Global Qualitative Nursing Research
Volume 10: 1–14
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DOI: 10.1177/23333936231155052
journals.sagepub.com/home/gqn
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The Lived Experiences of Nurses Caring for Patients With COVID-19 in Arabian Gulf Countries: A Multisite Descriptive Phenomenological Study

Husain Nasaif[1], Khaldoun Aldiabat[2], Muna Alshammari[3], Monirah Albloushi[4], Sumaya Mohammed Alblooshi[5], and Shafeeqa Yaqoob[6]

Abstract

Since the beginning of the COVID-19 pandemic, several studies worldwide have explored nurses' experiences of caring for COVID-19 patients in various healthcare settings. However, these studies were conducted in context, culture, and healthcare systems that differ greatly from the Arabian Gulf context. This descriptive phenomenological study aimed to understand nurses' lived experiences caring for patients diagnosed with COVID-19 in Arabian Gulf countries. Individual virtual interviews were conducted with 36 nurses from five countries and were analyzed using Giorgi's methodology. Four main themes were identified: (1) living with doubts, (2) living through the chaos of challenges, (3) moving toward professional resilience, and (4) reaching the maximum level of potential. The findings from this study hopefully will guide health organizations in this region in developing strategies and policies to support and prepare nurses for future outbreaks.

Keywords

COVID-19, lived experiences, nurses, phenomenology, Giorgi's method, Arabian Gulf countries

Received October 4, 2022; revised January 11, 2023; accepted January 16, 2023

Introduction

In January 2020, the World Health Organization (WHO) declared the outbreak of a new coronavirus disease (COVID-19) to be a Public Health Emergency of International Concern (WHO, 2020a). The virus infects the respiratory system and manifests as cough, fever, and shortness of breath, occurring for the first time in Wuhan, China, in December 2019 (Johns Hopkins Medicine, 2020). In March 2020, the WHO announced that COVID-19 was a pandemic (WHO, 2020b). The number of people infected has grown to more than 500 million worldwide, with more than 6 million deaths reported to the WHO. Public health authorities worldwide continued to mitigate the outbreak (WHO, 2021). As of the 9th of May 2022, there have been more than 21 million confirmed reported cases in the Eastern Mediterranean Region. *The number of confirmed cases and deaths in the Arabian Gulf countries is increasing (Saudi Arabia, Oman, Kuwait, Qatar, Bahrain, and the United Arab Emirates).* The number of people infected in all six countries has exceeded 3 million, with more than 20,000 deaths (WHO, 2022).

During the COVID-19 crisis, healthcare systems strained under the surge of patients, with healthcare professionals in many countries working in high-stress environments with shortages of personal protective equipment and inadequate mechanical ventilation devices (Rana et al., 2020; Ranney et al., 2020). Healthcare workers also experienced family and social avoidance due to stigma or fear of the disease (Centers for Disease Control and Prevention [CDC], 2020). This made

[1]Royal College of Surgeons in Ireland-Medical University of Bahrain, Busaiteen, Kingdom of Bahrain
[2]Cape Breton University, Sydney, Nova Scotia, Canada
[3]The Public Authority for Applied Education and Training, Safat, Kuwait
[4]King Saud University, Riyadh, Saudi Arabia
[5]Emirates Health Services, Abu Dhabi, United Arab of Emirates
[6]Ministry of Health, Bahrain

Corresponding Author:
Husain Nasaif, Royal College of Surgeons in Ireland-Medical University of Bahrain, Building No: 2441, Road: 2835, Busaiteen, 228, Kingdom of Bahrain.
Email: hnasaif@rcsi.com

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an already challenging situation much more difficult. Additionally, the pandemic has generated stress and added burden on healthcare providers, especially nurses worldwide. Nurses were at the frontline to provide direct care, such as screening, implementing protocols, communicating with families, and caring for unstable and critically ill patients in various healthcare settings. The pandemic continues to take a heavy toll on their physical and mental wellbeing (Awan et al., 2022). According to international news agencies, two nurses have committed suicide in Italy due to the burden of caring for patients with COVID-19 (Associated Press, 2020). At least 90,000 healthcare workers have been infected worldwide (Reuters, 2022). More than 170,000 healthcare workers died from COVID-19 between January 2020 and May 2021 according to WHO reports (WHO, 2021). As of January 2021, the cumulative number of reported COVID-19 deaths in nurses in 59 countries was 2,710 (International Council of Nurses [ICN], 2021).

Previous studies found that burnout among nurses was associated with the outbreak of Middle East Respiratory Syndrome coronavirus (MERS-COV), which occurred in 2012 and is largely similar to COVID-19. The level of burnout was found to be significantly higher in nurses who had nursed MERS-COV-infected or MERS-COV suspected patients (Kim & Choi, 2016). Additionally, recent studies have reported burnout, depression, and anxiety among nurses due to direct contact with COVID-19 patients (Awan et al., 2022; Murat et al., 2021; Nadeem et al., 2021; Odikpo et al., 2021). A cross-sectional study in China found that 50.4% of nurses who provided care to COVID-19 patients suffered from symptoms of depression. Of those nurses, 34%, 44.6%, and 71.5% reported insomnia, anxiety, and distress symptoms, respectively (Lai et al., 2020). A cross sectional large study in Saudi Arabia found a high level of burnout among nurses during the COVID-19 pandemic (AlJhani et al., 2021). According to a recent systematic review, the pooled estimate for the prevalence of anxiety and depression among healthcare workers during COVID-19 in the Arabian Gulf Cooperation Countries was 34.7% and 53.1% respectively.

As the COVID-19 pandemic intensified, there was an urgent need for an in-depth understanding of nurses' lived experiences and their fear, moral distress, and *challenges they experienced when caring for COVID-19 patients. Since the beginning of the pandemic, many studies have explored nurses' experiences of care of COVID-19 patients in different healthcare settings, including intensive care units (Brockopp et al., 2021; Gunawan et al., 2021;* Karimi et al., 2020; *N. Lee & Lee, 2020; H. Lee et al., 2022;* Melnikov et al., 2022; Ménard et al., 2022; Moore et al., 2022; *Moradi et al., 2021; Perraud et al., 2022; Robinson & Stinson, 2021)*. These studies were conducted in North America (USA, Canada), Europe (Sweden, Italy, France), and Asia (Chania, South Korea, Iran). However, while these studies were conducted among nurses, they were carried out in a context, culture, and health care systems that differ greatly both culturally and contextually from the Arabian Gulf context, with the exception of one *study to date that has been published in Qatar (Villar et al., 2021). Participants in Qatar study experienced stress, fear, and exhaustion. In an attempt to address* this gap, this study aims to explore the lived experience of nurses caring for patients diagnosed with COVID-19 in five Arabian Gulf countries.

Methods

Design

This is a multisite study involving nurses from Bahrain, Saudi Arabia, Oman, Kuwait, and the United Arab Emirates (UAE). The current study used a qualitative descriptive phenomenological design developed by Giorgi (1970, 1985, 2009) to describe the lived experiences of nurses who cared for COVID-19 inpatients. This method is useful when little is known about phenomenon and the aim is to conduct an indepth exploration of experiences as described by those who have lived the experience in order to capture and describe as closely as possible the meanings attached to those lived experiences (Giorgi, 1997).

Setting and Sample

The participants in this study were nurses who provided direct care for more than one month to COVID-19 patients who were admitted to the hospitals in intensive care units and medical units. A purposive snowball sampling method was used to recruit nurses from each study site who met the inclusion criteria and represented the targeted group. Giorgi's studies have utilized anywhere from 2 to 23 participants (Russell & Dickie, 2007), with an average of eight participants found in the literature. Russell and Aquino-Russel (2011) recommended using an average of eight participants for descriptive phenomenological studies. The required sample size for this study was estimated to be approximately six to eight participants from each selected country, including both male and female local and expatriate nurses. Participants who met the inclusion criteria and expressed interest in participating part in the study were invited to participate.

Recruitment Procedure

In one of the study sites (Saudi Arabia), the study was advertised with a poster on social media (Twitter and WhatsApp), and users were invited to share the poster with their social media groups. In Bahrain, Kuwait, United Arab of Emirates, and Oman, the poster was placed in the hospital units where COVID-19 patients were admitted. A gatekeeper within hospitals (a nurse who was not a part of this study) at each site who was not known to the study participants was utilized to

grant access and facilitate communications between the researchers and the participants. Participants interested in participating in the study were asked in the poster to contact the gatekeeper via email or telephone for more information about the study. The gatekeeper provided all information about the study, obtained a written consent form, and arranged for interviews at a convenient date and time for participants. Since the study was advertised through social media in one of the study sites (Saudi Arabia), the gatekeeper verified that participants who expressed an interest were nurses by asking them to share their nursing work ID. The verification was done before scheduling the date of the interview. This information was not shared with the interviewers. To ensure nurses recruited to the study met the study criteria, the gatekeeper asked the participants who expressed an interest to provide information about the length of time they were involved in caring for COVID-19 patients.

Data Collection Method

A semi-structured interview guide was used to collect the data. One pilot online interview was conducted at each site to allow interviewers to practice the interviewing techniques, investigate the appropriateness of the interview questions, and seek information on the context in preparation for conducting the main study interviews. The data from the pilot interviews were not included in the analysis. To adhere to the social distancing measures imposed by authorities and to ensure the safety of both researchers and participants, all interviews were conducted virtually via Microsoft Teams or ZOOM. The interviews took place between September 2020 and March 2021. They ranged in time between 45 and 90 min and were audio-recorded using the MS Teams integrated recording facility or a digital voice recorder (Phillips 1100 recorder). The interviews were conducted in the Arabic language for Arabic speaking nurses and English for non-Arabic speaking nurses. All Arabic speaking nurses were given the choice of Arabic or English and chose to be interviewed in Arabic. A primary investigator of the study and four co-investigators conducted the interviews, with one interviewer at each study site. All interviewers had previous experience in qualitative interviews. In addition, pilot interviews were conducted in all study sites and listened to by all interviewers to ensure consistency and consensus in terms of the initiation of the interview and probing questions. The guided interview questions were finalized and agreed upon following the discussion about the pilot interviews. The interviewers began the interview by asking the participant to respond to the following open-ended statement: "Tell me about your first experience caring for a patient infected with COVID-19 and how you felt about caring for a patient diagnosed with this disease." All recordings were manually transcribed by the researchers, and the Arabic transcripts were translated into English by bilingual professional culturally sensitive translators to minimize the loss of meaning. The participants were asked the following opened ended questions: Tell me about your first experience caring for a patient infected with COVID-19, and how do you feel about caring for patients diagnosed with this disease? What do you do to protect yourself, other patients, colleagues, family, and the public from possible COVID-19 infection? How do you think providing care for COVID-19 patients is different from providing care for other patients? How do you look at yourself as a nurse who is taking care of patients infected with COVID-19? How do you think others look at you (perceive you) as a nurse who takes care of patients infected with COVID-19? What are the personal, social, organizational, environmental, and financial challenges you face when caring for patients with COVID-19? How do these challenges inhibit or facilitate your work? and What kind of support do you receive while caring for COVID-19?. All interviews were conducted virtually by the study site authors on a date and time that were convenient for the participants.

Ethics

The ethical approvals were obtained from the research and ethics committees of the following institutions: Royal College of Surgeons in Ireland-Medical University of Bahrain, Ministry of Health in Bahrain, Sultan Qaboos University in Oman, King Saud University in Saudi Arabia, Ministry of Health in the United Arab Emeritus, and Ministry of Health in Kuwait. At some sites (Bahrain and Kuwait), we obtained permission from hospital administration and quarantine facilities to access the sites and recruit participants in the study. Participants' information sheet was provided to potential participants before commencing the study. The gatekeeper explains the purpose, benefits, risks, data collection methods, duration of the interview, right to withdraw, the confidentiality of information, participants' rights, and researchers' contact details. All participants gave written informed consent before the interview. The interviews were conducted via MS Teams or ZOOM, in compliance with the EU GDPR 2018 to ensure strict data protection per regulations and maintain participant confidentiality. To prevent recordings from being uploaded to the streaming platform of MS Teams, the privacy settings were adjusted to ensure that the recording was available to the researchers only. Any identifier that emerged from the recordings was anonymized in the transcripts. Any direct quotations from the participants used in the research were anonymized to avoid any link to their identity or their healthcare system. All recordings and transcripts were saved on the researcher's password-protected computer during the data analysis period.

Data Analysis-Synthesis

The verbatim transcripts of these interviews were analyzed using Giorgi's phenomenological method. We analyzed the data in two stages. Stage 1 involved the analysis of data

from each country separately using the following steps: (1) Contemplative dwelling with the descriptions; (2) Identifying meaning units; (3) Identifying focal meanings; (4) Synthesizing situated structural descriptions; (5) Synthesizing a general structural description. Step 1 involved reading the transcript freely and openly many times to gain an overall sense of the description of the whole statement. Step 2 involved an examination of the raw data descriptions, which are passages of text expressing meaning in the participant's own words. Approximately 1,000 meaning unit statements were extracted from all transcripts during this process. In the third step, we used our disciplinary language to abstract the meaning units to a higher level of discourse, transforming meaning units into focal meanings. In other words, the participants' meaning units was transformed into scientific expression. In step 4, the focal meanings synthesized from each participant were transformed into a situated structural description for each participant's specific situation. The situated structural description grasps the meaning of the experience and forms each participant's perspective. In step 5, the general structural description of the lived experience of nurses who took care of COVID-19 patients from the situated structural descriptions of the participants was synthesized into a statement that was more general than specific. In the second stage, a constant comparative method to compare and contrast the themes from all participants across all five countries was performed until the four general structural descriptions that describe the lived experiences of all participants were emerged. The general structural descriptions of the lived experiences of the research participants were synthesized from the situated structural descriptions of all the participants in the five countries. The data were analyzed as one entity for many reasons. Firstly, the five countries included in this study are under the umbrella of what is called the Gulf Collaborative Council countries. Secondly, they have many similar geographical, historical, social, political, and demographic characteristics. However, some differences fit the unique political and social systems of each country. In general, the health services in Gulf Collaborative Council countries are provided free of cost to all residents at primary, secondary, and tertiary levels. The purpose of the study was not to compare study sites but to understand the experience of caring for COVID-19 regardless of the available resources and types of care delivery and coordination.

Rigor

We used the criteria of credibility, transferability, dependability, and confirmability developed by Guba and Lincoln (1994) to ensure the trustworthiness of the data and analysis. In this study, credibility was achieved through consulting with peer researchers' activity. All researchers of this project worked hand in hand throughout all research steps. We pursued ongoing discussions, consultations, brainstorming, and feedback from each other to achieve this activity. For dependability, the data were analyzed based on Giorgi's method, and any differences in opinion were discussed and modified to ensure consistent results between the researchers at all sites. We achieved confirmability by using the same interview guide for all interviews and documenting in detail the research process, such as description of data collection and analysis-synthesis methods. For transferability, thick description and quotations from the participants ensured that the results from this study are meaningful to others who live the same experience in a similar context.

Findings

The study sample included 34 participants; men ($N=14$) and women ($N=20$) provided rich accounts of varied life experiences in caring for COVID-19 patients. The majority provided care for COVID-19 patients for more than three months, hold a bachelor's degree in nursing ($N=30$), and their ages ranged between 23 and 48 years. Fifteen were local nurses (citizens of Arabian Gulf countries). All were working in the ICU and medical units. Participants described their lived experience in caring for patients with, facing, and fighting COVID-19 as a journey that started from providing care in a context of doubt and uncertainty at the beginning of the pandemic. As time progressed, and with more experience and knowledge, nurses began to normalize and integrate care for patients with COVID-19 as part of their daily practice and felt confident they were practicing at their maximum potential as nurses. These lived experiences were categorized into four general structural descriptions and ten situated structural descriptions. The general structural descriptions were relevant to (1) living with doubts, (2) living through the chaos of challenges, (3) moving toward professional resilience, and (4) reaching the maximum level of potential. Relevant direct quotations from participants (meaning units) are provided. Table 1 illustrates the general structural descriptions and situated structural descriptions identified from the lived experiences of participants.

From Living With Doubt and Uncertainty to Reaching the Maximum Potential in COVID-19 Nursing Care

Nurses who were taking care of COVID-19 patients and fighting the pandemic described their experiences as paradoxical. They were living with doubts at the beginning of the pandemic because they were waiting for information about the new and unknown disease; they had no training and were uncertain. Their first experiences were described as shocking and difficult, accompanied by a feeling of fear and pride in managing the COVID-19 pandemic. Nurses lived through the chaos of challenges in dealing with the pandemic and reported experiencing a high level of physical, psychological, and social burdens. Nurses described their experiences

Table 1. General Situational Descriptives and Situational Structural Descriptives Identified From the Lived Experiences of Participants.

General situational descriptives	Situational structural descriptives
Living with doubts	Walking through a dark tunnel
	Paradoxical experience
Living through the chaos of challenges	Multidimensional burdens
	Fighting the invisible aggressive enemy without weapons
	Swinging between adequate and lack of resources, the low administrative support and power dynamics
Moving toward professional resilience	Living with ambivalent feelings
	From challenges to fully adaptation
	Role transition and exploring individual potentials
Reaching the maximum level of potential	Normalizing and reconceptualizing the nursing care
	Rewarding experience

metaphorically similar to fighting a battle where the enemy was hostile but invisible.

Nurses described how they tried at the beginning to fight the pandemic without "weapons." They used this phrase metaphorically to mean a lack of evidence-based practice knowledge or training related to COVID-19. Although nurses faced COVID-19 as a new challenge, they wanted to embrace and tackle it in ways acceptable within their profession. Nurses had to tackle the COVID-19 challenges with their full strength, focusing on the well-being of their patients and their families. As the pandemic progressed, nurses felt they developed a deeper connection to their inner selves and responses to situations. The availability of adequate medical supplies to fight COVID-19 helped nurses handle the challenges and made them feel safe in their work environment as they could protect themselves. Public perceptions of nurses who worked with COVID-19 varied widely and also influenced nurses' lived experiences. Some public perceptions negatively influenced nurses' self-confidence and made them feel stigmatized. However, when public perceptions were positive, they encouraged nurses and enhanced their self-confidence and feelings of pride. Nurses could manage the challenges professionally and felt themselves developing professional resilience. The participants in this study had an opportunity to reflect on how this experience had changed and made them understand or explore their potential. Over time, and with more knowledge and experience, nurses reached the maximum of their potential in taking care of COVID-19 patients and fighting the pandemic by normalizing and reconceptualizing the care of COVID-19 as part of their daily routine and described their experiences as rewarding and unforgettable.

General Situational Descriptive 1: Living With Doubts

Situational Structural Descriptive 1: Walking Through a Dark Tunnel

Before COVID-19 was classified as a pandemic, nurses described their experiences as walking through a dark tunnel because they had very little knowledge about the disease and its treatment, accompanied by a lack of training in managing and fighting the pandemic. This situation created a feeling of uncertainty about the treatment plans and how to deal with the new disease.

There was little knowledge available about the pandemic and the disease itself. During this time, although nurses were eager to learn more about it and how to take care of their patients and communities, the lack of evidence-based knowledge about COVID-19 left nurses feeling stressed and disappointed that they often didn't know more about COVID-19 than the general public. In addition, time pressures resulted in a lack of adequate training on dealing with and taking care of patients with COVID-19, and left nurses feeling unsure and less confident about their nursing care. They described caring for patients with COVID-19 during this time as complex and the work environment scary. The following are three quotations from three different participants:

> *All people were looking toward China to seek more information about this unknown and vague disease (COVID-19). Still, there was not enough information about its nature and treatment; no real facts about it but misconceptions . . . As a professional nurse, it was disappointing for me to know about this unknown new disease as other laypeople knew about it; I was waiting and watching its progression through the media. Waiting for the unknown was an unpleasant and stressful feeling, especially for nurses who would be on the frontline dealing with COVID-19.*

> *There was no time for us to get enough training to work with COVID-19 cases . . . There was only a one-hour introductory training session to control the infection. I wish I could get enough training about the disease's pathophysiology, the chain of the infection, the treatment and prevention control . . . The first COVID-19 case I dealt with was the most difficult one; I felt like a first-year nursing student who did not know how to manage the case; I asked many questions and asked my colleagues to stay around me until I finished the shift. When I finished the shift, I felt like I had achieved the impossible mission.*

> *Talking with other people and colleagues and listening to other contradicted news and facts about COVID-19 and nourished my feeling of uncertainty. I was uncertain about who am I. Am I a nurse who must take care of and protect society from the infection, or am I a layperson who has concerns about the pandemic like other people?*

Situational Structural Descriptive 2: Paradoxical Experience

The first experiences of the nurses caring for COVID-19 were accompanied by conflicting feelings of fear and pride. With

this paradoxical experience, many nurses reported that their first experiences were shocking and difficult for them. At the pandemic's beginning, some participants refused to join the COVID-19 centers and provide care to COVID-19 patients because the disease was new and unknown to them, but later, they decided to serve on the frontlines. Their first experiences in caring for COVID-19 patients and fighting the pandemic were described as terrifying and difficult to the extent that they did not want to talk about their suffering and the hours they spent with their patients. However, some expressed a feeling of being proud and happy in that they are making a difference and contributing to alleviating patients' suffering. They felt pride and were recognized by their family members, close friends, and the community as frontline nurses. The nurses reported that they accepted the challenges and were ready more than any other time to continue working hand in hand with the medical team. A high sense of national and professional responsibilities, ethical nursing values, and support from family and community motivated nurses to continue to be involved in the front line. Despite their fatigue, nurses wanted to continue until the end of the pandemic and provide care for critically ill COVID-19 patients. The following are two quotations from two different participants:

A harsh experience, psychologically and physically . . . We were shocked and were caught in a place where "No, this is real COVID-19, believe it." We will talk about the hospital's atmosphere and how it was changed but not about the COVID-19 ICU patients and the eight hours we spent with them, and we can't talk about how it was difficult.

"I feel more proud as a nurse now than ever . . . Some people praise the work I do . . . This gives me positive energy and a morale boost that I am taking longer to provide care. Patients' prayers are comforting us, and their impact on our hearts is great, it helps us to be in a better psychological state."

I was ready to offer my services to COVID-19 patients. It is a humanitarian duty, especially since the country had a health crisis and needs anyone who provides services in terms of humanity. This is our duty, and the service we provide must be done with love and not by force because, in the end, they are patients, and their disease is unknown . . . I feel like I am responsible for that, and it is my mission. Who would care for them [patients] if my colleague and I turnover and refuse to work with infected patients?

General Situational Descriptive 2: Living Through the Chaos of Challenges

Situational Structural Descriptive 3: Multidimensional Burdens

At the beginning of the pandemic, nurses described high physical, psychological, and social burdens. Most nurses reported physical symptoms such as exhaustion, energy loss, profuse sweating, fatigue, weight loss, and problems related to hearing and vision due to prolonged and continuous wearing of personal protective equipment (PPE). All participants felt fear of the unknown and vague disease, being infected with the virus, and transmitting the infection to their family members and other community members. The sense of fear led the participants to isolate themselves socially, minimize contact with others, and on many occasions, avoided meeting their close relatives for a prolonged period. Nurses reported that their social and family life was greatly disrupted, and they felt socially isolated. They believe that people avoided them, and they are stigmatized as virus carriers and sources of infection that must be avoided. This situation made them hide the fact that they were working with COVID-19 patients and refrain from engaging in any social activities. Many nurses experienced psychological symptoms such as nightmares, insomnia, sleep disturbance, absent-mindedness, and obsession. Nurses who worked in the intensive care unit (ICU) felt guilty, blamed themselves for deteriorating patients' health conditions, and held themselves accountable. The number of deaths in the ICU during the peak of the pandemic and the care of dying patients was very traumatizing. The following are three quotations from three different participants:

I was extremely physically and psychologically exhausted. I am putting more effort when wearing the PPE; it is draining all my energy, especially when the weather is hot . . . We are wearing PPE not only for one day; we have almost been wearing it for more than six months, and this is very tiring and hard. We are suffocated with an N95 mask and overall suits. Sometimes I feel faint, and I cannot continue doing the work; we want to rest and gain some energy to continue.

I was afraid that parts of my body were not protected from the virus. I lived in stress most time when I am at work and on my shift . . . We [nurses] were exhausted . . . The psychological thing is seeing patients' health deteriorate rapidly . . . We observe the deterioration of the patient's health condition despite the management done by the team; we feel that we are one of the reasons that the patient became critically ill . . . We start the shift by resuscitating the patient and ending it with the same. We do packing for the dead bodies at the beginning and end of the shift duty . . . The hardest thing is that you are afraid of saying you are working in the Covid-19 center, especially if you are in a restaurant or cafe; you feel that if people knew where you are working, they would run away from you.

Some people look at me as an "epidemic" that must be avoided, and I have a live experience in this aspect. When the crisis first started and I moved to the Covid-19 center, my friends were saying to me, "Do not meet or see us.," "You are dealing with Covid-19 patients and carrying the virus to us." Even family members told me that if you move to Covid-19 center, don't visit us. Thus, I did not tell them that I was working there.

Situational Structural Descriptive 4: Fighting the Invisible Aggressive Enemy Without Weapons

The nurses described their experiences metaphorically as fighting a battle where the enemy was hostile but invisible. They described it as trying to fight "without weapons" and without the practice knowledge and training they needed. Nurses had to manage their feelings of role ambiguity because they were unsure what their role was, and they had a sense of role conflict to balance their professional duty and their families. Nurses' self-confidence was altered and influenced by the health status of the COVID-19 patients and the messages they received from the patients' families and their superiors at work. The following are three quotations from three different participants:

> *When taking care of corona patients, the terrifying issue is providing them with the nursing care that I was as a nurse, not sure if it was the best care ever or not. My consciousness was always alert and alarming and left me wondering if what I did for patients was right or wrong or if there was something else better we nurses could provide to our corona patients. There were not enough studies or evidence-based practices that could maximize the efficiency of our nursing care.*

> *My wife and I are nurses and have kids; my older parents also live with us in the same house. Both of us were nurses in the hospital taking care of infected patients, and at the same time, we were nurses at home trying our best not to infect our beloved ones. We lived in a conflict during that time to balance our role as nurses and our role as caring and protecting parents; we struggled a lot, especially when we could not hug or kiss or touch our kids or parents and stayed away in quarantine for a few days before we could interact with them again.*

> *The self-confidence level was not the same all the time. Its level went up and down, and many factors jeopardized it. As you know, nurses are on the frontline in fighting this disease; nurses feel like they are soldiers in a battle. Sometimes we feel like we are very confident because we sacrifice ourselves to rescue and protect others, especially when others appreciate our altruism toward them, and when we witness many COVID-19 patients recover and discharged from the hospital, in addition to the superiors' encouragement for us, and patients' families recognition to our efforts. However, our self-confidence sometimes decreases when we see COVID-19 dying without being able to help them.*

Situational Structural Descriptive 5: Swinging Between Adequate, Lack of Resources, Low Administrative Support, and Power Dynamics

As nurses were faced with the challenge of COVID-19, they wanted to embrace the challenge and tackle it in ways acceptable within their profession. Nurses felt that certain decisions regarding preventing and treating COVID-19 cases required their input. Although they appreciated teamwork, the nurses in this study perceived doctors as adding pressure to them, particularly when they issued commands without involving the nurses in the treatment plan or listening to their voices. Nurses also felt that some physicians lacked knowledge about nurses' specific roles and preferred to nurture and advance an independent role in regard to nursing care for COVID-19 patients. Nurses also felt that they were not treated professionally, with some of their rights being denied by the administration. They lacked administrative support and experienced this as detrimental to their health and well-being. Some nurses in isolation were denied proper leave. One nurse described how a colleague was denied sick leave when found to be infected with COVID-19. These challenges were generally attributed to the heavy workload and limited manpower at the facilities. In addition, nurses noted a lack of some essential resources at work that contributed to their fears of acquiring/transmitting infections. However, most nurses reported that despite the large numbers of patients, they always had enough supplies and medical equipment to fight the pandemic. Having adequate supplies made nurses feel safe in their work environment since they could protect themselves. The following are two quotations from two different participants:

> *It is better if physicians communicate and negotiate the COVID-19 cases with us [nurses] rather than ask us to follow their orders. That is a bit difficult because it comes as physicians command us to do something. We don't need to go far; better if we share the things between us [nurses and physicians].*

> *That is the one great thing that the government provided us with many supplies and medical equipment like PPE kits. Whatever we wanted, they [the government] provided us with plenty of equipment. We were happy wearing of PPE equipment given to us. Like that, we were taking care of ourselves.*

Nurses also reported a lack of support from the administration that was detrimental to their health. Some entitlements, such as annual or maternity leaves, were denied to some nurses. Nurses felt that managers should not deny their workers' essential entitlements, for example, maternity and sick leave, even amidst epidemics. One of the participants said:

> *My wife just got the annual maternity leave of one month. And after finishing her one month, she joined duty. And they did not give her any extra allowance. She has a problem with this one. The episiotomy is still not completely healed, and she has pain over the side, and she didn't take proper post-delivery care, because I used to go on duty, she was alone here to do the housework. She has to handle the baby and other things also. Cooking and all she had to and she didn't get much rest, and she did not take any medicine after the delivery.*

A few nurses also reported occasional shortages of essential supplies, such as PPE, which put nurses at risk of infection. For example, some nurses reported recycling masks which

they felt was risky for them and their patients. Some nurses also reported that many patients resulted in limited space in the ICU to accommodate the patient load. The lack of necessary resources and the fear of getting infected affected the nursing care provided to COVID-19 patients. One participant said:

> *So, each time you have to go and come, you have to use PPE. And nowadays, we [nurses] don't have the N95 enough. We are recycling. Now no more in the hospital. Some of them they are recycling around six or seven times the same mask. And this one, I will not tell you about this mask, whether it is healthy or not, but this is the situation. And that's why we have too many miles going and coming for the patient as much as we can.*

General Situational Descriptive 3: Moving Toward Professional Resilience

Situational Structural Descriptive 6: Living With Ambivalent Feelings

Nurses who work with COVID-19 patients received different and contradictory messages from the public because they work with COVID-19. Some people perceived them as heroes fighting the disease and protecting society, while others feared that they may be potential sources of infection. The former view promoted their satisfaction and boosted their self-confidence, while the latter negatively influenced their feelings and made them feel stigmatized. The following are three quotations from three different participants:

> *Public perception influences our perception of ourselves; the positive perception enhances our self-esteem and vice versa. Many people perceive us as heroes and the white military who fight the disease to protect societies. People appreciate our efforts and always thank us for what we do. This positive perception makes us proud of ourselves and encourages us to give back more to the public. However, some people perceive us as the source of COVID-19 infection; they avoid interacting with us once they know we are nurses and care for COVID-19 patients.*

> *At the beginning of the pandemic, I did not feel comfortable telling people that I am a nurse working with COVID-19 patients; I tried hiding this truth from the public because I felt shy when people stigmatized nurses just because we work with COVID-19 patients; people give body language and facial expression clues that they are scared of being dealing with us.*

> *Actually, I am always proud of what I am doing because nobody else can do it; it depends on how you make other people deal with you. Showing people assertiveness and the importance of your role as a COVID-19 nurse and convincing them that you are proud of what you do, you will get their appreciation and their respect. I do not care how people perceive me; I care about how I perceive myself because I believe that I am unique in my knowledge, skills, job, and profession.*

Situational Structural Descriptive 7: From Challenges to Full Adaptation

Nurses felt that COVID-19 came as a new challenge that they had to tackle with their full strength, focusing on the well-being of their patients and their families. While nurses went through a challenging moment dealing with the COVID-19 situation, many positive perspectives contributed to their well-being and motivation to continue fighting. Nurses acknowledged that being appreciated for their contribution in the fight against COVID-19 was a strong motivation on a personal level. Nurses felt their work became valued and respected by people inside and outside the hospital. Receiving positive feedback and appreciation from others was a motivation to continue doing good. Nurses received complimentary reports and special treatment from the public about their work, which motivated them. People considered nurses the frontline care for patients with COVID-19 and accorded them a great deal of respect. Nurses considered themselves heroes in the fight against COVID-19 for risking their own lives to save others. Through support and other measures, nurses discovered ways of dealing with the challenges posed by the new disease and reached a state of coping. After acquiring some information about the disease, nurses described how their fears disappeared, and they started to cope positively and deal with the disease. Nurses' readiness was facilitated by getting adequate information about the pandemic and the ongoing experience acquired. The following are two quotations from two different participants:

> *Really, we are proud to be nurses. People respect us outside and inside the hospital and give us a priority and help us feel proud . . . we receive too much respect and acknowledgment . . . They [people] pray for us and tell us to take care. People around us pray for us and send messages that we are great warriors and front liners . . . This is nursing fighting to keep people survive . . . great thing that we are doing, and we feel proud and appreciate our care.*

> *And now, I think all nurses experience dealing with this Corona . . . So our feeling now it's completely different from how we would work, like if you compare the present time with the beginning.*

Situational Structural Descriptive 8: Role Transition and Exploring Individual Potentials

Participants in this study felt they developed a deeper connection to their inner selves and responses to situations over time dealing with COVID-19. These participants had an opportunity to reflect on how their COVID-19 experiences had changed and made them understand or explore their potential, such as working in teams. Nurses from different areas have been moved to the critical care area to help care for COVID-19 patients. This experience pushed

the participants to explore their strengths in leading patient care and enhanced their ability to appreciate working teams and do multitasking work while working in uncertain situations. The following are three quotations from three different participants:

> *Like identify our potential, how we overcame the challenges, and we [nurses] realize our potential, which is all our weapons for the future.*

> *Teaming with senior ICU nurses was used as a strategy to manage the challenges and gaps in knowledge and skill in the subject.*

> *It [COVID-19 experience] also helped me refresh my knowledge and skills by taking care of COVID-19 patients. It helped me in some way a lot as a nurse.*

General Situational Descriptive 4: Reaching the Maximum Level of Potential

Situational Structural Descriptive 9: Normalizing and Reconceptualizing Nursing Care

After gaining more profound knowledge and more experience dealing with the COVID-19 disease and patients, nurses started to normalize nursing care for patients with COVID-19 as similar to nursing care for any other illness. Nurses could also reconceptualize and redefine nursing care to involve and integrate the care for patients with COVID-19 as part of their daily practice. Nurses became familiar with COVID-19, and they could use their assessment skills and critical thinking to deal with any COVID-19 case. They reported that taking care of patients with COVID-19 became part of their daily work in nursing; they became independent, more confident, and knowledgeable in taking care of COVID-19 patients without being hesitant. The following are three quotations from three different participants:

> *Over time, taking care of COVID-19 patients became part of our daily routine . . . We [nurses] started not to be surprised or overwhelmed to take care of these cases using our assessment and critical thinking skills. We realized that taking care of these patients is similar to taking care of patients with any other disease. Because of the coronavirus's nature, taking care of COVID-19 patients needs special care and protocol, but we could integrate this special care and protocols into our daily practice. Our intuition and expectations of the cases became more predictable and reliable.*

> *With more experience, I started to get rid of this feeling of hesitancy in taking care of COVID-19 patients. I became independent in providing care or making decisions. My experience has empowered me and changed many misconceptions I had gained from the media about COVID-19.*

> *By immersing myself in literature and attending many online seminars and conferences, I became very knowledgeable about COVID-19 and more confident in providing the best care to my patients. I became a reference to my colleagues, and I started to disseminate the knowledge and skills I gained to other novice nurses in the COVID-19 unit . . . it was a very challenging period until I could gain knowledge and enhance my self-confidence and get rid of fear and anxiety about caring for COVID-19 patients.*

Situational Structural Descriptive 10: Rewarding Experience

Participants identified and reflected on their experiences with COVID-19 as learning experiences and a step in preparing for the future. Although they reported high workloads and presented areas of uncertainties and fear, especially with the lack of information, their experiences were positive in certain aspects and very rewarding with the prominent recognition by the community and colleagues. Overall, most of the nurses agreed that their experiences were unforgettable. One participant said:

> *But one thing I thought when others were telling about the dark phase of or the dark days of COVID, I always felt it always had a very colourful thing also. So, whenever we experience something, we should always learn from our experience because every minute is a learning moment. Whatever we have been going through, it's always a message for us to prepare for the future . . . I think it was an unforgettable experience . . . I will never forget it because it's part of who I am as a nurse.*

Discussion

The current study explored the experiences of nurses working in COVID-19 care facilities from the early stages of the pandemic in five Gulf countries, including the UAE, Kuwait, Bahrain, Saudi Arabia, and Oman. Nurses described their lived experiences in taking care of patients with, facing, and fighting COVID-19 as a journey that started from living with doubt and uncertainty at the beginning of the pandemic and ended with reaching their maximum potential in COVID-19 nursing care. This was, however, not a straightforward journey but one filled with uncertainty, anxiety, fears, and physical obstacles. They were living with doubts at the beginning of the pandemic because they were waiting for information about the new and unknown disease; they had no specific training and were also uncertain regarding its course of progression. Lack of information regarding the spread, prognosis, and specific management of COVID-19 have been documented elsewhere as key factors influencing nurses' reactions to the COVID-19 pandemic (Hu et al., 2021; Ménard et al., 2022; Mokhtari et al., 2022).

Nurses in our study described the initial experiences of working with COVID-19 as shocking and difficult. The initial experience presented nurses with several challenges that

shaped their reaction to the COVID-19 situation. They reported a high level of physical, psychological, and social burdens, which impacted their social life, health, wellbeing, and consequently their role performance. Several studies have been undertaken since the emergence of the COVID-19 pandemic, and consistent with our study, nurses working with COVID-19 have experienced physical, psychological, and social challenges (Khasne et al., 2020; Y. Kim, 2018; H. Lee et al., 2022; Liang et al., 2021; Mokhtari et al., 2022).

A study by Galanis et al. (2021) reported an overall prevalence of emotional exhaustion among healthcare workers in COVID-19 care of 34.1%, while another study reported high rates (50% and above) of burnout among healthcare workers in COVID-19 care (Khasne et al., 2020). Physical challenges such as burnout were generally attributed to work overload and inadequate human resources, resulting from the additional burden of COVID-19. Factors including job-related stress, poor hospital resources, and poor support from friends and family have also been documented to contribute to the burnout of nurses involved in coronavirus care (Kim & Choi, 2016; Wei et al., 2022).

Although measures were instituted to ensure normalcy, such as outsourcing nurses from other centers and abroad, these did not eliminate staffing challenges. The countries of the Gulf Cooperation Council instituted an emergency workforce to bridge human resource gaps in periods of pandemics that increased the burden on an already constrained healthcare system. The most reported psychological challenges faced by nurses during the COVID-19 pandemic include the fear of contracting COVID-19, seeing others die and being powerless to intervene, fear of delivering bad news to relatives of the deceased, fear that they could carry the virus to their families and infect them, having to endure uncomfortable protective wear, unmet needs and expectations, and general feelings of powerlessness (Ahmadidarrehsima et al., 2022; Akkuş et al., 2022; Galehdar et al., 2020; Hu et al., 2021; Lai et al., 2020; Stimpfel et al., 2022; Sun et al., 2020).

These concerns were similarly reported in the current study. Interventions such as providing safe and conducive working conditions, financial rewards, adequate supplies, and having necessary information have been recommended to address the psychological burden associated with COVID-19 care (Xu et al., 2021). Social burdens have been attributed to unpleasant social experiences, such as witnessing several deaths resulting from COVID-19 and feelings that society is noncompliant with COVID-19 control measures (Ahmadidarrehsima et al., 2022; Akkuş et al., 2022; Galehdar et al., 2020; Hu et al., 2021). These challenges have been reported to affect nurses' health and wellbeing and should thus be handled with great concern (Bergman et al., 2021; Galanis et al., 2021).

A lack of resources, such as personal protective equipment, and inadequate knowledge of COVID-19 care have emerged as serious obstacles for delivering quality care to COVID-19 patients. Nurses in the Gulf countries described their experiences as fighting a "hostile and invisible enemy," yet without weapons, a finding also reported in other studies (N. Lee & Lee, 2020; Mokhtari et al., 2022). While some nurses reported having adequate resources, the majority of the centers reported moderate to severe shortages of necessary supplies. Occasionally, nurses reported feeling frustrated and wanting to give up their duty, while those who reported having sufficient support were motivated to fight on. In a study by Chau et al. (2021), it was reported that adequate preparation and provision of adequate resources, such as personal protective equipment played a key role in how nurses approached the COVID-19 situation and contributed to the overall success of care. This evidence has been supported by several other authors who emphasized the need to provide adequate resources to facilitate the work of nurses and the COVID-19 workforce in general (Galanis et al., 2021; Liang et al., 2021; Stimpfel et al., 2022).

It is also important that nurses are continuously supported with relevant and up-to-date information regarding COVID-19 management. Authors have further encouraged authorities to pay attention to the overall working environment, including material and personal support (Chau et al., 2021; Kackin et al., 2021; Wei et al., 2022). Specifically, maintaining the physical and mental health of nurses should be prioritized (Kackin et al., 2021).

Despite the obstacles faced, nurses in this study reported tackling the COVID-19 challenge selflessly and with their full strength, focusing on the well-being of the patients and their families. Several factors were reported as motivating the nurses and facilitating positive experiences. These were being recognized as key contributors in the COVID-19 fight, collegial support, financial incentives, and the availability of necessary supplies. Some nurses reported that they derived motivation to work from within, irrespective of external negativities. As authors report, pleasant social experiences and inner satisfaction became a major motivation for work for nurses in their studies (Ahmadidarrehsima et al., 2022; Sun et al., 2020).

Collegial and management support was also reported as a key motivation for nurses in this study. The findings of this study further strongly support the notion of multistakeholder engagement in managing the COVID-19 pandemic. Stakeholders such as governments, NGOs, facility administrators, families, and the community were important in supporting the role of nurses in COVID-19 care provision. This finding is consistent with previous research (Chau et al., 2021; Khasne et al., 2020; Y. Kim, 2018). The various challenges encountered left nurses demotivated and with low self-confidence. They intentionally worked out ways to enhance their self-confidence and feelings of pride, thereby propelling them toward professional resilience and exploration of their potential as care providers. Although they faced

COVID-19 as a new challenge, they wanted to embrace and tackle it in ways acceptable within their profession. As other authors note, nurses working in COVID-19 care devise problem solving and stress management strategies as they navigate their journey of COVID-19 care (Ahmadidarrehsima et al., 2022; Bergman et al., 2021; Chau et al., 2021).

Consistent with other studies focusing on nurses' experiences during COVID-19, the nurses in this study experienced personal growth and developed a deeper connection to their inner selves and responses to the situation (Han et al., 2022; N. Lee & Lee, 2020). One study reported that nurses who worked in COVID-19 care possessed resilience, self-care, and adaptability when confronting resource shortages, changing nursing protocols, and physical and mental health threats during the COVID-19 pandemic (Chau et al., 2021), while another reported how the challenging journey resulted in adaptation and survival (Hu et al., 2021). Over time, and with more knowledge and experience in COVID-19 management, nurses in the Gulf Cooperation Council countries reached the maximum of their potential in taking care of their patients and fighting the pandemic. They tried to normalize and reconceptualize COVID-19 care provision as part of their daily routine and described this experience as rewarding and unforgettable. The possible explanation for the normalization of COVID-19 care provision was the effectiveness of vaccination and preventative measures that have been implemented in the community and hospital-based settings in mitigating the spread of the virus and mortality rate.

Strengths and Limitations

Recruiting 34 nurses who worked with COVID-19 patients for more than three months in five countries generated a wealth of information. The diversity among study participants in relation to gender, nationality, and area of practice is one of the strengths of this study. Another strength of this study is that the interviews were conducted in the Arabic language for the majority of Arabic speaking nurses. This approach allowed participants to express the in-depth meaning of the experience in their preferred language. However, the non-Arabic speaking participants were disadvantaged because the interviews were not conducted in their first language. The interviews were conducted in the English language for non-Arabic speaking participants. The study involved nurses from intensive care units and medical units for stable asymptomatic COVID-19 patients. Therefore, the findings captured the experience of nurses working not only in critical care settings but also in other medical units.

Implications for Practice

The findings of this study indicate the need for concerned authorities to pay special attention to nurses' challenges and needs while they engage in COVID-19 care or other similar pandemics. The focus should be placed on addressing the nurses' physical, psychological, and social needs. Nurses should be prepared and supported to cope with some of the inevitable challenges of caring for COVID-19 patients. Providing appropriate information, initial and refresher training, constant emotional support, and monitoring and support supervision of nurses will enhance their ability to provide quality care. Adequate financing for COVID-19 activities would go a long way in mitigating many challenges identified in this study.

Conclusion

Nurses who were taking care of COVID-19 patients and fighting the pandemic in the Gulf region described their experiences as paradoxical. In the initial phases of the pandemic, nurses lived in doubt as they were skeptical about the new and unknown disease. The lack of training and limited information about the disease caused intense uncertainty among them. Nurses reported a high level of physical, psychological, and social burdens, which were metaphorically reported as "fighting a battle with a hostile but invisible enemy" and "without weapons." Nurses had to tackle the challenges imposed by the COVID-19 pandemic with their full strength, focusing on the well-being of their patients and families. The availability of medical supplies and support from superiors, colleagues, the community, and family helped nurses navigate the challenges and provide professionally acceptable patient care. Nurses moved toward professional resilience and achieved a fulfilling level of their role performance by normalizing and reconceptualizing the care of COVID-19 patients as part of their daily routine. Support at various levels is still required to enhance the role of nurses in COVID-19 care in the Arabian Gulf Region. The findings from this study provide insights and a deeper understanding of the experience of nurses who provide care for patients diagnosed with COVID-19 within the Arabian Gulf context. A new and deeper understanding provides a rationale for nurses to establish a safer healthcare system in preparation for infectious disease outbreaks and improve nursing practice to respond to future outbreaks. We hope that the findings from this study will help organizations develop new strategies and policies to support and prepare the nursing workforce for any future pandemic and outbreaks.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Husain Nasaif https://orcid.org/0000-0001-5793-3512

Muna Alshammari https://orcid.org/0000-0002-7286-3556

Monirah Albloushi https://orcid.org/0000-0001-8232-1040

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Author Biographies

Dr. Husain Nasaif is a Senior Nursing Lecturer and director of the undergraduate nursing programme at the Royal College of Surgeons in Ireland – Medical University of Bahrain. He is a fellow of the Faculty of Nursing & Midwifery RCSI Dublin. He is the principle of investigator for a couple of primary research and systematic review projects at the national, regional, and international levels.

Dr. Khaldoun Aldiabat is a Faculty member and the Assistant Dean for Research and Scholarship at the School of Nursing at Cape Breton University – Canada. He is a scientist affiliate in three research centers in Nova Scotia province. Among his research interest areas are community and mental health nursing and self-management using qualitative methods.

Dr. Muna Alshammari is an assistant professor and Head of the Bachelor of Science in Nursing Department College of Nursing, Kuwait. She leads a national initiative to introduce postgraduate education for nursing in Kuwait.

Dr. Monirah Albloushi is an assistant professor at King Saud in Saudi Arabia. She is the head of the Medical-Surgical Nursing Department. Her areas of research interest are nursing education and qualitative research.

Dr. Sumaya Mohammed Alblooshi is the President of the Emirates Nursing Association and Director of the Nursing Department at EHS. She leads the National Nursing & Midwifery Strategy in the UAE. She is the first Emirati recipient of a fellowship from the American Academy of Nursing.

Ms. Shafeeqa Yaqoob is a senior nurse with twenty-four years of experience in secondary care. She is a part-timer lecturer and external examiner at the College of Health Sciences and Sport at the University of Bahrain and the School of Nursing and Midwifery at the Royal College of Surgeons in Ireland.