

# Nursing care during COVID-19 at non-COVID-19 hospital units: A qualitative study

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## Abstract

The maintenance of physical distance, the absence of relatives and the relocation of registered nurses to COVID-19 units presumably affects nursing care at non-COVID-19 units. Using a qualitative design, this study explored registered nurses' experiences of how COVID-19 influenced nursing care in non-COVID-19 units at a Danish university hospital during the first wave of the virus. The study is reported using the COREQ checklist. The analysis offered two findings: (1) the challenge of an increased workload for registered nurses remaining in non-COVID-19 units and (2) the difficulty of navigating the contradictory needs for both closeness to and distance from patients. The study concluded that several factors challenged nursing care in non-COVID-19 units during the COVID-19 pandemic. These may have decreased the amount of contact between patients and registered nurses, which may have contributed to a task-oriented approach to nursing care, leading to missed nursing care.

## Keywords

content analysis, COVID-19, non-pandemic units, nursing, qualitative, registered nurses

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## Background

The coronavirus (COVID-19) is a highly contagious disease that has rapidly spread globally, and healthcare systems have struggled to manage the increased burden of COVID-19 patients.<sup>1</sup> To prevent the spread of the virus, healthcare professionals have been guided by recommendations to practice good hand hygiene, use appropriate personal protective equipment (PPE), keep physical distance and regularly clean equipment and the environment. In addition to these recommendations, the presence of relatives at the hospital has been restricted; this has been a determining factor in avoiding the spread of the virus.<sup>2</sup> With COVID-19, the context of healthcare has changed, affecting not only nursing care in pandemic units but also nursing care in non-COVID-19 hospital units that care for non-COVID-19 patients.

Physical distancing has particularly been recognised as one of the most effective means of managing the pandemic. However, closeness to patients is one of the key features of nursing care,<sup>3,4</sup> which requires physical contact, for example, when helping patients with personal hygiene or measuring their vital parameters.<sup>5,6</sup> Furthermore, touching the patient is an essential and often unavoidable part of nursing care and a powerful tool for non-verbal communication.<sup>4,7</sup> Touch can be task-oriented, promote physical and/or emotional comfort.<sup>8,9</sup> Due to the recommendations, there is a risk that nursing care may be affected negatively, as physical contact and touch may primarily be used for

inevitable task-oriented purposes. This is the case even though registered nurses (RNs) do not necessarily choose this behaviour but are inhibited by expectations and competing priorities.<sup>10</sup> The

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fact that their work is more task-oriented than person-centred may leave RNs feeling morally distressed and dissatisfied with their work, as person-centeredness is congruent with their nursing values.<sup>10</sup> Furthermore, task-oriented care may dehumanise patients, leading to poor quality of care and major risks to patient safety.<sup>11</sup> In addition, restricted visiting hours challenge RNs' involvement and collaboration with relatives, as only critically ill patients in Denmark were allowed visits from their next of kin. These restrictions are detrimental, as involving relatives is essential when considering the individual patient's life circumstances in planning and delivering care.<sup>12,13</sup> When denied the ability to be present at the hospital, relatives were also denied the opportunity to act as a resource for the hospitalised patient by providing emotional support,<sup>14,15</sup> advocating for the patient<sup>14,16</sup> and helping to understand information and make decisions.<sup>17</sup>

Another important aspect to address is that COVID-19 units in Denmark were staffed with RNs from non-COVID-19 units. The relocation of RNs did leave many non-COVID-19 units with fewer and often less experienced RNs to care for non-COVID-19 patients. A decrease in the number and experience level of the RNs on duty increases the risk of missed care and the likelihood of patients dying during hospitalisation.<sup>18–22</sup> In summary, the restrictions and the relocation of RNs may have affected the RNs' ability to provide high-quality nursing care and to involve patients and their relatives in their care at non-COVID-19 units.<sup>23,24</sup> However, the experience of RNs working at non-COVID-19 units during the pandemic has been inadequately explored. To address this, the aim of this study was to explore RNs' experiences of how COVID-19 influenced nursing care in non-COVID-19 units at a Danish university hospital during the first wave of the virus.

## Aim

The aim was to explore RNs' experiences of how COVID-19 influenced nursing care in non-COVID-19 units at a Danish university hospital during the first wave of the virus.

## Methods

This study applied a qualitative study design. We used semi-structured interviews for data generation based on the method of Brinkmann and Kvale.<sup>25</sup> To analyse and interpret the data, inductive qualitative content analysis, according to Graneheim and Lundman, was used, as this approach allows for descriptions of the manifest content and interpretation of the latent content.<sup>26</sup> This article is presented according to the Consolidated Criteria for Reporting Qualitative Research checklist (COREQ).<sup>27</sup>

## Setting

The study was conducted at a Danish university hospital in a range of specialised medical, surgical, oncological and paediatric in- and outpatient units during the first wave of the pandemic that took place in the spring of 2020. At that time, the COVID-19 testing capacity was insufficient, and there was insecurity about the various restrictions along with an overall

uncertainty about the COVID-19 pandemic situation. During the COVID-19 pandemic, the non-COVID-19 units in this study all had to send RNs to the pandemic units. In addition, a great deal of contacts in both in- and outpatient units between healthcare professionals and patients and/or relatives were changed from face-to-face contacts to telephone contacts.

## Recruitment

Participants were purposively recruited<sup>28</sup> either during in-person interactions, by email or by phone among RNs who were working in non-COVID-19 units during the pandemic. Across all units at the hospital, 11 RNs from in- and outpatient units were invited for an interview. None of them declined to participate. All but one of the participants were females between 32 and 60 years of age. Their experience in nursing and experience in a specific specialty ranged from 5 to 33 years.

## Data collection

Data collection through semi-structured interviews took place between June and August of 2020. An interview guide was used to facilitate the exploration of the participants' perspectives on nursing care during the pandemic. The interview guide contained a starting question, 'How did the pandemic influence your nursing practice?' and probing questions, such as 'How did the restrictions related to physical distance influence your collaboration with patients?' The guide also contained suggested topics to follow up on if they were not addressed by the questions. The topics included were 'The absence of relatives and planning admissions, hospital stays and discharges' and 'Establishing a relationship'.

The 11 interviews were conducted by six female researchers from the research team. All interviewers have a PhD and are experienced in research processes. None of the researchers were involved in patient care at the non-COVID-19 units or had a daily working relationship with the participants beforehand. The interviews were recorded and transcribed verbatim. The duration of the interviews varied from 22 to 45 minutes (mean: 33.91 min). The interviews were conducted either face-to-face in a secluded room at the hospital or by telephone with only the participant and the interviewer being present. No repeat interviews were conducted. After 11 interviews, the data were assessed to provide a detailed understanding of nursing care in non-COVID-19 units during the pandemic.

## Data analysis

According to Graneheim and Lundman, data have to be sorted into content areas when using inductive content analysis.<sup>26</sup> During this process, the transcribed text was read several times to get an overall sense of the data. Data were sorted into meaning units before being condensed into manifest and latent content while looking for recurring themes. This enabled movement from 'what was in the text' to 'what the text was about', using interpretive thinking (Table 1). Graneheim and Lundman consider themes to elucidate threads of the underlying meanings and an expression of the latent content.<sup>26</sup> The analytical process is a co-creation

**Table 1.** Examples of the analytical process.

Quotations from the text	Condensed meaning units: manifest content	Condensed meaning units: latent content	Themes
We [the non-COVID-19 units] were forgotten in the beginning of the pandemic because some colleagues were relocated. We were in a situation with resignations and nurses starting their maternity leave. Furthermore, the recommendations meant that two RNs had to start their maternity leave earlier. A couple of month later we got substitutes. (ID 10)	Several RNs left the unit due to relocation of RNs to the pandemic wards and due to maternity leave and resignations. They were superseded months later.	The RNs on the non-COVID-19 units felt that focus exclusively was on the pandemic wards. They felt forgotten.	The challenge of an increased workload for RNs remaining in non-COVID-19 units
I have missed to see them together [the patient and their relative]. I have missed to see the patients as I am used to ... to sit around a table and communicate, read their body language, observe their reactions ... is hasn't been the same. (ID 4)	The RN has missed seeing the patient and having the possibility of observing the patient.	Not being physically together affects nursing care negatively as it hinders RNs using all their senses to get a more holistic picture of the patient's situation and condition.	The difficulty of navigating the contradictory needs for both closeness to and distance from patients

Note. RN: registered nurse.

between the authors and the text, and the text can be interpreted in various ways depending on the subjective interpretation.<sup>26</sup> The authors emphasised the co-creation by examining their roles and recognising their potential biases, preferences and influences on the process, making their preunderstandings more visible, which is important in qualitative research.<sup>29</sup> Two authors conducted the analysis until agreement about the essential themes was reached. This process aimed to prevent premature closure of the analysis and to support rigor.

**Ethics**

The regional Danish Data Protection Agency was notified (ID 2020-072), and ethical guidelines as well as regulations regarding data management materials were followed.<sup>30,31</sup> According to Danish legislation, the study was not in need of further ethics approval. The participants received information about the study in written and verbal formats and provided informed, written consent when agreeing to participate. To maintain the participants' confidentiality, we replaced their names with ID numbers.

**Results**

The analysis revealed two main themes: the challenge of an increased workload for RNs remaining in non-COVID-19 units and the difficulty of navigating the contradictory needs for both closeness to and distance from patients. The two themes will be explored in detail in the following sections.

*The challenge of an increased workload for RNs remaining in non-COVID-19 units*

Due to the need for experienced RNs in the pandemic units, the remaining RNs in the non-COVID-19 units were challenged in

different ways. Their units were short by one or more RNs, and they were challenged by working with less experienced RNs, as expressed in the following quotation:

We sent five RNs [to the pandemic unit] and had to cover these with substitutes. It is great to be able to get substitutes, but they did not have the same competencies as the five experienced RNs who were relocated. For example, in some evening shifts, there were only two RNs left with three substitutes to care for an entire unit of 25–30 patients. So, you are responsible for a lot of patients, and it has been hard. (ID 8)

The RNs had to be responsible for more patients than usual, which contributed to an increased risk of being unable to provide the needed nursing care and of affecting quality care and patient safety. Even though the substitutes were very helpful, the relocation of RNs contributed to a higher workload, as the substitutes' experience and competencies in the specific specialty of the unit were insufficient. This situation caused RNs at non-COVID units to express that it was important 'not to forget the units that are left behind' (ID 5). The increased workload stems from seeing colleagues relocated and feeling left behind, as well as difficulties arising from the restrictions on relatives visiting their next of kin at the hospital. Before the outbreak of COVID-19, these relatives contributed with physical as well as emotional support during patient admissions and during visits. The lack of support from relatives has resulted in RNs having 'to walk extra kilometres because the relatives often used to help with practical things, such as helping their mother or father to the toilet and things like that' (ID 7).

In addition to missing the relatives' participation in physical care, the absence of a physically present relative has required RNs to be more attentive to patients' psychosocial needs:

In many situations, they [the patients] have probably needed us more to talk to because they do not have the opportunity to unload [their concerns] onto relatives or get support from relatives. (ID 9)

This illustrates that the RNs had to spend more time with patients who needed to express their feelings and thoughts when their relatives were not allowed to visit them at the hospital, which required the RNs to be even more present and listen to the patients' concerns. Even though the RNs were aware of the patients' increased need for emotional contact, this quotation indicates that they may not have been fully able to provide attention, care and presence comparable to that of a close relative.

The prohibition of relatives' visits required RNs to find alternative ways to involve relatives in caring for patients, for example, by coordinating the patients' discharge by phone. However, this communication approach challenged the RNs to identify and address important issues and get relevant information from the relatives in order to prepare them for changes in the patients' situation:

I remember a discharge where there was a lot of communication back and forth, because she [the patient] misunderstood something, and then I had to call and make sure that the relatives actually understood. So there has definitely been an extra role for me. (ID 7)

This is an example of how RNs have had to be more aware of communication errors when preparing the relatives for managing a patient's return home. These situations could potentially have been minimised if the relatives had been able to participate in a face-to-face dialogue. In addition, sharing information with relatives over the phone has required RNs to spend more time assuaging the relatives' worries and offering information in lieu of the ability to be near their next of kin:

Many relatives had to check up and make sure that the patient was okay ... You cannot explain properly over the phone, and it has been difficult for them [the relatives] because they needed to see the patient with their own eyes to confirm they were okay. Sometimes we have had to take the patient to an open window for five minutes where he/she could talk with their relative, who would stand outside. (ID 10)

As illustrated, alternative ways to establish a meeting between the patient and his/her relative were used, even though this added to RNs' workload. Although the RNs experienced more telephone contact with relatives compared to usual practice, an interesting reflection was expressed by an RN:

I wondered about talking with someone on the phone versus talking with them face-to-face. In our busy department, we do not have enough time to actually establish a relationship with the relative because it might be in the middle of a shift and they do not have an appointment. The telephone, however, actually set the frame for the conversation in a different way. As an RN, you have been forced to concentrate on the phone conversation to a different degree. (ID 7)

This shows that telephone calls could frame the conversations with relatives and make the RNs more focused on the conversation and the relatives' verbal expressions. However, the RNs expressed that they were unable to observe body language or how the relative was doing, as they would have been able to do in a face-to-face conversation. The RNs agreed that establishing a relationship with the relatives was easier in face-to-face contacts. However, this quotation also illustrates a discrepancy: even at times when the relatives could be present, the RN did not always engage in conversation with them. Hence, the RNs' focus on relatives could be disturbed by busyness in the unit, the fact that conversations often were without appointments and the fact that they often took place in the hall or in a doorway. Regardless of the framing of the conversation, the RNs described remembering to call the relatives as an extra assignment.

Besides compensating for the lack of relatives, the RNs described how they needed to step in for interdisciplinary colleagues because liaison psychiatry, the Danish Cancer Society and the social counselling department were shut down during lockdown:

In terms of assisting the patient, our social workers would not visit the patient in person. They have been assisting by phone or email, and that does not work equally well for all. So, we have had [their job] too. Also, the patient who had consultations twice a week with liaison psychiatry was suddenly, from one day to the next, ended. (ID 8)

This shows how RNs had to act as social workers, psychiatrists and cancer counsellors as well as RNs because patients were unable to get their usual help from other healthcare groups. In addition, the ability to refer patients to other relief measures was restricted, which added more responsibility for the RNs and may have resulted in unmet needs for patients, and missed care.

### *The difficulty of navigating the contradictory needs for both closeness to and distance from patients*

In general, the COVID-19 pandemic has required RNs to keep a distance from their patients in order to prevent transmission of the virus in case a nurse or a patient was infected. This created a dilemma between closeness and distance that affected nursing care in several ways.

Because of the COVID-19 pandemic, many face-to-face consultations became telephone contacts at both in- and out-patient units. One effect can be seen below, when a patient received a serious answer over the phone:

You can't see the patient's body language, which is necessary in nursing. It's from the body language that we pick up cues. The patient may be at home alone and trust in authority such that they don't ask questions when a physician delivers a message ... In addition, patients are expected to describe their wounds, but the patient sees one thing, and we are looking for another. (ID 4)

This quotation illustrates that delivering a serious message over the phone and making adequate observations based on the patient's description was challenging, as the RNs only had their sense of hearing to rely on. During a telephone conversation, RNs were unable to use their other senses to get a picture of the patient's actual situation and respond to the patient's physical and psychological needs. However, even when care was delivered face-to-face, the COVID-19 situation challenged nursing care, as one of the requirements was to keep a distance from the patient:

We don't shake hands anymore. I shake hands to feel if they [the patients] are warm, dry or sickeningly sweaty. Now, I must make these observations in other ways. (ID 2)

In addition to welcoming patients, shaking hands assisted the RNs in observing patients' conditions by using diverse senses, such as the sense of touch. However, using this sense was impeded, and the RNs had to learn about the patient's condition in other ways. Although touch was perceived as a crucial part of care, the pandemic and the risk of transmitting the virus influenced how they experienced touch, when touching was unavoidable:

The pandemic caused a reluctance to touch patients, and this was very unpleasant because a great deal of our work is to touch other people. We help them get out of bed, hold their hands when they are sad and hug them when they are unhappy. In our work, we need to be close to people. Suddenly, we were not allowed to do this anymore. This created quite a disgusting distance, and the relationship to others [patients] became strange and affected. Every time I touched somebody, I thought about how we might have just infected each other. (ID 2)

This illustrates that touch helped the RNs make patients feel well and comfortable and was thus an important part of nursing care. However, the meaning of this practice was altered during the pandemic, as RNs were worried about becoming infected and transmitting the virus to patients. Some RNs said that avoiding touch was unnatural and that this avoidance affected their job satisfaction, as they considered it to be a core element of nursing care. Consequently, they were forced to establish relationships at a distance, which 'may have affected the relationship' (ID 5).

Although the RNs worked on non-COVID-19 units, they nursed patients who were potentially infected with COVID-19. In these cases, the RNs wore full PPE, which also challenged the relationship with patients and contributed to making nursing care unpersonal, since it affected patients' ability to see the RNs' facial expressions:

It is a problem that the patients are unable to see my face. I need to speak more clearly as some of the conversations are very serious. I really try to specify what I am talking about. [Wearing a mask] is like sending an SMS, where you can't hear the tone. I think it is difficult, and sometimes more explanations are needed. (ID 10)

This signified that the RNs needed to change their verbal and non-verbal communication when using PPE, since patients might have difficulty hearing and understanding what was said and reading the RNs' non-verbal cues and facial expressions. This increased the risk of misunderstandings and could potentially reduce patients' comfort and well-being. In addition, wearing PPE affected the RNs' well-being and thereby contributed to reducing the contact between patients and RNs:

It has been difficult to wear PPE because it is hot, and my glasses steam up. Contact with patients is reduced. It is time-consuming to put on all this equipment. (ID 10)

This shows that wearing PPE had negative consequences for the RNs in terms of discomfort and time spent dressing and undressing. Furthermore, wearing PPE also had consequences for the patients, as RNs reduced their contact with them, which may have affected the RNs' ability to identify the patients' fundamental needs and to observe their condition. Helping patients with fundamental care needs is a central dimension of nursing care that often requires physical closeness to patients. Although the guidelines concerning COVID-19 recommended distance, nursing care requires a balance between closeness and distance as described in this quotation:

We wash them [the patients]; we dress their wounds; we help them with their compression stockings. We have physical contact in several situations ... Sometimes, we have patients who get a respiratory illness. At one point, we were not allowed to give inhalation medicine because they cause too many airborne drops. It was an unpleasant experience, as this was usually the first choice of treatment for patients having trouble with breathing. (ID 3)

In situations where the patients' suffering required RNs to make prompt care decisions and when patients had low self-care capability, the distance restrictions forced RNs to change daily practices, making them uncertain about how to care for patients without risking infection with COVID-19. Although the RNs were frustrated by the risk of infection, they sometimes forgot the distance requirements when they were caring for patients:

When you are with the patient, then you sometimes forget, because I can't help with an ostomy or insert a drip from two meters. I need to do my job as good as possible, and then there may be a risk, but it is how it is. However, I have noticed that some patients get worried if I come too close. When I have had to touch a vein gateway, some patients have turned their heads. (ID 9)

The fear of infection and/or transmission of the virus has contributed to an altered and challenging nursing care practice. Constantly maintaining distance from patients is not feasible because nursing care is situational and requires activities that necessitate closeness to patients. However, this was a concern for both RNs and patients.

## Discussion

The aim of the study was to explore RNs' experiences of how COVID-19 influenced nursing care in non-COVID-19 units at a Danish university hospital during the first wave of the virus. The analysis resulted in two themes that illustrated how RNs navigated a challenging nursing care practice.

The workload and mental health of RNs who treated patients suffering from COVID-19 have been claimed to be significantly worse than RNs who were not caring for COVID-19 patients.<sup>32</sup> Our study demonstrated that nursing care and RNs caring for patients in non-COVID-19 units were also affected, as fewer and sometimes less experienced RNs were left to care for patients. A study by Aiken et al.<sup>22</sup> showed that an inadequate number of RNs on duty might lead to missed care, such as a reduction in comforting and talking with patients, as well as teaching patients and their relatives how to manage care after discharge. Other studies confirmed that a higher workload seemed to be associated with adverse patient outcomes, even though the evidence base is not sufficient to identify safe staff thresholds across different types of departments.<sup>33,34</sup> Our study revealed an increased workload for the RNs in non-COVID-19 units, as there was a reduction in the number of RNs, and the RNs had to undertake some of the physical and psychosocial support that relatives or other healthcare initiatives previously provided. Due to the relocation of experienced RNs, the remaining RNs probably had to care for more patients than usual as the substitutes had fewer patients assigned to them, depending on their competences. The remaining RNs also had to coordinate all work on the units and concurrently guide the substitutes in addition. If the working conditions of RNs in non-COVID-19 units are not addressed, the risk of burnout, leading to sick leave, may increase among RNs. Our findings, therefore, indicate that it is important to consider RNs' working conditions in non-COVID-19 units to avoid burnout. Kakemam et al.<sup>35</sup> demonstrated that higher levels of burnout were correlated with a higher number of adverse patient events and a reduced quality of care. This is supported by a systematic review in which most of the studies showed a relationship between burnout and reduced patient safety.<sup>36</sup>

In our study, RNs in non-COVID-19 units were exposed to COVID-19 due to the fact that testing capacity and PPE supplies were inadequate. This affected the RNs negatively; they feared being infected or infecting others, and this created a distance between the patients and the RNs. This two-sided fear was demonstrated by Sampaio et al.<sup>37</sup> to be the only predictive factor for depression, anxiety and stress that could be directly related to the COVID-19 outbreak. It might be challenging to prevent this fear, since nursing care often requires close interactions with patients during care-related activities, such as bathing and wound care, as described in our study. Therefore, our study illustrates a concern that care interactions in general might become affected due to a reduced length of contact, which could be a consequence of the precautions and the discomfort of wearing PPE. Because of these precautions and discomforts, the RNs always considered carefully whether it was necessary to enter a patient's room to care for the patient. A potential risk of this behaviour is that RNs'

contact with patients became task-oriented, which is inappropriate, given the associated risk of missed care when the nurse's goal is the task rather than the patient, resulting in poor quality care and more complaints from patients.<sup>11</sup>

As demonstrated in our study, the COVID-19 pandemic has severely affected the way patients and RNs communicate with each other. Precautions to limit the spread of the virus have required a shift in the communication paradigm when it comes to greetings and handshakes. RNs have been asked to adopt solutions that do not employ physical contact, which is unnatural. For example, shaking hands was part of a set of values for establishing a relationship between patients and RNs. Furthermore, using the sense of touch helped RNs assess whether the patient was, for example, warm and dry or sweaty and sick. In general, touch is an essential part of nursing care and a way of communicating attention, sympathy, closeness and presence<sup>7,38</sup> and helps establish a trusting relationship between RNs and patients. Hence, this may be inhibited when RNs were not allowed to, for example, shake hands and when touch in general was limited due to distance requirements. This also shows the pervasive influence of COVID-19 on non-COVID-19 units. In addition, wearing PPE, such as face masks, severely affected interpersonal communication when patients could not see the RN's face. This is in agreement with the study by Mheidly et al.,<sup>39</sup> which suggested that face masks muffle sounds and cover facial expressions that ease comprehension during conversations and may therefore affect nursing care significantly. As a result of the demands of social distancing, the number of telephone calls increased, which affected the ability to see the patient's face and their non-verbal expressions. According to Pedersen et al.,<sup>40</sup> this may harm the quality of nursing care because RNs feel limited by only using their auditory sense and not what they call the 'clinical eye', which they normally use to deduce patients' situations. Our findings therefore suggest that the RNs' usual understanding of what characterises good nursing has been challenged by the pervasive influence of COVID-19 and, consequently, that RNs must redefine how they can provide high-quality nursing care.

## Limitations

For the sake of the trustworthiness of this study, data collection and analysis are presented transparently and systematically to demonstrate the analytical process and that the findings are based on the participants' views. Consistency and trustworthiness were achieved through the researchers' continuous discussions of each step in the analytical process until consensus was reached.<sup>29</sup> However, the data only imply one meaning, as it is the researchers' interpretation of the most probable meaning that is presented.<sup>41</sup> An increase in the number of authors taking part in the primary analysis (and not only later in the analytical process) may have improved the analysis, as the authors' interpretive repertoire may have varied.<sup>41</sup> Still, all authors in this study are experienced qualitative researchers.

Other potential limitations are concerned with the number of interviewees, which may have decreased the depth of the interviews, as knowledge from one interview was not necessarily added to the next interview. Content analysis emphasises variation in content and multiplicity,<sup>29</sup> and we perceived that the data from the 11 interviews covered a significant variation of

the RNs' experiences of nursing care in non-COVID-19 units. Data saturation was obtained, and further data collection seemed redundant. Member checking was not performed, as the analysis involved a synthesis of all data, and it was unlikely that the participants would recognise their own stories.<sup>42</sup>

## Conclusion

This study presents RNs' experiences related to nursing care in non-COVID-19 units at a Danish university hospital. Several factors made nursing care challenging during the first wave of the COVID-19 pandemic. Due to the relocation of colleagues to other units and the inability of relatives to visit, the RNs' areas of responsibilities were expanded, resulting in an increased workload. They had to redefine their ways of providing nursing care. This led to an increased use of telephone-mediated care, limiting the ability of RNs to observe patients' body language and to use touch for observation or support. The study also demonstrated that continuously keeping a physical distance was infeasible, as care often requires closeness to patients. However, closeness induced a fear of virus transmission to or from the patient, which led to additional distance between patients and RNs. Furthermore, wearing PPE may have decreased the amount of contact, which, in addition to the restrictions, may have contributed to a task-oriented approach to nursing care, leaving patients with unmet needs. This study contributes with knowledge that may strengthen future pandemic preparedness in uninfected units and reduce the risk of inadequate care. In addition, this study may help address the risk of burnout among RNs in non-COVID-19 units if a new pandemic should arise.

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## Author contributions

The study was designed and conducted in collaboration with researchers affiliated to the Clinical Nursing Research Unit, Aalborg University Hospital, Denmark. LJ, BP, BL, CBT, HH and KB conducted the interviews. LJ and KB primarily analysed the data and drafted the paper. All authors contributed to revising and approving the paper that presents the original results of the research.


## Conflict of interest


The authors declare that there is no conflict of interest.

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## Supplemental material

Supplemental material for this article is available online.

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