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EMPIRICAL RESEARCH QUALITATIVE

Psychological impact of COVID-19 on nurses caring for patients during COVID-19 pandemic in Gaborone

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Abstract

Aim: Nurses as front liners have direct contact with COVID-19 patients during the pandemic. Carrying the heavy burden during the pandemic has a mental health toll on healthcare professionals. The study explored nurses' experiences of psychological distress during the COVID-19 pandemic in Botswana's two COVID-19 special care centres.

Design: The study used qualitative case study research to solicit nurses' experiences caring for patients with COVID-19 in selected COVID-19 centres in Gaborone.

Method: Researchers purposively recruited nurses from two COVID-19 centres in Botswana. Data were collected using semi-structured telephone interviews and analysed through inductive thematic analysis. Various institutional review boards ethically cleared the study.

Results: Six themes emerged from the thematic analysis: feelings of fear and anxiety, hopelessness and helplessness, loneliness, physical distress, support mechanism and commitment to care.

Public Contribution: The results offer important insights into the nurses' experiences during the COVI-19 pandemic.

KEYWORDS
COVID-19, experiences, nurses, mental health, botswana

1 | INTRODUCTION

Pandemics are generally a source of psychological distress due to the panic and distress they bring upon people (Rathod et al., 2020). Studies have documented a trail of disasters in previous pandemics, such as Middle East Respiratory Syndrome (MERS), Severe Acute Respiratory Syndrome (SARS), Ebola and others (Afolabi et al., 2021). The ongoing COVID-19 pandemic has affected and killed many people globally and threatened to collapse the global economy (Mishra, 2020). The heavy burden of the pandemic was more felt in the healthcare sector as the struggle to protect the public and prevent the spread of infection stretched the resources thin. Furthermore, healthcare workers worldwide were left with having to fight the virus with limited resources, and therefore they lived in fear of contracting and dying from the virus (World Health Organisation, 2020). In addition, there was an increased workload emanating from the fact that COVID-19 clients were critically ill and needed more attention than regular clients. As a result, nurses were doing work beyond their job description, and some were infected and in isolation centres, just like the rest of the public (Kader et al., 2021). The current study explored the psychological impact of COVID-19 on nurses caring for patients during the ongoing pandemic.

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2 | BACKGROUND

The end of 2019 saw the emergence of a new virus, COVID-19, in Wuhan City, Hubei Province, in China (Zhu et al., 2020). When it became clear that the virus had spread to most cities in China, on 30 January 2020, the World Health Organisation (WHO) declared COVID-19 a public health emergency (WHO, 2020). Furthermore, by March 2020, WHO characterised COVID-19 as a pandemic considering its worldwide spread level (WHO, 2020).

The ongoing COVID-19 pandemic has left a disaster trail and killed millions. According to the University of John Hopkins (, 2021), as of 08 February 2021, 106 million people have been infected by COVID-19, 2.3 million have lost their lives globally, 26 million have active COVID-19 and 78 million have recovered. By January 2021, Africa had registered a total of 3.6 million cases, 94 thousand deaths and 3.1 million recoveries (African Union, 2021). Southern Africa was the most affected region, with at least half of the total COVID-19 reported cases at about 1.7 million and 51 thousand deaths. South Africa accounted for more cases in Southern Africa, with 1.5 million cases, followed by Zambia with 61,427 infections, and the remaining countries were below 60 thousand cases (African Union, 2021). It is worth noting that at least 1.5 million people have recovered from COVID-19 as of writing this article.

Botswana confirmed its first case of COVID-19 on 30 March 2020 (Ministry of Health and Wellness (MoHW), 2020). As of 02 April 2021, Botswana had 39 313 registered COVID-19 infections, with 36,745 recoveries, 1952 active cases and 616 fatalities. About 2397 foreign nationals with COVID-19 infections got transferred from Botswana to their respective countries (Botswana COVID-19 case report, 2021). The MoHW designated healthcare professionals to Sir Ketumile Masire Teaching Hospital (SKMTH) for treatment and containment of COVID-19. As numbers increased, other healthcare facilities were designated as COVID-19 specialised areas across the country.

Pandemics generally bring panic and overwhelming fear during and after they have passed, leading to psychological outbreaks such as depression, panic disorders and anxiety (Rathod et al., 2020; Van Bortel et al., 2016). Previous research has shown that healthcare professionals working during epidemics such as SARS (Chong et al., 2004; Lau et al., 2006), MERS (Chong et al., 2004; Kim et al., 2018) and Ebola (Jalloh et al., 2018; WHO, 2016) highlighted acute stress disorder, anxiety, adverse psychological effects, general mood disorders, post-traumatic stress disorders (PTSD) and both short- and long-term psychosocial consequences on the public.

Similar results have been reported globally. For example, a study from China reported depression, anxiety, insomnia and some form of psychological distress among healthcare workers working with COVID-19 patients (Lai et al., 2020). The same study also found that mental health symptoms were more severe in nurses, other frontline healthcare workers and mostly women. Also, about 45% of the adult population in China reported stress and anxiety (Duan & Zhu, 2020). One study in Ghana showed that the prevalence of depression, anxiety and stress among health workers was 21.0%, 27.8% and 8.2% respectively (Oforil et al., 2021).

Nurses constitute the majority of healthcare providers and are among the most involved in fighting COVID-19. Furthermore, they provide direct holistic care to all types of patients and therefore that could expose them to psychological distress, job stress, mental distress (Rossi et al., 2020; Gorbalenya, 2020; Eghbali et al., 2020) and attempted suicide (Shen et al., 2020) compared to other healthcare workers during the pandemic.

Studies have paid attention to the psychological problems of nurses and the urgency of providing psychological care for them (Chen et al., 2020). However, according to our searches, no studies have been published about the psychological experiences of nurses giving care to COVID-19 patients in Botswana. Therefore, this study explored nurses' experiences of psychological distress during the care of patients with COVID-19.

3 | DESIGN AND METHODS

A qualitative case study approach was used, and data were collected and recorded using semi-structured interviews with nurses caring for COVID-19 patients in Gaborone, Botswana. Qualitative research allows people to describe phenomena in their context and emphasise the richness of the data as described by participants (Daniel, 2016). The study received approval from the institutional review boards of the University of Botswana (UBR/RES/IRB/BIO/290), MoHW (HPDME: 13/18/1), Greater Gaborone DHMT (GGDHMT 6/8/5 1 (16)) and SKMTH (SKMTH 01/11).

3.1 | Participants and study sites

The study was conducted at two healthcare facilities that provided specialised services for COVID-19 patients; Block 8 clinic and SKMTH in Greater Gaborone District Health Management Team (DHMT). Block 8 clinic had 14 nurses, while SKTMH had 59 nurses at the time of data collection. Gaborone was the most affected area with a high number of COVID-19 cases (Botswana COVID-19 Case Report, 2021). Nurses with at least 1 month of experience caring for patients with COVID-19 were targeted for inclusion in the study. COVID-19 was a new disease, and it was believed that nurses with at least 1 month's experience would be in a better position to express how COVID-19 had affected them psychologically.

3.2 | Subject recruitment/sampling

The study targeted 83 nurses that were working at the two study sites. Purposive and convenience sampling were used to select twelve (12) participants from SKTMH and eight (8) from Block 8 Clinic who were available and willing to participate in the study.

3.3 | Procedures

The researchers contacted the gatekeepers (Nurse in charge) of the facilities, explained the study's purpose and requested their clinic staff's participation in the proposed study. The gatekeepers then explained the study to the potential participants, and the recruitment of study participants started with the help of the nurse in charge and human resource officers in the two COVID-19 facilities. Those willing to participate in the study forwarded their names to gatekeepers, and the list was used to contact participants. Participants received an explanation of the study's purpose that participation was voluntary, and they consented verbally over the phone to participate and to be recorded. Participants were assured of confidentiality that codes would be used instead of their names and that recordings would be stored on a password-protected computer. The semi-structured interview guide was pilot-tested, and modifications were made to guide how probing and follow-up questions would be done.

3.4 | Data collection

Semi-structured interviews were conducted via telephone and recorded on Microsoft Teams due to COVID-19 protocol measures that were in place that restricted face-to-face contact. The interviews started following approval from the relevant ethical review boards (Ministry of Health and Wellness (HPDME 13/18/1), (University of Botswana), SKMTH (SKMTH 10/11) and Greater Gaborone DHMT (GGDHMT 6/8/5 1 (16))). The consent was obtained again from the participants before the interviews. Researchers KK, EN and OT conducted the interviews in English between March and May 2022. The researchers explained the study's aim and process to potential participants by phone, and an interview date was set with each participant. During the interview, demographic information such as age, gender, marital status, education level, religion and length/time working with COVID-19 patients was obtained.

One central question asked was, 'What was your experience with giving care to COVID-19 patients?' The question was followed by a set of semi-structured pre-determined open-ended questions that prompted the discussion further by probes for clarification and an in-depth understanding of the participants' experiences. Interviews were recorded with the participant's permission, and online recordings were transcribed within 2 days by the interviewer. Unfortunately, two (2) participants could not be reached during data collection. The study reached data saturation at participant 12; two (2) more participants were interviewed to confirm the informational redundancy of themes. The researchers conducted one interview per day. The interviews lasted between 25 and 45 min.

3.5 | Data analysis

Data were analysed using inductive thematic analysis, as described by Braun and Clarke (2006). The three researchers independently and repeatedly read and re-read the transcripts to make sense of the whole and coded responses using the initial codes. The implicit data within the statements were identified and analysed. Important statements in the interview texts were selected, restated and expressed in categories. Initial coding was commenced to identify codes in the transcripts and compare data readings to identify emerging themes through inductive thematic analysis. The identified themes were discussed, coded and a consensus was reached and validated until a final agreement.

Rigour was observed using Lincoln and Guba's framework through the criteria of credibility, dependability, transferability and confirmability (Lincoln & Guba, 1985). The study achieved credibility through researcher triangulation, which included multiple reviews of the researchers' audio recordings, comparing the data readings and identifying emerging themes. Dependability was achieved by clearly documenting the research plan and process and reporting the study based on the consolidated criteria for reporting qualitative studies (COREQ) (Tong et al., 2007). Transferability was ensured by describing the research setting, study participants and a thick data description, including quotations. Finally, confirmability was ensured by documenting all the research procedures.

4 | RESULTS

The results are categorised into nurses' demographic profiles (Table 1) and the Themes identified (Table 2).

Six themes were identified (Table 2) 'Feelings of fear and anxiety', 'Hopelessness and helplessness', 'Loneliness', 'Physical distress', 'Support mechanism' and 'Commitment to nursing care' and 11 sub-themes.

4.1 | Feelings of fear and anxiety

The nurses reported having fear and anxiety about the possibility of contracting the disease and infecting family members.

> What if I get infected and pass it on to my family, who will take care of us, what if we all die
>
> N08

The nurses reported that COVID-19 is a frightening, new, unknown illness. The participants experienced anxiety as they witnessed patients dying daily. The loss of patients and other staff members through death aggravated their fear of dying. As patients died, they were concerned about their survival.

Some had this to say:

> I was a bit anxious and frightened. As you know COVID-19 was a new disease. Not knowing what to do
>
> (NO4)

TABLE 1 Demographic characteristics of the participants

Age	Gender	Marital	Level of education	Months of experience
37	M	S	DP	24 months
32	M	S	DP	12 months
24	F	M	Degree in nursing	9 months
54	F	M	DP	24 months
31	M	M	DP	11 months
24	M	S	Degree in Nursing	11 months
30	F	S	DP	9 months
27	F		DP	16 months
25	F	S	Degree in nursing	10 months
32	M	M	DP	16 months
41	F	S	Degree in nursing	10 months
27	M	S	DP	18 months
35	F	S	DP	24 months
55	F	M	Diploma in nursing (midwife)	24 months
Mean age 33	Female 8 Male 6		All Christians	

Abbreviations: DEG, Degree in Nursing; DP, Diploma in nursing.

Note: A total of 14 participants were interviewed. The sample comprised eight females and six males, aged between 24 and 55 years, with a mean age of 33. The duration of work when caring for COVID-19 patients ranged from 9 to 24 months.

TABLE 2 Main theme and sub-theme categories

1. Feelings of fear and anxiety
1.1. Fear of contracting COVID
1.2. Fear of transmitting COVID to family
1.3. Feeling of depression
1.4. Fear of patients and relatives
2. Feeling of hopelessness and helplessness
2.1. Feeling of powerlessness
2.2. Situation beyond control
3. Feeling of loneliness
3.1. Feeling of isolation
3.2. Stigma and discrimination
4. Overwhelmed by physical distress
4.1. Overwhelmed with the workload
4.2. Prolonged working hours
5. Need for support mechanisms
5.1. Provision of physical support
5.2. Provision of psychological support
5.3. Provision of spiritual support
6. Commitment to nursing care
6.1. Professional obligation
6.2. Learning new things
6.3. Provision of quality care

> We didn't know much about COVID-19. So, there was so much speculation that when you get the infection you are going to die. The fear came from that, who wants to die, we were in same pool with some people who didn't know what to do, and were looking up to us to care for them
>
> (N04)

The constant fear of contracting COVID-19 caused distress among the nurses. One participant fell into depression and was on antidepressants. Other participants reported dealing with difficult patients who became violent, which was traumatising for them.

> I was most of the time overly concerned about being infected by COVID-19 and that added more stress to me. I feared my fellow colleagues. Eventually, I got infected and that alone made me live in fear every day. Especially more so I knew what COVID-19 can do to patients. Generally, I was scared for my life.
>
> (N02)

> It was traumatic for me because post-COVID-19, I fell into a deep depression. I was on medication for about 3 months, Antidepressants. The whole thing in itself was very traumatic. It was very traumatic for me.
>
> (N03)

Other nurses reported that patients exhibited aggressive behaviours towards them due to their perception that they did not have COVID-19.

> As time went on more people tested positive for COVID-19, there were many admissions and things

> started getting tough, some patients were admitted against their will such as truck drivers, and they really gave us a tough time, as they would really get aggressive/saying they tested negative in their country why are the tests here turning positive, and because of that they will become very uncooperative to a point of threatening to beat us, and this was very scary, we were always scared of being assaulted, as they also threatened to burn down the hospital with their gas cylinders, and some will abscond
>
> (N08)

4.2 | Feeling of hopelessness and helplessness

Recurrent themes included a feeling of helplessness and hopelessness brought by the pressure of having to provide care, inadequate resources and work overload.

> Ah it was ...Let me say the way people were dying from it, it was very ... we are human beings. It was causing us a lot of stress to deal with COVID-19 patients and sometimes at times oxygen will be limited. And it was not a good thing to see patients suffering.
>
> (N06)

> I think with normal wards, say medical ward you will experience one or two deaths in a day or two days. That one is very easy to deal with. Now with a pandemic such as COVID-19 where you can see 8 to 10 people die. I don't think anyone was ever ready to deal with that. You know you give care with the hope of seeing people go home, umm but with COVID-19, you just knew they could change within a second and one could just die and it was very hard. It was very hard. I don't think it can be compared to a normal ward. With a normal ward patients are there and with COVID-19, patients were there constantly on oxygen and you know that was the only thing that was keeping them alive.
>
> (N03)

Others reported feeling helpless as they had to break the bad news to the families and see patients die without knowing how to help them.

> It was more difficult to deal with the family members, especially having to break the sad news. You also had to deal with the relatives of the patients.
>
> (N05)

> Seeing patients die because of lack of oxygen. It was too much. That really affected us.
>
> (N06)

> It was frustrating and very stressful; because that was beyond our control.
>
> (N01)

4.3 | Feeling of loneliness

The participants reported being lonely since they were in isolation and visitors were not allowed. In addition, the participants felt victimised and discriminated against because of working in the COVID-19 facilities.

> I was stressed. I felt stigmatised by my family and this affected me. People were asking us a lot of questions that I did not have answers to. It was just painful and I felt isolated.
>
> (N02)

> Another challenge. I can say it's something like stigma... discrimination. When you knock off from the COVID-19 isolation center and you are on uniform, the people knew that you are from isolation center. They know that you are from caring for COVID-19 patients. Taxi drivers will not stop and would say you will take the next taxi. They knew that you were from COVID-19 isolation center. So, we were not welcome in their taxis.
>
> (N13)

4.4 | Overwhelmed by physical distress

Participants reported being pressured and experiencing work overload.

> Most patients came when the illness or their conditions worsened and there was too much to do. We had a lot of work to do.
>
> (N05)

> We were supposed to start 7 to 7, but we will stretch because the patients were many, and the staff was limited.
>
> (N14)

Additionally, a lack of knowledge on using PPE added to the physical distress. Participants reported discomfort with prolonged use of PPE, such as difficulty breathing and pressure around the nose because of the N95 mask. Lack of knowledge on PPE use also puts pressure on nurses caring for COVID-19 patients.

> Protective clothing was very uncomfortable for an 8hr shift. It was also challenging because we were not

> taught how to use it very well especially for a long time that made us very uncomfortable.
>
> (N01)

4.5 | Need for support mechanisms

Participants in this study expressed the need to be provided with physical, psychological and spiritual support. The support was from the hospital and clinic management, family members and social workers. There was a general feeling that though the support was provided, more could have been done.

One of them states that:

> From the clinic initially, we were provided with transport during lock down but it was short-lived. Other than that, there was nothing.
>
> (N02)

Other participants indicated that they received support from their management.

> Moral support from the management was encouraging. We also received counselling from the social worker. It was not enough, but it was better than nothing.
>
> (N02)

> We had a counselling office, where we dropped in to talk to someone. There was support from management. They gave us almost anything we needed. There were so many educational materials. Hand washing was also encouraged.
>
> (N03)

Other participants reported that they received support from family members and friends.

> My family was very supportive though they were scared. Like when the pandemic started, we knew that there was COVID-19, but we didn't know how dangerous it was. But my family was very supportive through it all and during the depression phase.
>
> (N03)

Even though some form of counselling was offered, participants indicated that it was not enough and did not help that much. For those who received support, it was offered in another facility far away from their facilities, and they felt it was discouraging.

> There was counselling. And at times, group counselling and individual counselling. But uh, it didn't help you that much. The problem continued. COVID-19 continued
>
> (N01)

> Counselling was provided, and the counsellors tried their best to counsel you, but the situation remained the same. More people continued to die
>
> (N04)

> There was counselling provided at another facility at the beginning, but now a social worker is available at the facility
>
> (N06)

Most participants reported that counselling was mainly for patients and that nothing was implemented for them. However, the participants reported how they felt they could have been supported during the peak of the COVID-19 pandemic. The support participants needed ranged from psychological, monetary and spiritual resources.

> May be from the spiritual side. We were not getting much of it. We needed spiritual support. May be it could have helped.
>
> (N08)

> Counselling should be provided within the health facility where one is working, not having to go to another facility like what happened when the pandemic started.
>
> (N06)

> May be if we had psychologist I guess. Because at the time I guess a lot of us needed someone to talk to. Instead of having to get through the phase and get the help after. I think that would have been really great.
>
> (N03)

Although participants appreciated government efforts in providing PPE, some felt they should be given some incentives and risk allowance.

> I think it was going to be motivating if we were given incentives, umm, for those working directly with patients like risk allowance and availing necessary protective clothing all the time. And, of course, giving us that skilled counselling almost every day. That was going to be much better.

> It will be better if we were supported with accommodation so that we don't pose a risk to our families. It would have been best if were transported so that we did not have use public transport
>
> (N06)

However, some reported that they were initially provided with accommodation and transport, but it was short-lived.

> From the clinic initially, we were provided with transport during lockdown, but it was short-lived.
> (N02)

> Initially the clinic provided all nurses with transport during lockdown and was stopped, this was very demoralising because it was the only incentive we had
> (N014)

Others emphasised that they just needed to be appreciated.

> Appreciation from management and the public would have been enough. But at times we mostly received criticism
> (N03)

> The other thing is just to be appreciated. I wish we could have been given some time off by our employer just to appreciate that we were there. Sometimes we did long hours without any time off. Government can do more. A lot of people lost their lives we are lucky to still be alive.
> (N02)

4.6 | Commitment to nursing care

Despite the challenges experienced, nurses expressed passion, empathy and commitment towards their patients. In addition, they had a sense of duty which motivated them to provide care.

> With COVID-19, we were advised to reduce contact time with patients to reduce the risk of getting infected. However, as a nurse, this is not possible because certain procedures require time and continuous monitoring
> (N08)

> Patients didn't have to wait. The moment they called, they knew they will be attended to. We tried in a period of 8rs to give them the maximum amount of care as quickly as we could. We made sure they were as comfortable as they could. Umm we made sure that we clean and anybody could appreciate that. All of us were hard working
> (N03)

> You know with COVID we had to spend a maximum of 2hrs with the patients but sometimes it was impossible. Because at times you had to bath over 5 to 6 patients and you had to make sure that you squeeze in all of that within 2 hrs so it was impossible. So, the time spent with the patients depended on the tasks that had to be done which means we spent more hours with patients
> (N03)

Even though they were anxious, nurses said they encouraged and prayed with patients who were anxious and afraid of death, which comforted them.

> Sometimes they asked that I read Psalm 23 for them or a verse in the bible. Although some would die, it was reassuring that you were there for them
> (N014)

The nurses motivated themselves and felt obliged to care for the patients as it was their calling. They felt they had no other choice but to serve people.

> You cannot say I am scared I can't go in even if they are struggling to breath, you have to be there for them. Yet you know that I am scared of this virus, but now you have to take care of someone who's already positive.
> (N013)

5 | DISCUSSION

The study explored nurses' experiences caring for COVID-19 patients in Gaborone, Botswana. The findings revealed six main themes: 'feelings of fear and anxiety, 'Feeling of hopelessness and helplessness', 'feeling of loneliness', 'overwhelmed by physical distress', 'Need for support mechanisms' and 'commitment to nursing care' and 11 sub-themes.

COVID-19 pandemic predisposes nurses and other frontline workers to significant risk for adverse mental health outcomes resulting from limited knowledge about the viruses, long working hours and risk of contracting infection, physical fatigue, loneliness and separation from families (Mekonen et al., 2020); fear, stress and depression; and some form of psychological distress (Lai et al., 2020; Oforil et al., 2021). Participants in this study reported similar results. In particular, they reported having fear, stress, panic and anxiety because of the risk of exposure to contracting COVID-19 and dying. Another genuine concern was the high possibility of transmitting it to the family and death anxiety. These feelings can negatively affect their psychological health. Death anxiety affirms the findings of other studies. For example, Aydin and Fidan (2022) https://journals.sagepub.com/doi/10.1177/10436596211017968 reported that nurses had moderate death anxiety during the Covid-19 pandemic. Similarly, Yiğit and Açıkgöz (2021) alluded that concern about death and nurses' anxiety levels were high.

Nurses constantly feared the unknown while feeling stigmatised and rejected by the community. Periods of isolation, *emotional*

separation from the family, stigma and discrimination can pose additional psychological stressors, such as increased emotions of loneliness and a further decrease in social connections. The stigmatisation finding was consistent with Simeone et al. (2022) study. These authors reported that social rejection behaviours were produced slightly or unclearly by people's desire to avoid infection and remain healthy. Faced with stigma and rejection, participants felt unaccepted.

Similarly, during the Ebola outbreak, participants described repeated stigmatising behaviours towards them and limited community property use, such as public transport (Raven et al., 2018). Similar incidents were reported in Singapore during the SARS epidemic in the early 2000s. For example, taxi drivers refused to transport health workers and were forbidden to travel on the subway in uniforms (Koh et al., 2005).

Lack of support, in part, has been reported to have been responsible for the psychological effects that some nurses encountered during the COVID-19 pandemic (Rathnayake et al., 2021). Some nurses in this study reported depression, high stress and flashback. This could be possible because they reported receiving little support during the pandemic's peak. Coping styles and social support are mediators of psychological distress. Studies have shown that psychological adaptation and social support are intermediate in psychological rehabilitation under outbreak stress (Mak et al., 2009). A meta-analysis of nurses' experiences caring for patients in intensive care units indicated that they needed support from friends and families when caring for patients during COVID-19 (Han et al., 2022). In this study, participants reported that they resorted to their families and friends for strength and support. A study by Chau et al. (2021) on the qualitative experiences of nurses during COVID-19 in Hong Kong also indicated that nurses found support from peers and family members. Providing support is another vital way to mitigate worries, enable coping and reduce stress.

Although some participants indicated that they received some support through counselling during the pandemic's peak, they felt it was not enough. They also felt that the accommodation and meals provided at the beginning of the pandemic could have continued. Furthermore, others indicated that all they needed was just a word of appreciation, considering their work conditions.

Some participants reported several challenges, such as discomfort with PPE. Similar findings were reported by Rathnayake et al. (2021), who identified nasal rash, and nostril blocking as discomforts and burdens among nurses taking care of patients.

A feeling of powerlessness and helplessness dominated the experiences of nurses based on their knowledge that the disease was fatal and that there was not much that they could do for the patients. It was made worse by inadequate resources. On the other hand, though also feeling hopeless and powerless, Chinese nurses perceived the failure to do anything for clients with COVID-19 and performing professional responsibilities as reducing their professional identity (Sheng et al., 2020). This finding is similar to previous studies in situations of hopelessness and helplessness during COVID (Khanal et al., 2020).

Despite the raging COVID-19 and high numbers of infected clients, nurses provided care tirelessly and risked their lives every day. Furthermore, they endured bodily aches as often, and they were overstretched because of shortage and high levels of absenteeism due to sickness and being in isolation.

Nurses' experiences were sometimes polarised: some reported empathy and acceptance, as well as fear and stigmatisation. Despite the psychological distress, the nurses were committed to nursing the patients and expressed passion for their profession and empathy for the sick people. Research has shown that healthcare workers are especially concerned about working during virulent infectious disease outbreaks (Barnett et al., 2009). On the contrary, some indicated that they would abandon their profession (Raso et al., 2021), and others reported that they had no other choice but to care for the patients despite being afraid of contracting the disease (Khanal et al., 2020).

Some participants reported something positive about COVID-19. For example, highlighting positive aspects of caring for COVID-19 patients; for example, participants reported being exposed to and learning new things in nursing. This was seen as something positive despite the adverse effects of caring for COVID-19 patients. This could decrease stress and limit the impact on mental health due to the crisis. Naseem and Khalid (2010) literature review on Positive Thinking in Coping with Stress and Health Outcomes, a group that did not report any positive aspect experienced substantially more stress than individuals who saw at least one positive aspect. Although seeing something positive about the crisis may be associated with the individual situation, personality traits and response, the psychological well-being of healthcare workers during infectious disease outbreaks, is essential.

5.1 | Lesson learned

COVID-19 centres were deemed challenging environments, and measures should be taken to ensure they are well-resourced and staffed with skilled health personnel. Nurses were exposed to psychological distress in the form of fear, panic, anxiety and emotional distress, and some took antidepressants. As a result, nurses must introduce debriefing sessions and counselling as part of their daily work routine. This can be carried out as part of the formal programme in the respective units/wards whereby specifically appointed therapists conduct formal counselling and debriefing sessions.

5.2 | Recommendations

The study recommends that continuous in-service training about distress is introduced and intensified at the healthcare facilities. All staff should be encouraged to attend such training. The in-service training may be carried out in practical workshops by multi-disciplinary team members focusing on practical aspects of distressing. In addition, further research must be conducted nationwide on nurses'

experiences caring for COVID-19 patients. This will help have a comprehensive picture of how nurses experienced caring for COVID-19 patients, quantify the problem, determine ways to deal with psychological distress and follow-up research on nurses needing intervention.

5.3 | Limitations of the study

The results are limited to the two sites where the study took place and had a small sample size. Even though the study had a small sample size and therefore not generalisable, it helped understand the phenomenon. Future studies should analyse this phenomenon in other locations.

6 | CONCLUSION

Nurses caring for COVID-19 patients described their experiences. The study reported varying concerns and experiences concerning caring for COVID-19 patients. Nurses described caring for COVID-19 patients as challenging. They had fear and anxiety and were concerned about contracting COVID-19 and infecting their families. They felt stigmatised, lonely and unsupported by management and the government. Previous studies support our results. Nevertheless, they continued as it was their professional and ethical duty.

AUTHOR CONTRIBUTIONS

The first authors conceptualised the paper and started the proposal write-up. From there, all authors edited and collected the data, analysed and wrote the manuscript. In addition, the first author served as an administrator.

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CONFLICT OF INTEREST

There is no conflict of interest.

ETHICAL APPROVAL

The study followed all the ethical considerations needed to conduct research using human subjects.

DATA AVAILABILITY STATEMENT

Data can be availed following reasonable requests and proper consultation with relevant authorities and bodies.

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