Received: 7 January 2022 | Revised: 16 February 2022 | Accepted: 23 February 2022

DOI: 10.1111/jonm.13571

ORIGINAL ARTICLE

WILEY

The lived experience of nurses who volunteered to combat the COVID-19 pandemic in South Korea: A qualitative phenomenological study

Hyunjie Lee MSN, RN, PhD candidate[1] | **Seung Eun Lee PhD, RN, Assistant Professor**[2] | **Somin Sang RN, MSN student**[1] | **Brenna Morse PhD, RN-BC, NCSN, Associate Professor**[3]

[1]Yonsei University College of Nursing, Seoul, South Korea

[2]Mo-Im Kim Nursing Research Institute, Yonsei University College of Nursing, Seoul, South Korea

[3]Solomont School of Nursing, University of Massachusetts Lowell, Lowell, Massachusetts, USA

Correspondence
Seung Eun Lee, PhD, RN, Assistant Professor; Mo-Im Kim Nursing Research Institute, Yonsei University College of Nursing, Seoul, South Korea.
Email: leese@yuhs.ac

Funding information
Faculty student Research, Grant/Award Number: 6-2020-0049

Abstract

Aim: To explore the motivation and lived experience of nurses responding to the COVID-19 pandemic in South Korea.

Background: Identifying motivation, barriers and facilitators to nurses' willingness to work during a pandemic is necessary to prepare for future pandemic responses.

Methods: Ten individual interviews were conducted. Interviews were analysed and synthesized following Colaizzi's method.

Results: Six major themes identified: *Decision to participate in the COVID-19 response*; *Facing hardship*; *Distress due to the nature of COVID-19*; *Overcoming hardship; Growing through the COVID-19 response*; and *The need for reciprocity*.

Conclusion: The increased demands for nursing care during the pandemic highlight the need for strong organisational support and effective workforce strategies. Our study results can inform the development of programmes and policies that are proactive, rather than reactive, to prepare for future pandemic situations.

Implications for Nursing Management: To recruit and manage nurses during a pandemic effectively, a safe work environment with proper resources should be established. Additionally, adequate education, training and compensation are needed.

KEYWORDS
COVID-19, nurse, qualitative, South Korea, willingness

1 | BACKGROUND

In late 2019, the novel coronavirus (COVID-19) emerged, threatening the health of the global population and posing a formidable challenge to the health care workforce (Phelan et al., 2020). In South Korea, the first large cluster of COVID-19 infections was reported in February 2020 in the city of Daegu, affecting more than 2000 people in less than 10 days (Kim et al., 2020). The rapidly increasing number of patients accelerated the shortage of hospital beds, medical supplies and health care workers (Kim, 2020; Yoon & Martin, 2020). Accordingly, the government and the Korean Nurse Association recruited health care workers to staff designated infectious disease hospitals, community treatment centres and COVID-19 screening clinics. Ultimately, 2392 health care workers across Korea were deployed to Daegu to help care for patients with confirmed or suspected COVID-19 infection (Kim et al., 2020). The peak of infection in Daegu has since resolved; nevertheless, COVID-19 hotspots continue to emerge and dissolve in South Korea and globally. With the continuation of the pandemic, there is a need for a strong workforce to combat the disease; consequently, the recruitment of health care workers continues. South Korea, however, is not alone.

COVID-19 has affected communities worldwide, and other nations, such as the United States, the United Kingdom and China, continue to struggle to maintain a workforce that is adequate in number and skill level to provide care to those with COVID-19 (Alharbi et al., 2020).

Nurses are frontline responders and play significant roles during pandemics by providing the needed direct care to affected patients (Fernandez et al., 2020; Nayna Schwerdtle et al., 2020). While patients with COVID-19 need access to equipment, such as hospital beds and ventilators, facilities must have a sufficient number of qualified nurses to provide the necessary care (Fernandez et al., 2020). However, understaffing of nurses has been identified as a major global problem during respiratory disease outbreaks, including the COVID-19 pandemic (Fernandez et al., 2020). Failure to have an adequate workforce during respiratory pandemics results in increases the workload of nurses (Karimi et al., 2020) and turnover rates (Labrague & De los Santos, 2020) and leads to decreased job satisfaction and coping abilities, all of which lead to inefficiencies under highly volatile circumstances (Barello & Graffigna, 2020). Securing an adequate workforce in number and skillset is a clear global priority for nursing leaders to meet the care needs of those with confirmed and suspected COVID-19 infection (Danielis et al., 2021).

There is a growing body of research on nurses' experiences during the COVID-19 pandemic in various countries. To respond effectively to concerns, support the workforce and better prepare for the future, it is important to accumulate international evidence regarding the experiences of nurses working during the pandemic. To date, most studies have primarily focused on the psychological well-being of nurses; there is a lack of evidence on the experiences of nurses who were urgently recruited to newly established medical institutions at the forefront of the fight against COVID-19 (Danielis et al., 2021), and this is an area for a future investigation.

1.1 | Study objective

This study aimed to (1) explore the motivation and lived experience of frontline nurses responding to the COVID-19 pandemic in South Korea and (2) suggest efficient methods of supporting and managing the nursing workforce during a pandemic.

2 | METHODS

2.1 | Design

This qualitative study used Colaizzi's phenomenological approach (Colaizzi, 1978), which focuses on finding and describing the essential and universal structure of the phenomenon under investigation with the holistic perspective of lived experience (Holloway & Galvin, 2016). We adopt this approach as it is appropriate for understanding the essential circumstances of nurses' experiences as volunteering members of the emergency workforce addressing the COVID-19 pandemic in its early stages.

2.2 | Participants

Participants were nurses who voluntarily provided direct care to patients with confirmed or suspected COVID-19 at nationally-designated care centres in virus hotspots in South Korea. A purposive sampling method (Suri, 2011) was used to select participants who could share vivid and rich experiences. We recruited nurses who volunteered to participate in the medical response and shared their personal experiences on publicly-viewable social media, such as blogs and Instagram. We contacted them and explained the necessity, purpose and process of the study. We strove for variation in gender and work settings.

A total of 10 nurses participated in this study. Most were female ($n = 7$), with a mean age of 28 years ($SD = 1.6$) and an average of 4 years ($SD = 2.2$) of nursing experience. Participants worked in various care settings: general wards ($n = 4$), intensive care units ($n = 3$) and temporary living/testing facilities for inbound passengers (also known as visitors or immigrants, $n = 3$).

2.3 | Ethical considerations

Prior to the interview, we confirmed voluntarily participation through written consent. Participants also consented to audio/video-recording of interview proceedings. Their names were replaced by numerical codes in the recording process to guarantee anonymity and confidentiality. Institutional Review Board approval was obtained from Yonsei University Health System (blinded for review 4-2020-0092).

2.4 | Data collection

The data were collected from August to November 2020. Per participant preferences and local safety guidelines, interviews were conducted face-to-face, via telephone, or WebEx (a video meeting programme). Each respondent participated in one 60-min interview. Interview questions were open and semi-structured, such as 'What was your experience of participating in the medical response to the COVID-19 pandemic?', 'What made you participate in the medical response to the COVID-19 pandemic?' and 'What is needed to encourage nurses to participate in pandemic medical response programs?'. The detailed interview process is presented in Appendix S1. Non-verbal characteristics, such as facial expressions, gestures and intonation, were observed and recorded in field notes. The in-depth interviews were conducted until data saturation was obtained by the research team determining that no new statements, concepts or topics would appear with additional interviews.

2.5 | Data analysis

All steps of data analysis were performed manually. Data analysis was conducted cyclically using Colaizzi's method (Colaizzi, 1978). First, the

recorded data were carefully listened to and transcribed verbatim, and field notes were carefully checked several times for accuracy. After reading the transcriptions repeatedly, important phrases or sentences were extracted, and their meaning was determined and explained. While collecting data, the above processes were repeated for each of the 10 transcriptions. Through this process, data saturation was confirmed. Data were independently analysed by two researchers and discussion continued until an agreement regarding themes and findings was reached.

2.6 | Trustworthiness

To ensure the rigour of the study, we followed evaluation standards of Schwandt et al. (2007). Credibility was ensured by recruiting participants who could describe the detailed experience of participation in the COVID-19 response. All interviews were conducted by the same researcher, and interview proceedings were transcribed verbatim. Directly after each interview, the researcher reviewed and noted impressions related to the research questions and interview proceedings. Transcripts were reviewed and compared with recordings multiple times to ensure accuracy. Transferability was supported, as many nurses globally have been called to respond to the COVID-19 pandemic; to ensure credibility, our study involved only nurses who elected to participate in special calls for pandemic workforce support. The original data were independently analysed by two researchers, and discussion continued until an agreement regarding themes and findings was reached, which contributed to dependability in this study. The researchers asked questions for clarification regarding ambiguous statements during the interviews to ensure confirmation. At the end of each interview, the contents were reviewed and summarized by the researcher and confirmed by participants. For unbiased reporting of qualitative studies, the Consolidated Criteria for Reporting Qualitative Research (COREQ) reporting guidelines were adopted (Tong et al., 2007) and are reported in Appendix S2.

3 | RESULTS

Following analysis of the 10 interviews, we derived 6 themes and 13 sub-themes. Table 1 displays the themes and sub-themes, as well as exemplar quotes from participants.

3.1 | Decision to participate in the COVID-19 response

3.1.1 | Desire for new experiences

Participants shared the rationales or antecedents behind their decision to volunteer for emergency COVID-19 work assignments. Most participants volunteered to work in the COVID-19 medical support sites for an opportunity to refine or gain new practical knowledge and skills, desiring to achieve new professional experiences. They wanted to prepare for the long duration of work that would ensue from the pandemic with the knowledge or skills they could gain from this experience.

3.1.2 | Desire to be helpful as a nurse

Many participants had a desire to be helpful during the emerging pandemic situation. They regarded working in the COVID-19 medical support sites as their essential duty as a nurse during a national disaster. Beyond the duty to serve the nation and community, several participants said they had volunteered because they knew that other nurses working on the COVID-19 frontlines were facing hardship. Participants wanted to help other nurses who were taking care of patients with actual or suspected COVID-19.

3.1.3 | Concerns about the risk of infection

Although most participants showed strong motivations to support COVID-19 workforce efforts, at the time of their early decision-making, they were hesitant to work due to the risk of infection. Some participants' family members and friends tried to persuade them to not work at COVID-19 medical support sites; respondents themselves were worried about becoming carriers of COVID-19, infecting their friends, family and communities. Some participants shared their beliefs regarding potential infection. Some nurses, however, believed that if they became infected, they might be able to survive due to their good physical strength and general health status. They also believed that the government would support them during their recovery if they were infected when responding to the national workforce need.

3.2 | Facing hardship

3.2.1 | Poor work environment

Most participants worked in the COVID-19 medical support sites when the virus first began to spread among the South Korean population. They had to encounter and adapt to an unprepared work environment that had no established approaches towards a novel disease. Such a work environment was the biggest cause of stress to most participants regardless of the area or facility in which they worked.

In temporary living/testing facilities for inbound passengers, facility managers were non-medical staff, such as public officers. Because of managers' lack of awareness about infection control, the nurses had to educate them on the basics of infection control during meetings. To reduce fatigue levels of workers, all personnel were supposed to be replaced every 2 weeks. However, all participants volunteered to stay for longer than their initial 2-week contract because they wanted to orient newcomers on efficient operations, as there were no

TABLE 1 Exemplar quotations from interviews regarding nurses' experiences of the COVID-19 response

Themes	Sub-themes	Participant quotation
Decision to participate in the COVID-19 response	Desire for new experiences	It seemed like… this kind of thing (taking care of the infected or suspected to be infected patients) will continue to happen and I knew, someday, I had to deal with the situation anyway. (P6)
	Desire to be helpful as a nurse	But as a nurse, um…I really thought this (participating in the COVID-19 medical support) was the right thing to do. (P4)
	Concerns about the risk of infection	If I fail to get myself together, I might be infected during the process of working or donning and removing PPE. Later (when the medical support is over), I have to go back to Busan (where she lived), but what if I become a carrier … I was worried about that. (P7)
		I was putting it this way that If I get infected, it will be God's will. Also, even if I get infected, the government will take care of me, so I thought that it would be fine. (P7)
Facing hardship	Poor work environment	There were a lot of areas where I felt insufficient supports… One thing was about board accommodations. We were not provided proper accommodations or even for food. Nurses had to spend their own money for food and accommodations and had to wait for a long time for reimbursement. (P5)
		Even a basic stuff like the thermometer was not given. A really basic item wasn't provided. Inadequate supplies for these kinds of things … Well … Lack of supplies were worse for non-hospital settings. It took so long to get supplies. (P10)
	Lack of information and education	Until the very day before, no important information was given and I got no training. So, I had to prepare myself and rush to the scene. I must admit that it was the most daunting part. (P5)
		Well, there was a briefing … But we were not properly given any specific information like what kind of tasks we would do at the frontline. The briefing was about the basic information of the structure of hospital. Well, during the briefing, I finally was informed that all patients in that hospital were infected with COVID-19. (P2)
	Lack of skilled workforce	It was difficult to work because there was a lack of skilled medical personnel. Although in mass media, it advertised that nurse officers took the lead for caring patients, well, the truth was there was insufficient skilled workforce. (P4)
Distress due to the nature of the COVID-19	Physical distress due to personal protective equipment (PPE)	I was very stressed at the time of donning PPE when I entered patients' rooms. I really did not like wearing PPE … (P2)
		Things like goggles and face shields kept pressing on my forehead, which gave me headaches. So, I had to take Tylenol from time to time. (P3)
	Unabated risk of infection	Fear of infection continued until I completed the mandatory self-isolation and finally confirmed the negative test result … Even until the morning of that day when the test result was released, I though … really … oh please … It cannot be me … It should not be … All these negative thoughts rushed into my mind uncontrolled … It was mentally difficult … The fear of infection … (P5)
Overcoming hardship	Teamwork; do one's best with the common goal	We had a sense of comradeship between dispatched nurses and us. It was like "I'll do more." "No, I'll take care of this …" Such experience made me decide that I will take an initiative if I work at a medical support site again. (P7)
		The most important thing is that we are healthcare professional, so we think it's natural to do things in a certain way (e.g. keeping infection control), but others in this facility do not have that kind of awareness … I think it is important to share the knowledge in order everyone to notice how important infection control is… Through a meeting, we decided where we would don and remove PPE, considering factors like ventilation. (P10)
	Individual effort	When I came to this site, I brought a medical-surgical nursing textbook with me, because thought that I might be dispatched to a clinical setting that does not match with my clinical background… So I brought my text book to refer in case I had to provide care that I am not familiar with. (P7)
Growing through the COVID-19 response	Being competent for providing future help	If infectious disease outbreaks again, and if I get dispatched again, I think I will be able to adapt to the environment faster than this time thanks to my experience. I think I would be able to provide more skilled nursing care than now. (P10)
	Achievement of personal growth	When I managed the hopeless situation and successfully handed over the patients, I found that I used to set limits for myself. I felt like I have pushed through the limits a bit. (P2)
		People around me applauded me, saying to me that "you made a big contribution, you are amazing…" … … … So I felt that my ability as a nurse was helpful to someone and to my country. This became a source of great pride for me as a nurse. (P7)

(Continues)

TABLE 1 (Continued)

Themes	Sub-themes	Participant quotation
The need for reciprocity	The need for reciprocity	I think that the spirit of sacrifice and the spirit of service is possible in an environment that provides basic needs. In fact, like other people, nurses also need to make a living, so financial compensation should be provided. (P1)
		Looking back, taking care of infected patients could risk my life. I did not realize it back then, but now I think nurses should be well treated and supported according to what we do for patients because we are potentially at high risk of being infected as well. (P4)

common guidelines or procedures for onboarding in the facilities. In hospitals, participants had to work without breaks due to an increased workload with high acuity patients. Furthermore, in the early days of the COVID-19 deployment, volunteers were not provided with proper accommodations.

3.2.2 | Lack of information and education

A lack of information and education was a primary concern of the participants. They did not receive thorough or accurate information about their frontline placement before deployment. Whereas training sessions were offered, nurses reported that the sessions did not help them gain sufficient skills and knowledge to address COVID-19 patient needs. Due to the urgent nature of the response, training regarding infection prevention and control was sometimes omitted. Participants, thus, were left without proper information in an unpredictable situation, where resources did not match needs, thus exacerbating their frustration.

3.2.3 | Lack of skilled workforce

Participants experienced a heavy workload related to the relatively unskilled workforce that was replaced every 2 weeks. Many of the nurses who were dispatched to the medical sites were new graduates who lacked patient care experience. When the number of critically ill patients was soaring due to the rapid spread of COVID-19, nurses without prior intensive care experience were suddenly obligated to work in intensive care settings. Participants, thus, had to teach themselves how to use complex intensive care technologies, such as continuous renal replacement therapy or extracorporeal membrane oxygenation, in addition to addressing the nursing care needs of their assigned patients.

3.3 | Distress due to the nature of COVID-19

3.3.1 | Physical distress due to personal protective equipment (PPE)

Participants experienced physical and psychological distress due to the nature of COVID-19. While participants acknowledged the necessity of using PPE in preventing COVID-19 infection among staff, wearing them was a source of physical distress. Some participants experienced physical symptoms such as headaches due to PPE.

3.3.2 | Unabated risk of infection

Even after completing the medical response, participants faced difficulty in reducing anxiety about the risk of infection. Those who cared for patients with confirmed COVID-19 reported that they self-isolated and tested for the virus after the medical response and were unable to stop worrying about the infection risk until they received the results of the COVID-19 test.

3.4 | Overcoming hardship

3.4.1 | Teamwork: Do one's best with the common goal

Participants experienced stressors from many sources during their time at the medical support sites. Teamwork enabled them to overcome hardships under this unique work situation. Although nurses who participated in the COVID-19 emergency response had different backgrounds and experiences, they had a common goal. They relied on each other to provide high quality care to patients with confirmed or suspected COVID-19, and even with the few resources, strived to provide the best nursing care to their patients during the pandemic.

With their colleagues, participants developed work systems and educational programmes for themselves. For example, in hospitals, they clarified the tasks to be done during each shift and arranged shift schedules to ensure an appropriate mix of skills in consideration of nurses' work experiences. In temporary living/testing facilities for inbound passengers, nurses developed and implemented infection control education programmes for medical and support staff, such as how to don and doff PPE. Participants also shared opinions and specific strategies for improving the safety of the work environment, reducing the spread of the virus and increasing care quality, with site administrators and managers.

3.4.2 | Individual effort

Most participants had never worked in a respiratory ward or intensive care unit, which left them with limited competencies in the respiratory care needed at the medical support sites. Consequently, participants

used textbooks or web sources, such as YouTube videos, to teach themselves and gain the knowledge necessary to care for patients with COVID-19. Nurses found that this self-teaching helped them overcome limitations related to a lack of relevant professional experiences.

3.5 | Growing through the COVID-19 response

3.5.1 | Being competent for providing future help

Although not all participants' experiences were positive, they nevertheless reported their growth through the pandemic response work, as they learned how to take care of patients during the pandemic as nursing professionals. Because of their experiences, participants believe that they are now well-equipped to contribute professionally to any future pandemic situations. To use the knowledge and skills gained from their current experiences, nurses shared their willingness to participate in future pandemic situations.

3.5.2 | Achievement of personal growth

Most participants reported that overcoming individual limitations in poor work environments helped them broaden their worldviews in the nursing profession and increase their professional growth. Working in this unique emergency situation made them feel proud of being a nurse and confirmed that their mission or purpose as a nurse is truly to care for patients in need.

3.6 | The need for reciprocity

All participants opined that the government should prioritize a safe work environment and provide appropriate compensation to nurses in the pandemic response. They emphasized that the government and society should not simply glorify the nurses' spirit of sacrifice, adding that the spirit of sacrifice or commitment to social responsibility are only possible when basic work conditions are met. Participants faced a high risk of infection, poor work environments and inappropriate compensation. The poor working conditions posed a tremendous risk to participants both personally and professionally. Thus, the nurses believed that proper financial compensation and follow-up programmes for nurses' physical and psychological well-being should be considered in future pandemic response plans.

4 | DISCUSSION

This study explored the lived experience of nurses who volunteered to participate in the national emergency response to the COVID-19 pandemic in South Korea. The nurses' meaningful experience was characterized by six main themes: *Decision to participate in the COVID-19 response*; *Facing hardship*; *Distress due to the nature of the COVID-19*; *Overcoming hardship*; *Growing through the COVID-19 response*; and *The need for reciprocity*.

Consistent with findings from a meta-synthesis on frontline health care workers' experiences during respiratory pandemics, we found that the risk of infection accounts for a large percentage of the health care workers' worries (Billings et al., 2021). More importantly, we found that the organisational structure, or a lack thereof, and working conditions served as more influential antecedents to nurses' work stress. Furthermore, we confirmed the previous research evidence (Fernandez et al., 2020) that revealed the importance of strong teamwork and a supportive work environment in the medical support sites with health care workers from diverse backgrounds. Similarities among findings of international studies provide us with confidence that there are universally consistent, specific ways to improve preparation efforts and responses to the ongoing pandemic situation, as well as future pandemics.

In this study, we investigated the motivation of nurses to participate in the COVID-19 medical response and their intention to volunteer again. Despite concerns regarding risk of infection, our participants agreed to be stationed in hotspot areas to overcome professional challenges, gain new experiences and honour perceived social responsibilities as a nurse to contribute to pandemic relief. The nurses were also willing to participate again as they believed that their work experiences related to the emergency response improved their professional competencies. Therefore, participants believed that in the future they could contribute to improving pandemic response programmes by organising training, workflow organisation and overseeing staffing models.

We found that reciprocity is important in promoting nurses' participation in emergency response efforts. Nurses risk their personal safety and the safety of those close to them when they work in situations such as the COVID-19 response. Thus, nurses expect adequate support, resources, and rewards from hospital systems and governments in return. The reciprocal obligation includes not just suitable monetary compensation, but also a proper work environment with support from supervisors and hospital management, adequate PPE and necessary training that enable nurses to provide good patient care. Under crisis situations, nurses expect, at a minimum, that they will be working in a safe environment (Billings et al., 2021). However, this expectation has not matched reality during their pandemic responses. Previous researchers have reported that in clinical settings, undergoing drastic changes with a lack of adequate provisions contribute to nurses' increased workplace stress and distress about physical and mental safety (Danielis et al., 2021; Holroyd & McNaught, 2008; Shiao et al., 2007). In the current study, our participants shared that the chaotic and unprepared work environment was the greatest challenge. Thus, it is imperative to structure work environments in such a manner that nurses can successfully carry out their duties, even during a pandemic.

Additionally, participants also reported that staff were replaced every 2 weeks. This quick and constant turnover made their work more difficult. Although 2-week rotations have been offered to reduce staff fatigue levels (Kim et al., 2020), Zhang et al. (2020) found

that nurses' psychological adaptation generally began around the 1-month mark of working in an isolation unit during the COVID-19 pandemic. Thus, determining proper timing of workforce replacement, balancing fatigue, safety and adaptability, is essential. Furthermore, our participants believed that the exclusion of health care personnel from facility management teams was problematic. The non-medical team managers were unfamiliar with infection control methods and did not have competencies in the basic principles of public health and emergency preparedness. Working with such managers exacerbated nurses' work stress. Researchers previously determined that the presence of nursing managers in the wards and their close communication with nurses played an important role in optimizing nurses' workflow and improving the work efficiency and nursing quality during the pandemic (Gao et al., 2020). Therefore, nurse managers should be included in the leadership of facilities to establish a safe work environment and promote nurses' motivation.

We also observed that participants were dispatched to unfamiliar settings which did not match their current nursing specialty or professional preparation. Unexpected assignments to different departments or units during pandemics (Danielis & Mattiussi, 2020) can make nurses feel unprepared and insecure about meeting the job demands (Danielis et al., 2021). In our study, nurses were stressed because of their lack of work-related skills and inadequate training from the medical sites to provide good care to patients. Employing a 'buddy' system between a newer nurse and a critical care specialist to assist inexperienced staff was reported to be an effective way to provide better patient care during the COVID-19 pandemic (Marks et al., 2021). An educational programme that helps less experienced nurses build required skills and confidence should be developed for the current and future pandemic situations.

Despite the challenges, the participants in our study expressed their willingness to work in future pandemic situations. They learned a great deal from their experiences, which increased their confidence in their enhanced capabilities. This highlights the importance of providing regular education or training, even during non-pandemic situations, to ensure that nurses are better prepared to work in unfamiliar situations. Developing confidence in advance, coupled with adequate workplace structure, could positively impact nurses' willingness to respond to special pandemic situations in the future.

This study has several limitations. First, we identified participants from their social media posts about pandemic work experiences. Those inactive on social media may be more likely to report different experiences that may weigh more on one side, whether positive or negative. Second, data collection was conducted from August to November 2020 and focused primarily on the early stages of the pandemic in South Korea. As the pandemic is still ongoing, there is an opportunity to make workforce improvements and reevaluate nurse experiences. More research on the experiences of health care workers who volunteered for an emergency medical response is needed to confirm the suggested strategies to build safe and efficient workplace environments during a pandemic. The availability of vaccinations as well as newly-developed COVID-19 treatments may have changed the experience of nurses addressing the pandemic and their professional perceptions of what is needed to improve working conditions. Future work of the present pandemic may also evolve as the COVID-19 infection rates change and the knowledge of pathogen transmission modifies the perceptions and comfort level of nurses.

5 | CONCLUSIONS

Nurses who participated in the COVID-19 medical response did their best with the available resources to care for patients while fulfil their role as nurses, even under poor working conditions. They participated in the emergency response as part of their social responsibilities and to have new experiences, despite risks of infection with a disease agent that had an unknown mode of transmission, no definitive treatment at the time and still unknown long-term effects. Nurses who achieved personal and professional growth through working in the COVID-19 medical sites expressed their intention of responding to calls for nurse deployment again in the event of a future pandemic. The experiences of our participants, combined with the research findings of other teams, clearly point to workplace modifications that can be made to more effectively recruit, manage and support the nursing workforce during a pandemic. Proactively preparing for unfamiliar situations, as opposed to reactive employment and training, and continuous development of appropriate and safe working environments, should be a priority in the 'new normal' days during and after COVID-19.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

To recruit, manage and, most importantly, *support* the nursing workforce during a pandemic effectively, a safe work environment with proper resources should be established. First, it is necessary to determine an ideal replacement time of the workforce by considering not only their fatigue and need for respite, but also the need for experienced staff members to continue work at the sites until new staff members are competent in care during the special situation. Second, COVID-19 facility management teams must include direct-care nursing personnel and health care personnel as managers and directors. Communication between management and the workforce requires improvement; nurses need an environment where their concerns about workplace safety and conditions are not only heard but also addressed. Finally, regular training for a pandemic should be implemented for all health care workers to assist them in developing the capacity to respond to unexpected pandemic situations efficiently and effectively.

ACKNOWLEDGMENTS

We thank nurses who participated in this study.

This work was supported by the Facultystudent Research Grant 6-2020-0049 from College of Nursing, Yonsei University. No funding body had a role in the study design and collection, analysis and interpretation of data and in manuscript writing.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

ETHICS STATEMENT

Ethical approval of this study was obtained from the Institutional Review Board of Yonsei University Health System (Y-2020-0092).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Hyunjie Lee https://orcid.org/0000-0002-4237-6175
Seung Eun Lee https://orcid.org/0000-0002-4173-3337
Somin Sang https://orcid.org/0000-0002-9023-3240
Brenna Morse https://orcid.org/0000-0001-9876-4700

REFERENCES

Alharbi, J., Jackson, D., & Usher, K. (2020). The potential for COVID-19 to contribute to compassion fatigue in critical care nurses. *Journal of Clinical Nursing*, *29*, 2762–2764. https://doi.org/10.1111/jocn.15314

Barello, S., & Graffigna, G. (2020). Caring for health professionals in the COVID-19 pandemic emergency: Toward an "epidemic of empathy" in healthcare. *Frontiers in Psychology*, *11*, 1431. https://doi.org/10.3389/fpsyg.2020.01431

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

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential phenomenological alternatives for psychology* (pp. 48–71). Oxford University Press.

Danielis, M., & Mattiussi, E. (2020). The care of patients through the lens of the fundamentals into times of the COVID-19 outbreak. *Intensive and Critical Care Nursing*, *60*, 102883. https://doi.org/10.1016/j.iccn.2020.102883

Danielis, M., Peressoni, L., Piani, T., Colaetta, T., Mesaglio, M., Mattiussi, E., & Palese, A. (2021). Nurses' experiences of being recruited and transferred to a new sub-intensive care unit devoted to COVID-19 patients. *Journal of Nursing Management*, *29*, 1149–1158. https://doi.org/10.1111/jonm.13253

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

Gao, X., Jiang, L., Hu, Y., Li, L., & Hou, L. (2020). Nurses' experiences regarding shift patterns in isolation wards during the COVID-19 pandemic in China: A qualitative study. *Journal of Clinical Nursing*, *29*, 4270–4280. https://doi.org/10.1111/jocn.15464

Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare*. John Wiley & Sons.

Holroyd, E., & McNaught, C. (2008). The SARS crisis: Reflections of Hong Kong nurses. *International Nursing Review*, *55*, 27–33. https://doi.org/10.1111/j.1466-7657.2007.00586.x

Karimi, Z., Fereidouni, Z., Behnammoghadam, M., Alimohammadi, N., Mousavizadeh, A., Salehi, T., Mirzaee, M. S., & Mirzaee, S. (2020). The lived experience of nurses caring for patients with COVID-19 in Iran: A phenomenological study. *Risk Management and Healthcare Policy*, *13*, 1271–1278. https://doi.org/10.2147/RMHP.S258785

Kim, J. S. (2020, February 29). Confirmed patients who couldn't even go to the hospital. Jungang Daily. https://news.joins.com/article/23718609

Kim, J. H., An, J. A. R., Min, P. K., Bitton, A., & Gawande, A. A. (2020). How South Korea responded to the Covid-19 outbreak in Daegu. *NEJM Catalyst*, *1*(4). https://doi.org/10.1056/CAT.20.0159

Labrague, L. J., & De los Santos, J. A. A. (2020). COVID-19 anxiety among front-line nurses: Predictive role of organisational support, personal resilience and social support. *Journal of Nursing Management*, *28*, 1653–1661. https://doi.org/10.1111/jonm.13121

Marks, S., Edwards, S., & Jerge, E. H. (2021). Rapid deployment of critical care nurse education during the COVID-19 pandemic. *Nurse Leader*, *19*, 165–169. https://doi.org/10.1016/j.mnl.2020.07.008

Nayna Schwerdtle, P. N., Connell, C. J., Lee, S., Plummer, V., Russo, P. L., Endacott, R., & Kuhn, L. (2020). Nurse expertise: A critical resource in the COVID-19 pandemic response. *Annals of Global Health*, *86*, 49. https://doi.org/10.5334/aogh.2898

Phelan, A. L., Katz, R., & Gostin, L. O. (2020). The novel coronavirus originating in Wuhan, China: Challenges for global health governance. *JAMA*, *323*, 709–710. https://doi.org/10.1001/jama.2020.1097

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation*, *2007*(114), 11–25. https://doi.org/10.1002/ev.223

Shiao, J. S. C., Koh, D., Lo, L. H., Lim, M. K., & Guo, Y. L. (2007). Factors predicting nurses' consideration of leaving their job during the SARS outbreak. *Nursing Ethics*, *14*, 5–17. https://doi.org/10.1177/0969733007071350

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63–75. https://doi.org/10.3316/QRJ1102063

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*, 349–357. https://doi.org/10.1093/intqhc/mzm042

Yoon, D., & Martin, T. W. (2020, February 21). Not enough doctors in Daegu: As virus cases rise, South Korea's response is criticized. *The Wall Street Journal.*. https://www.wsj.com/articles/not-enough-doctors-in-daegu-as-virus-cases-rise-south-koreas-response-is-criticized-11582547600

Zhang, Y., Wei, L., Li, H., Pan, Y., Wang, J., Li, Q., Wu, Q., & Wei, H. (2020). The psychological change process of frontline nurses caring for patients with COVID-19 during its outbreak. *Issues in Mental Health Nursing*, *41*, 525–530. https://doi.org/10.1080/01612840.2020.1752865

SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

How to cite this article: Lee, H., Lee, S. E., Sang, S., & Morse, B. (2022). The lived experience of nurses who volunteered to combat the COVID-19 pandemic in South Korea: A qualitative phenomenological study. *Journal of Nursing Management*, *30*(4), 864–871. https://doi.org/10.1111/jonm.13571