysemetoder i sundhedsforskning*. Klim.
- Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Sage Publications Inc.
- ICN. (2020). *Protecting nurses from COVID-19 a top priority: A survey of ICN's national nursing associations*. ICN.
- Inter-Agency Standing Committee. (2020). *Briefing note on addressing mental health and psychosocial aspects of COVID-19 Outbreak-Version*.
- Kalateh Sadati, A., Zarei, L., Shahabi, S., Heydari, S. T., Taheri, V., Jiriaei, R., Ebrahimzade, N., & Lankarani, K. B. (2020). Nursing experiences of COVID-19 outbreak in Iran: A qualitative study. *Nursing Open*, 8(1), 72–79. <https://doi.org/10.1002/nop2.604>
- Khalid, I., Khalid, T. J., Qabajah, M. R., Barnard, A. G., & Qushmaq, I. A. (2016). Healthcare workers emotions, perceived stressors and coping strategies during a MERS-CoV outbreak. *Clinical Medicine & Research*, 14(1), 7–14. <https://doi.org/10.3121/cmr.2016.1303>
- Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., Wu, J., Du, H., Chen, T., Li, R., Tan, H., Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020). Factors associated with mental health outcomes among health care workers exposed to Coronavirus Disease 2019. *JAMA Network Open*, 3(3), e203976. <https://doi.org/10.1001/jamanetworkopen.2020.3976>
- Lambert, S. D., & Loisel, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, 62(2), 228–237. <https://doi.org/10.1111/j.1365-2648.2007.04559.x>
- Maben, J., & Bridges, J. (2020). Covid-19: Supporting nurses' psychological and mental health. *Journal of Clinical Nursing*, 29(15–16), 2742–2750. <https://doi.org/10.1111/jocn.15307>
- Malterud, K. (2012). Systematic text condensation: A strategy for qualitative analysis. *Scandinavian Journal of Public Health*, 40(8), 795–805. <https://doi.org/10.1177/1403494812465030>
- Maunder, R., Hunter, J., Vincent, L., Bennett, J., Peladeau, N., Leszcz, M., Sadavoy, J., Verhaeghe, L. M., Steinberg, R., & Mazzulli, T. (2021). The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *Canadian Medical Association Journal*, 168(10), 1245–1251.
- Maxwell, J. A. (2005). *Qualitative research design* (2nd ed.). SAGE Publications.
- Moerck, L. L., & Huniche, L. (2006). *Critical psychology in a Danish contexts* (pp. 192–211). www.discourseunit.com
- Mohindra, R., R. R., Suri, V., Bhalla, A., & Singh, S. M. (2020). Issues relevant to mental health promotion in frontline health care providers managing quarantined/isolated COVID-19 patients. *Asian Journal of Psychiatry*, 51, 102084. <https://doi.org/10.1016/j.ajp.2020.102084>
- Morley, G., Grady, C., McCarthy, J., & Ulrich, C. M. (2020). Covid-19: Ethical challenges for nurses. *Hastings Center Report*, 50(3), 35–39. <https://doi.org/10.1002/hast.1110>
- Ness, L. R. (2015). *Are we there yet? Data saturation in qualitative research*.
- Nielsen, D. S., & Dieperink, K. B. (2020). Cultural perspectives and nurses reactions on the corona pandemic: A critical view from Denmark. *Journal of Transcultural Nursing*, 31(4), 333–336. <https://doi.org/10.1177/1043659620924118>
- Nowell, L., Dhingra, S., Andrews, K., & Jackson, J. (2021). A grounded theory of clinical nurses' process of coping during COVID-19. *Journal of Clinical Nursing*. <https://doi.org/10.1111/jocn.15809>
- Nurses abused over COVID-19 fears. (2020). Nurses abused over COVID-19 fears. *Australian Nursing & Midwifery Journal*, 26(11), 17.
- Petzold, M. B., Plag, J., & Strohle, A. (2020). Dealing with psychological distress by healthcare professionals during the COVID-19 pandemic. *Nervenarzt*, 91(5), 417–421. <https://doi.org/10.1007/s00115-020-00905-0>
- Schraube, E., & Osterkamp, U. (2013). *Standpoint of the subject: Selected writings of Klaus Holzkamp*. Palgrave Macmillan.
- Smith, G. D., Ng, F., & Ho Cheung Li, W. (2020). COVID-19: Emerging compassion, courage and resilience in the face of misinformation and adversity. *Journal of Clinical Nursing*, 29(9–10), 1425–1428. <https://doi.org/10.1111/jocn.15231>
- Spoorthy, M. S., Pratapa, S. K., & Mahant, S. (2020). Mental health problems faced by healthcare workers due to the COVID-19 pandemic-A review. *Asian Journal of Psychiatry*, 51, 102119. <https://doi.org/10.1016/j.ajp.2020.102119>
- Wibeck, V., Dahlgren, M. A., & Oberg, G. (2007). Learning in focus groups: An analytical dimension for enhancing focus group research. *Qualitative Research*, 7(2), 249–267. <https://doi.org/10.1177/1468794107076023>

- Yang, S., Kwak, S. G., & Chang, M. C. (2020). Psychological impact of COVID-19 on hospital workers in nursing care hospitals. *Nursing Open*, 8(1), 284–289. <https://doi.org/10.1002/nop2.628>
- Zhang, M., Zhou, M., Tang, F., Wang, Y., Nie, H., Zhang, L., & You, G. (2020). Knowledge, attitude, and practice regarding COVID-19 among healthcare workers in Henan, China. *Journal of Hospital Infection*, 105(2), 183–187. <https://doi.org/10.1016/j.jhin.2020.04.012>

How to cite this article: Thrysoee, L., Dyrehave, C., Christensen, H. M., Jensen, N. B., & Nielsen, D. S. (2022). Hospital nurses' experiences of and perspectives on the impact COVID-19 had on their professional and everyday life—A qualitative interview study. *Nursing Open*, 9, 189–198. <https://doi.org/10.1002/nop2.1053>