

## ORIGINAL ARTICLE

# Nursing during the COVID-19 outbreak: A phenomenological study

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## Abstract

**Aim:** The aim of this study was to explore the experience of Italian nurses engaged in caring for patients with COVID-19.

**Background:** COVID-19 found the health care world unprepared to face an emergency of such magnitude. Italy was one of the most affected European countries, with more than 250,000 cases. Understanding the impact of events of this magnitude on nurses provides a framework of knowledge on which educational training could be based to face similar situations in the future to prevent further breakdown.

**Methods:** The hermeneutic approach by Cohen was used. Semi-structured interviews were conducted using a voice-over Internet protocol. Interviews were transcribed, read in depth and analysed.

**Results:** Twenty nurses were interviewed. Four themes were extracted: uncertainty and fear, alteration of perceptions of time and space, change in the meaning of 'to care' and changes in roles and relationships.

**Conclusions:** Psychological support in association with emergency training prevents stress and helps tackle compassion fatigue.

**Implications for nursing management:** Policies to improve nursing science should be developed to ensure better quality of care, a higher number of professionals and, consequently, an increase in the safety of patients.

## KEYWORDS

COVID-19, educational need, experience, nurses, qualitative research

## 1 | BACKGROUND

Coronavirus disease 2019 (COVID-19) was identified in December 2019 in Wuhan, China, and spread rapidly, with more than 81,000 confirmed cases in all of China (World Health Organization, 2020a).

In January 2020, COVID-19 moved through other countries near China (Thailand, South Korea, Japan and Australia), also spreading to the United States and Europe. On March 11, the World Health Organization declared SARS-CoV-2 a pandemic emergency. In Europe, Italy was one of the most affected countries, and a rapid

increase in contagion quickly followed in countries, with the main outbreaks located in the northern regions, leading to one of the most dramatic epidemic scenarios in Europe. Italy is among the European countries that reported the highest number of confirmed cases ( $N = 403,000$ ) (Johns Hopkins University, 2020), and the number of total confirmed deaths was 36,474, with a detectable peak of cases between March and April.

Due to this unpredictable health care need, organisational models were modified to provide suitable routes for symptomatic patients, managing cases at home or (when necessary) in hospitals, depending on the clinical-care complexity. It was crucial to intensify the role of nurses to increase the number of intensive or subintensive care units and, in extreme situations, set up entirely new hospitals. Health care professionals worked beyond the real possibilities, sustaining pressing work rhythms, often without the minimum adequate personal protective equipment to protect themselves and others in a situation of continuous change and uncertainty (Bagnasco et al., 2020; Liu et al., 2020; Nacoti et al., 2020).

Although there are studies available about the impact on the nurses on the front lines, few studies have analysed their lived experiences in taking care of COVID-19 patients. The limited literature about COVID-19 and previous epidemic diseases (e.g. SARS, MERS, H1N1) reports fatigue regarding acts of compassion, courage and resilience of health care workers (Legido-Quigley et al., 2020; Liu et al., 2020; Smith et al., 2020). Nurses in particular showed coping skills and a spirit of service that sometimes compromised their well-being and underestimated their needs (Fernandez et al., 2020; Kang et al., 2018; Sun et al., 2020). Moreover, the virus has had an emotional impact on health care professionals' mental health problems, such as increasing anxiety, sleep disorders, stress and depression symptoms (Huang & Zhao, 2020; Jackson et al., 2020; Kang et al., 2020; Lai et al., 2020; Usher et al., 2020; Zhang et al., 2020). Another issue was the fear of transmitting the infection from health care professionals to their families, especially those who cared for an elderly family member outside a clinical setting or had children, with the anxiety caused by the awareness that they could be carriers of

infection to others (Bagnasco et al., 2020; Chiang et al., 2007; Nacoti et al., 2020).

Despite other illnesses with an epidemic impact, after the epidemic of Spanish influenza (1918–1920), Italy had not faced emergency situations of this magnitude, and studies aimed at investigating their experiences in this pandemic situation are lacking. Understanding the impact of this event could provide a framework of knowledge on which educational training could be based in order to face similar situations and prevent further breakdown.

## 2 | AIM

The purpose of this study was to explore the experience of Italian nurses engaged in caring for patients with COVID-19 during the outbreak period through a phenomenological approach.

## 3 | METHODS

### 3.1 | Design, setting and participants

The study was driven by the phenomenological hermeneutic approach developed by Cohen, which combines features of Husserlian descriptive and Gadamerian interpretive phenomenology. This method is ideal for research in nursing, especially when the topic of research is new, because it focuses on questions of meaning and on the lived experience of the subjects (Cohen et al., 2000). The phases in which the method is articulated (Vellone et al., 2011) are summarized in Figure 1.

Participants were recruited in converted COVID-19 hospitals, and those who expressed their will to participate and gave their contacts were phone called to have a full explanation of the project and an appointment for the interview. The day of the interview was selected by participants according to their shifts and availability.

This study followed the consolidated criteria for reporting qualitative research standards for the reporting of qualitative research (Tong et al., 2007).

### 3.2 | Sample

Purposive sampling was used. All participants were nurses involved in hospital care of COVID-19-positive patients along the Italian peninsula. They were included if involved in direct care between March and April 2020. The interviews continued until the data were saturated with 20 nurses enrolled.

### 3.3 | Data collection

The interviews were conducted in the native language (Italian), using a video call voice-over Internet protocol (VoIP) platform chosen by each

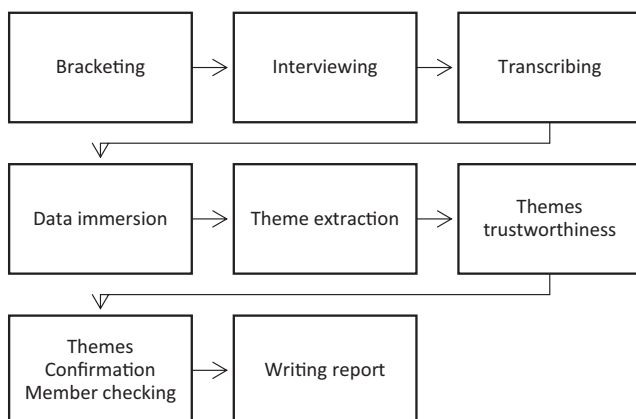


FIGURE 1 Method phases

participant according to his/her degree of confidence. This technology helped to catch nonverbal communication while protecting those interviewed and the researchers from the risk of contagion. The setting was chosen by the participant. A welcoming and reassuring tone was used by all interviewers, who were previously trained.

The study aims were explained before starting.

The following questions were asked:

1. Could you tell me about your lived experience in caring for patients affected by COVID-19? What does this experience mean to you?
2. Could you tell me about a positive and a negative experience that were particularly significant to you during this outbreak period?

Interviews proceeded until data saturation was reached, which, Adler and Adler (Baker & Edwards, 2012), advise in a range from 12 to 60 participants. In the methodological text used for this study, it is defined as 'the idea that researchers have obtained enough data to have a complete description of the experience being studied' (Cohen et al., 2000; Polit & Beck, 2013). Thus, once the teams were redundant and corroborated in their contents, at a raw analysis, data collection was declared closed.

By video call interview, field notes were collected replicating the characteristics of classic face-to-face interviews (Janghorban et al., 2014). Researchers' attention was focused on nonverbal content such as hand wringing or lack of eye contact which enrich the phenomenon comprehension (Phillippi & Lauderdale, 2018). Finally, a sociodemographic questionnaire, created for this project, was used to collect information about the participants' characteristics.

### 3.4 | Ethical considerations

The study complies with the Declaration of Helsinki. Ethical approval was obtained before the study began by the institutional review board of Policlinico of Rome 'Tor Vergata'. Each participant submitted the informed consent form, which was collected via the voice-over Internet protocol platform in a separate audio file from the interview, to ensure anonymity to all participants. Data were kept confidential, and freedom to withdraw from the study at any time was guaranteed.

### 3.5 | Analysis

Once transcribed verbatim, the interviews were checked for their accuracy by spot-checking, taking a subset of the transcripts (4 of 20) (MacLean et al., 2004), reading and rereading the transcripts, and the field notes were repeatedly analysed following the method described above.

Data analysis was conducted according to Hermeneutic Phenomenological process, described in chapter 7 of Cohen's Book (Cohen et al., 2000). The interviews, data analysis and results check were conducted in the native local language of the study participants

(Italian). The interviews and field notes were read and re-read in depth by two researchers (PA and AD) independently to provide theme extraction. Once all the interviews were analysed for themes, the two researchers met to state their agreement about the findings and definitions of theme extraction to establish trustworthiness (Guba and Lincoln criteria were used) (Gunawan, 2015; Lincoln & Guba, 1986).

To ensure dependability, an external expert researcher nurse, not involved in the analysis process assessed the adequacy of the data and the preliminary results obtained checking the accuracy of the findings. Transferability was performed declaring the common values of nursing and the specific opportunities, conditions and limits of the settings in which it is performed in Italy. To assess reflexivity, bracketing was performed before analysing each interview by any researcher to avoid any preconception. To ensure confirmability, research steps taken from the start of a research project to the development and reporting of the findings were transparently described.

To ensure credibility, the final organisation of the themes and subsequent content justifications were agreed by all members of the research team. No discrepancies or discordance was detected during these procedures; thus, the member checking with participants was performed to validate the themes and triangulation between analysts was performed to converge the findings.

After having prepared the scientific report, translation processes and back translation were performed according to the WHO methodology for the validation of instruments in different cultures and languages from the source language, and it was chosen due to its scope. The methodology focuses on conceptual content rather than literal equivalent. In this way, it was possible to ensure that the meaning behind the data obtained was respected (World Health Organization, 2020b). Hence, the whole meaning was preserved according to the original data.

## 4 | RESULTS

Twenty nurses were interviewed according to the inclusion criteria. Most of the participants were male ( $n = 13$ ). The mean age was 32.8 ( $SD = 7.8$ ) years old. The main sociodemographic results are reported in Table 1. The length of the interviews ranged from a minimum of 27 min to a maximum of 90 min, and the mean length was about 50 min.

### 4.1 | Findings

Four themes were extracted: uncertainty and fear, alteration in perception of time and space, change in the meaning of 'to care' and changes in roles and relationships.

#### 4.2 | Theme 1: Uncertainty and fear

This theme encompasses a group of feelings shared by all study participants as distinctive to the experience of the pandemic.

TABLE 1 Sociodemographic variables

ID	Gender	Age	Marital status	Number of children	Clinical working area	Years of experience in nursing	Education in emergencies	COVID education	Attending COVID patients by choice
AD01	Female	45	Single	0	Emergency Department	22	Yes	No	Yes
AD02	Male	30	Single	0	Emergency Department	8	Yes	No	Yes
GP02	Male	54	Married	1	Emergency Department	22	Yes	No	Yes
GP03	Male	25	Single	0	Emergency Department	2	No	No	No
PA01	Male	31	Married	1	Emergency Department	10	Yes	Yes	Yes
RA01	Male	32	Single	0	Emergency Department	10	No	No	No
RA02	Male	29	Single	0	Emergency Department	2.5	No	Yes	No
RA03	Female	36	Single	1	Emergency Department	11	No	No	Yes
RA04	Female	35	Married	1	Emergency Department	12	No	Yes	No
RA05	Male	25	Single	0	Emergency Department	2	No	No	No
SS01	Male	37	Married	1	Emergency Department	16	Yes	Yes	No
SS02	Female	45	Married	3	Emergency Department	27	No	No	Yes
SS03	Male	37	Married	0	Home Care	6	Yes	No	No
VS01	Male	24	Single	0	Emergency Department	2	Yes	No	No
VS02	Male	27	Single	0	Emergency Department	4	No	No	No
VS03	Female	29	Single	0	Emergency Department	6.5	No	No	No
VS04	Male	32	Single	0	Emergency Department	7	No	No	No
VS05	Female	27	Single	0	Medical Department	4	No	No	No
VS06	Male	27	Single	0	Emergency Department	4	Yes	No	Yes
VS07	Female	29	Single	0	Emergency Department	2	Yes	No	No

Uncertainty and fear have been manifested by nurses almost to the point of disruption since the initial days of the contagion, in such a way that a disorientation never experienced before was accompanied by the fear of the unknown. The possibility of direct involvement in a pandemic had been perceived as 'something far away' that would not directly touch their reality; this thought underlines a lack of awareness of pandemic situations.

A participant reported this experience during the interview: RA02: *The fear of the unknown, the fear of facing something that is not known, not only from a clinical point of view, but also epidemiological*

*... then initially fear, a disconcerting [fear] ... we were not prepared, because we thought this could not happen to us.*

AD01: *There is no reference anymore, you know. We were just overwhelmed. We didn't know what to do and how to intervene. We just felt overwhelmed.*

A violent first impact was reported by most of the participants, characterized by a sense of inadequacy and helplessness driven by a lack of information about the virus and of skills to take care of patients.

Another example of these feelings was reported by VS05: *We had to change our practice in a completely different way from one day to*

another. We had to change our mindset about what we used to do and start learning in the field, with the mistakes and the consequences that this means. This way of working through trial and error also helped to fuel the climate of uncertainty and (as described later) to build a solid team relationship among health care professionals.

Worries about contagion were expressed with anguish. Nurses experienced guilt due to the possibility of infecting family members and loved ones so much, so that most of them decided to stay away from their own homes and live-in isolation, as described by AD02: *The other big fear is bringing the virus home and infecting the people you care about, which is why I've been self-isolated [speaks with a trembling voice] and decided to rent a house and go live alone where I am now.*

### 4.3 | Theme 2: Alteration in perception of time and space

Time occupies an important place in the meanings that emerged from the interviews. In fact, the pandemic caused a substantial change in the perception for the study participants. A common denominator can be summed up in this statement: there was a time before the experience and a time after it. COVID-19 acted as a watershed between the reality experienced before the impact of the pandemic and what happened during the period of greatest contagion. There was a suspended time, in which attention was focused on the present, with an uncertain outlook for the future. Time alteration is well described in the following interview: RA01: *It seems to me years since I received the communication, but instead it has only been three months, because everything had been dilated a lot, as if there had been a bubble in which we all remained closed. There's a before and an after.*

In this time dimension, the spaces and times of care were marked by gruelling shifts and complex dressing and undressing procedures that became a metaphor for the physical fatigue to which nurses were subjected, as one participant tells us: VS03: *As an experience from a professional point of view, it is heavy because all those hours and all these PPE take away energy because you sweat so much, you get so tired, you suffer from thirst, you suffer hunger, and you lose lucidity.*

A participant properly described this theme with these words: PA01: *We were tight in the grip of time, which reminded us of our helplessness[crying], and we saw patients get worse without being able to do something to help them.*

Despite the scenario described, the desire to maintain a historical memory of the time lived in the pandemic was universal. Through photographs and narratives, the nurses attributed an important meaning to this experience in their professional and personal lives that they wanted to preserve, despite the pain.

AD01: *Some moments I took pictures. If I went back I would do much more because it's just a moment of almost journalistic storytelling like when you take war photos. They had to be done; they had to be done more.*

### 4.4 | Theme 3: Change in the meaning of 'to care'

Watson defines caring as: *'the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity'* (Watson, 1988) and this is the meaning we take in count while describing this theme.

The experiences that nurses reported were rich in considerations of how this pandemic infection and the consequences of contagion have influenced the main paradigms of care in nursing. Most of the participants reported that COVID-19 put everyone face to face with the inevitability of death. Without distinctions of age, comorbidities or criteria of frailty, anyone could be infected and have serious consequences. All the participants talked about the experience of death that characterize this pandemic situation. The participants described a death experienced in absolute loneliness, without the affection and consolation of loved ones, almost without proper dignity and, at the same time, filled with the closeness and exclusive presence of carers.

A quotation regarding this is taken from the interview with PA02, who said: *I'm not even able to 'digest' all these deaths, that is to see again the body rolled up in the bed sheets, in the same sheets of the bed that we changed before, to say, not even a last change of bed sheets, a gesture of dignity, of treatment, to honour the body of what had been in life.*

Another significant quotation comes from SS03: *Seeing these people die in total solitude struck me very much as they had absolutely no way to communicate with relatives or with the people important to them. There was only us.*

Nurses always took on the role of conduit for family members during illness and hospitalization, fulfilling the function of advocacy and acting as guarantor, as the main point of reference during the patient's isolation regime. This latter function was cited by participants with simultaneous emotion and discomfort because of the emotional commitment that characterizes it. Approaching the suffering that accompanies COVID-19 patients, in fact, involves great fatigue due to the risk of empathizing with their experience. In the words of one of the participants, empathy led to compassion: VS 07: *The aspect that I think touched us so much was the loneliness and suffering of patients. And it also seems to be a phrase made, but it is not: we were their family [the interviewee is particularly emotional while trying to speak], which in the end they could no longer see, so you did everything for them and suffered with them.*

The caring gestures made by the nurses went beyond the level of protection. They were realized above all through the gaze, the touch of a hand with two pairs of gloves, a word of help or comfort, and were recognized by the participants as the main valuable elements in care, despite the barriers. AD 02: *Almost all patients before the induction phase ... before falling asleep asked for the hand... contact, as if it were the last contact with someone, beyond the distance.*

What was known as 'caring', by participants, was strongly altered by the pandemic measures of contagion prevention; but, despite this, none of them stop in taking care.

#### 4.5 | Theme 4: Changes in roles and relationships

The pandemic has caused an upheaval in ordinary organisational and professional structures. All the participants said they perceived a change in both their role within the organisation, perceived as essential for the success of the treatments, and in the relationships with other professionals. Nurses perceived their role changed, notice this through the external recognize of their role. Not only by the eco of the media but also by the enhanced acknowledgment received by the organisations. VS02 express this saying '*Somebody (referring to the organizational sphere) notice the importance of nurses in the caring...*'.

Regarding the relationships this is a theme characterized by multiple, sometimes contrasting, experiences. On one hand, the most positive experience, that emerges from the interviews, concerns the relationship within the nursing group. On the other hand, nurses really perceive the strong collaboration with other professionals despite the different 'labels' of the titles. Being all together to face a new situation highlighted a spirit of cohesion and mutual solidarity that had never been experienced before by the participants. Nurses found support and comfort in their professional group, thanks to which they were able to give a sense of the physical and psychological fatigue experienced in the most difficult moments of the pandemic.

VS 01: *So help each other; help each other. We know all of us were under stress. Here we say that there was a lot of closeness between us because in the end it was us ... only us ....This was particularly important for those of us alone at home like me. The family was the place of work, the colleagues.*

Skill perimeters and boundaries between professions were blurred. Each professional felt part of a group sharing common language, codes and goals, regardless of each person's history, functions, or roles, in a respectful climate. VS 06 said: *We worked closely, despite our professional role.*

Despite this, there was a perceived abandonment by the management and the organisation of the hospitals. Perhaps due to the lack of clear guidelines, organisational chaos was experienced, along with a lack of adequate personal protection devices, especially in the first period of contagion.

The first nurse interviewed introduce this theme saying: AD01: *The negative aspect, with great regret, I point it to my manager. She was a completely absent figure and this at the nursing level is disarming, we felt completely abandoned by the managers and the organization. (...) It was a disarming absence (...) the group needed a reference (...) we were saved by ourselves ...*

Moreover, another nurse tells us: PA 01: *If I have to be honest, there has not been a real line of address from the senior management saying, 'Look, tomorrow you will do this; there will be this and this. We expect from you a number of things, and the organisation of the company will change.'... We used the PPE badly; there was no clarity at the beginning ... if I think about it, we were all exposed to contagion.*

The perception of their roles was also experienced in terms of self-image and how they were described by the media and citizens.

Nurses lived the spirit of service and a professional identity that distanced itself from the idea of a 'hero' with which they felt identified by society, maybe downplaying those competences that had always been embodied, even before the pandemic. SS01: *I don't feel anything like a hero, because I simply did my job.*

## 5 | DISCUSSION

In this study, we explored the lived experiences of nurses who cared for COVID-19 patients. The analysis of the interviews allowed the identification of our themes: uncertainty and fear, alteration in perception of time and space, change in the meaning of 'to care' and changes in roles and relationships.

Fear and uncertainty pervaded all the experience of the nurses interviewed, especially at the beginning of the pandemic. Facing something unknown is described in the literature as the element of commonality between all experiences of contact with an unknown health emergency (Chiang et al., 2007; Nacoti et al., 2020). The experience of professionals of the subversion of the usual patterns of action in a context of uncertainty, which increases the perception of danger for themselves and for others, inevitably weighs on their psychological well-being. This phenomenon was previously described in several studies that analysed the psycho-physical consequences (mainly anxiety and stress) reported by nurses engaged in epidemic situations (Huang & Zhao, 2020; Jackson et al., 2020; Kang et al., 2020; Lai et al., 2020; Usher et al., 2020; Zhang et al., 2020).

Fear is often accompanied by a sense of helplessness and inadequacy in the face of an increase in limitations in coping with the demands of patients in a suspended time when the unknown of the future increased the fatigue experienced by the nurses we interviewed. Despite the fear of contracting the infection and the concern about passing it on to their loved ones, nurses showed a high sense of responsibility, choosing to stay with patients and face the physical fatigue of stressful shifts and prolonged use of personal protective equipment out of a spirit of service and a sense of duty. A vision that strays from the idea of 'heroism' proclaimed by the Italian media and that confirms what has been reported in the literature on the topic states that nurses engaged in emergency situations are attracted to their work and consider the care of patients as an essential professional duty, regardless of the clinical and organisational condition (Fernandez et al., 2020; Sun et al., 2020; Wong et al., 2012; Yin & Zeng, 2020). Nurses' well-being has a strong clinical implication for the quality of the outcomes sensible to nursing. As underlined recently by Lee and colleagues, coping strategies and psychological well-being directly impacted safety attitudes, which mediated nurses' practice environments (Lee et al., 2019).

In this study, the attitude towards duty and responsibility becomes a value shared by the whole community of health care professionals. Italian nurses strongly highlight the meaningful cohesion developed with their peers and the support and mutual solidarity that crossed the borders between the different professions. Those mechanisms of compensation allowed them to face



with resilience the consequences of the pandemic on the entire health care system and the carers, confirming what has been experienced by colleagues in similar contexts (Legido-Quigley et al., 2020; Liu et al., 2020; Smith et al., 2020; Sun et al., 2020; Yin & Zeng, 2020). All these characteristics and aspects of nurses contributed to overcome the outbreak despite lacks the system. Mutual adaptation between health care professionals has emerged from this situation as the most important implication we can assume for nursing management.

In this scenario, even the paradigms of care have changed, but the fundamental assumptions of nursing have remained intact. The meaning of 'to care' in the COVID-19 pandemic consists of closeness, gestures of care and protection, and action despite distance. In fact, the words of the interviewed nurses revealed pure attributes of advocacy, the core principle of nursing care. The concept of advocacy, described in the literature, contains multiple elements that we find in the meanings expressed by the participants to our study. Being an 'advocate' means putting in place behaviours to promote and protect the well-being of those cared for and is achieved by helping them obtain from the health system what they need most, by virtue of the role of interconnection between those cared for, family members and the health organisation (Bu & Jezewski, 2007; Choi et al., 2014). The experience of accompanying to death, often experienced more than once per shift, creates an emotional contagion reported by all participants in different forms, such as compassion, 'suffering with' in its original meaning (*cum patior* in Latin). Alignment with the meaning of compassion described by Schantz (2007) was detected through our interviews, defined as the feeling that allows an individual to emotionally perceive the suffering and pain of others in order to alleviate it, which is almost associated with the ethical principle of altruism (Schmidt & McArthur, 2018). The 'invisible care' emerged through nursing outcomes, during the outbreak, implicate the importance of the proper ethical aspect as core content of the discipline, which go beyond the technicisms of the gestures. This implication is important not only for the management, who should invest in ethical care programmes but also recognize the development of nursing as a discipline through the academic teaching.

Finally, in our last theme, nurses were resentful about their experience of being 'abandoned' by the organisational sphere, maybe due to the lack of clear and unique guidelines and the lack of adequate individual protective equipment. This peculiar aspect of the theme is strongly influenced by the Italian context in which, during the outbreak, the lack of an updated pandemic plan had been underlined by media. Nurses perceived themselves as exposed and as unprotected by those who should guarantee the organisation of the care systems during the emergency. This was previously reported in the literature in similar conditions as additional cause of stress and fatigue for health professionals (Liu et al., 2020; Nacoti et al., 2020; Usher et al., 2020).

This theme underlines how the communication is crucial, between all the professionals, at any level, in a health care organisation. It is plausible to hypothesize that a stronger and better communication between the organisational spheres and the 'first line' would

have reduced, if not eliminated, the sense of being abandoned expressed by our participants.

Despite all the important results emerged, this study has some limitations. Beginning with the need for further studies on long-term impacts to detect which outcomes, in terms of stress and fatigue symptoms, this emergency will leave behind. The choice of a voice-over Internet protocol system to conduct the interviews because of COVID-19 restrictions, which does not allow for proper nonverbal communication and empathic listening, is another limitation. These limitations of the study should be considered when using our findings, even if it is plausible that the feelings and meanings are the same among nurses, even in other contexts, due to the strength of nursing principles with regard to the care of others.

## 6 | CONCLUSION

The purpose of this study was to explore the experience of Italian nurses engaged in caring for patients with COVID-19, what this study provides are the basis for work on the renewal of nurses and nursing identity in pandemic emergencies. This experience surely highlights the value of nurses and nursing care for the health care system, so policies of improvement of nursing science should be developed to ensure better quality of care, a higher number of professionals and, consequently, an increase in the safety of those cared for.

## 7 | IMPLICATIONS FOR NURSING MANAGEMENT

The sense of loss and inadequacy should induce deep reflection on nursing education and organisational instruments of management. As highlighted in the introduction, the novelty of this study is the possibility of using its findings to improve nurses' preparation to face extreme situations, such as COVID-19, and to help those who lived through it to explain the meaning they gave to it through the narration of their experience. The psychological impact of the pandemic disease generates a need for psychological support in association with emergency training (few study participants had received appropriate training) to prevent stress and help tackle compassion fatigue. The intent of this paper is to highlight the positive aspects of nursing such as advocacy, elevated responsibility of the role and humanity to the point of self-sacrifice (e.g. isolation from loved ones) for 'common sense and well-being'. These values should be preserved and enhanced not only for the 'heroes' of this emergency but for the health care service of tomorrow.

### CONFLICT OF INTEREST

Nothing to declare.









### ETHICAL APPROVAL

Ethical approval was granted by the Institutional Review Board of the University of Rome Tor Vergata (Reference n. 157/2020).

## DATA AVAILABILITY STATEMENT

Research data are not shared.

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