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An uncertain time: Clinical nurses' first impressions during the COVID-19 pandemic

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Abstract

The COVID-19 pandemic overwhelmed the US healthcare system and healthcare providers. Nurses, who comprise one of the most affected groups because they are the largest group of healthcare providers, were in a unique position to speak about their perspectives. As a result of the COVID-19 pandemic, nurses have experienced ongoing physical and psychological challenges while displaying strength and perseverance during uncertain times. In this study, we explored the perceptions and experiences of nurses in clinical practice caring for patients diagnosed with COVID-19 during the pandemic. Researchers conducted a qualitative descriptive study with 20 clinical nurses most of whom were enrolled in a graduate program while working in healthcare settings. Semi-structured interviews conducted through Zoom occurred between August 2020 and December 2020. Thematic analysis was used to analyze the transcripts. Five themes emerged: navigating uncertainty, managing death and loss, acknowledging emotional responses, learning opportunities, and facing community undercurrents. Lack of clinical practice guidelines, and inconsistent access to personal protective equipment when providing care to patients with COVID-19 caused emotional strain for nurses and highlighted future learning opportunities. Providing support to dying patients was devastating to nurses. Concern about community misunderstandings of the pandemic created challenges. Evolving teamwork provided invaluable support to study participants. Nurses shared essential information for revising and creating clinical practice guidelines. Nursing interventions and strategies were used to produce humane and positive patient outcomes and provide a foundation for nurse-driven care in possible future pandemics.

KEYWORDS
coping, COVID-19 pandemic, frontline nurses, nurse experience, uncertainty

1 | INTRODUCTION AND BACKGROUND

The COVID-19 pandemic, caused by the SARS-CoV-2 virus, was first identified in December 2019, declared an international public health emergency by the World Health Organization (WHO) in January 2020, and declared a pandemic in March 2020 (WHO, 2022). Despite efforts to contain its spread, COVID-19 continues to challenge the healthcare system. Since the beginning of the pandemic, it became apparent that nurses as healthcare providers were undergoing unique and new experiences as they provided care for patients

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with COVID-19. In the early months of the pandemic when little was known about the deadly COVID virus, nurses were involved in the evolving patient care as evidence and treatment protocols were being developed. The COVID-19 pandemic continues to overwhelm the US healthcare system and providers, including nurses who comprise the largest workforce in healthcare. Research on the experiences of nurses is critical to examine how nurses encountered this novel coronavirus. Nurses continue to care for patients with COVID-19 and experienced the struggles of healthcare systems (Khandia et al., 2022). Moving into year 3 of the pandemic, healthcare systems continue to respond to ongoing surges of patients diagnosed with the newest variants or breakthrough infection (Elicker, 2022; Wang et al., 2022). Studies conducted early in the pandemic reported the emotional responses of nurses at the bedside: anxiety, stress, helplessness, and worry about transmission of the virus to friends and family members (Gordon et al., 2021; Sun et al., 2020).

The emotional and mental toll among healthcare providers, including nurses, was predicted to be more significant and widespread in countries with large numbers of confirmed cases, due to a lack of personal protective equipment (PPE), hospital beds, and lifesaving equipment (Gunawan et al., 2021; Joo & Liu, 2021). The response of nurses to the COVID-19 pandemic has been physically, psychologically, and professionally demanding (Bozdag & Ergun, 2021; Kovner et al., 2021).

Other researchers have investigated the challenges, stressors, and effects of the pandemic on nurses. Gordon et al. (2021) examined the experiences among critical care nurses caring for patients diagnosed with COVID-19 and reported fear and helplessness as well as headaches and exhaustion. The psychological experience of nurses caring for COVID-19 patients was summarized by Sun et al. (2020), indicating that nurses were fatigued at the onset of the pandemic, which later was replaced by feelings of gratefulness and professional responsibility for providing patient care. Chen et al. (2021) reported additional concerns such as a lack of preparedness for working with full PPE for a prolonged period of time.

The present study was conducted during a 5-month period (August–December 2020) in the first year of the pandemic. It addresses clinical nurses' daily struggles at the bedside while caring for patients diagnosed with COVID-19. Given nurses' significant role in providing healthcare during the pandemic, it is essential to understand their experiences. Thus, the purpose of this study was to explore the perceptions and experiences of nurses in clinical practice engaged in caring for patients diagnosed with COVID-19 during the early months of the pandemic.

2 | METHODS

At the time of conceptualization of this study, there was limited literature available related to what nurses were experiencing and how the various aspects and decisions about care were being established. With limited to no validated practice guidelines, nurses were learning about patients who required intensive care for the life-threatening symptoms that occurred with COVID-19. When there is little to no information available, it becomes essential to explore the phenomena of concern, describe and explore its complexities in the context in which it is occurring to provide an explanation and better understanding of the situation. The researchers employed a rigorous descriptive qualitative approach to understand the perceptions and experiences of nurses caring for patients with the COVID-19 virus.

2.1 | Sample and setting

One of the challenges associated with recruiting study participants was the difficulty in obtaining access and approval by healthcare institutions because of the workload associated with the unanticipated pandemic. As a result, the researchers considered other possible ways to recruit study participants. They determined that the registered nurses who were students in a university graduate program might be willing to share their experiences in a study. Thus, registered nurses who were both graduate students and employed in agencies working with COVID-19 patients were contacted and invited to participate. Twenty nurses who completed the consent and demographic forms were interviewed. They cared for patients diagnosed with COVID-19 during the early months of the pandemic and data were collected from August 2020 to December 2020.

2.2 | Ethical considerations

Following Institutional Review Board approval, a recruitment email was sent to nurses in clinical practice who were graduate nursing students at a university in the Mid-Atlantic region of the United States. Through snowball sampling, several participants forwarded the recruitment email to other clinical nurses. The recruitment email contained a description of the study, its purpose, and the strategies in place to ensure anonymity, confidentiality, and security of all data collected, including the identity of participants' healthcare work sites. The email was sent by a person other than the researchers to prevent direct email contact of potential participants with a faculty member who was part of the research team. After participants agreed to be contacted, the informed consent form was emailed to them. After consent was obtained, the participants completed a demographic form via Qualtrics and were contacted to schedule the online interview.

2.3 | Data collection

The interviews were conducted using a researcher-developed, semistructured interview guide (see Table 1). In the interview, participants were asked to describe their experiences of caring for patients diagnosed with COVID-19. Interviews were conducted through Zoom, transcribed by a professional transcription service, validated for accuracy, read, and analyzed. Five researchers analyzed the data.

TABLE 1 Interview questions

1. Please describe the experiences you had while providing nursing care to patients diagnosed with COVID-19.
2. Please share your concerns about being prepared to care for patients with COVID-19 in your clinical agency.
3. Please share your feelings about caring for patients with COVID-19 in your clinical agency.
4. Please share your experience the first time you told a family member, close relative, or friend that you were caring for patients with COVID-19.
5. Please describe your experience working with other healthcare professionals and staff during the COVID-19 pandemic.
6. What are the barriers that you experienced while caring for clients diagnosed with the COVID-19 virus?
7. Is there anything about your experience of being a nurse during the pandemic that has influenced the person you are today?
8. Are there any personal struggles that you faced related to being a nurse during the COVID-19 pandemic?
9. Is there anything else that you would like to share about your experience?

Relevant statements were identified in each transcript and grouped together through an iterative process until a set of themes emerged. Concepts were coded in accordance with the developed interview guide that aided in organizing the data.

2.4 | Data analysis

Data analysis was undertaken using Braun & Clarke (2006) method of thematic analysis. Each transcript was individually examined by each researcher, and all data were analyzed. Interviews were continued until data saturation was reached. This occurred at 20 participants when no new issues were identified by the study participants. This method of determining data saturation was described by Saunders et al. (2018) as related to the degree to which new data repeat what was previously expressed by study participants and occurs largely at the time of data collection. Throughout the study, the researchers worked collaboratively and met frequently to process and analyze the data.

2.5 | Trustworthiness

Trustworthiness was established through using a cooperative approach, prolonged engagement with the data, and reaching consensus by the research group on all aspects of the study. The researchers decided not to ask for member validation to prevent the risk of retraumatizing participants as they recalled their experiences.

3 | RESULTS

Twenty nurses who completed the consent and demographic forms were interviewed. They had cared for patients diagnosed with COVID-19 during the early months of the pandemic and data were collected from August 2020 to December 2020. The sample was female, white, Christian, in a staff nurse position, employed full-time, and in the age range of 25–59 years with a mean age of 35.7 years. Table 2 displays the sample's demographic characteristics.

Five themes and nine subthemes emerged from participants' descriptions of their experiences of caring for patients with COVID-19. The themes were: navigating uncertainty, managing death and loss, acknowledging emotional responses, learning opportunities, and facing community undercurrents. Themes and associated subthemes are listed in Table 3 with several pertinent statements that exemplify the themes. The five themes were addressed by all participants.

3.1 | Theme 1: Navigating uncertainty

Navigating through uncertainty focused on the role strain experienced and perseverance demonstrated as nurses accepted the responsibility of caring for patients with COVID-19, along with meeting institutional and personal expectations. All participants spoke about their feelings of uncertainty related to not knowing the trajectory of the pandemic, along with their personal and professional doubts. The nurses felt "unprepared" and referred to this fluctuating period as "unreal" as if they were "navigating through ambiguity." Nurses had inconsistent access to PPE, were never certain the PPE would provide adequate protection, and resigned themselves to working within this uncertainty.

3.1.1 | Subtheme 1: Acknowledging unpredictability in clinical practice

The healthcare environment underwent constant modifications, with nurses reporting "the guidelines changed all the time," and "nurses took on tasks performed by other team members." Nurses received new information about COVID-19 daily along with what PPE to wear to protect themselves from the virus. Nurses discussed the variations in practice standards and absence of protocols, resulting in "self-doubting" and "questioning if we were doing the right things."

Caring for patients with COVID-19 was "a very different experience." Patients' conditions changed from stable to critical in minutes. Nurses commented that patients were seriously ill, quickly decompensated, and died within several hours. The uncertainty and unpredictability of the illness trajectory "was much scarier because we didn't know anything about it."

A nurse explained, "Many patients…talked about dying…expressing they were afraid they were going to die." Even with patients who survived the initial phase of COVID-19, nurses acknowledged how

TABLE 2 Demographic characteristics of sample

Characteristic	Value
Age	Mean age 34.7 years
	Median age 42 years
Gender	
Women	18
Men	2
Race	
White	18
Black/African American	2
Religion	
Christian	15
None	3
Agnostic	2
Relationship status	
Single	11
Married/domestic partner	9
Highest level of nursing education	
BSN	16
MSN	4
Program enrolled	
MSN	15
Ph.D.	3
Other	1
No response	1
Current role	
Staff nurse	18
Nurse practitioner	1
Clinical nurse educator	1
Years practicing as a nurse	Mean 11.9 years
	Median 19 years
	Range 3–35 years
Employment status	
Full-time	13
Part-time	5
Per diem	2
Specialty	
Telemetry/PCU	6
Intensive care unit	5
Medical surgical	2
Emergency department	2
Maternity/OB	1
Pediatric ICU	1
Home care	1
College health	1
Other	1
Shift worked	
Day	17
Night	2
Split day and night	1
Tested for COVID-19	
Yes	12
No	6
Test scheduled	2
Tested positive for COVID-19	
Yes	1
No	11
Results pending	6
No answer	2
Setting	
Suburban/regional hospital	11
Home healthcare	5
Federal/military	1
Large metropolitan hospital	1
Rural/community hospital	1
Clinic/outpatient	1

"deconditioned people were afterwards and how the next phase of care and rehab would be a long road ahead." These patient situations created feelings of uncertainty and unpredictability about patients' conditions and how to address their needs.

3.1.2 | Subtheme 2: Addressing interdisciplinary team dynamics

The nurses identified the positive and negative aspects of working with interdisciplinary team members. Nurses facilitated teamwork and created strategies for working in a chaotic environment. They reported that wearing masks made it difficult to recognize each other; however, they frequently asked about each other's needs and their patients' needs. One stated, "The support we gave to each other was one of the shining lights." When patients deteriorated, nurses were there: "When we knew that somebody was withdrawing life support, every 10 minutes we would come by, ask 'do you need anything, should I do anything for your other patients, are you still okay staying in there?'"

TABLE 3 Selected statements that exemplify the themes

Theme/subtheme	Participant quote
Theme 1: Navigating uncertainty	
Subtheme: Acknowledging unpredictability in clinical practice	"I was concerned about reusing our N95s until they were falling apart … and what diseases are we going to have ten years from now from reprocessing our N95s?"
	"Every day I felt so frustrated that the rules had changed again … and we had to figure out how to do it and get it done."
	"At first it was hard to be on the COVID unit … our team has grown stronger in our relationships because we were experiencing this trauma together."
Subtheme: Addressing interdisciplinary team dynamics	"I had a patient in desperate need of a psych eval, and it was embarrassing that it was done from outside the door."
Theme 2: Managing death and loss	
Subtheme: Experiencing patient death	"It took almost two hours for the patient to pass, and I didn't want to leave her to die alone …"
	"We kept admitting patients, coding them, and seeing them die every day on our COVID unit."
	"There were so many difficult conversations that I had with families … especially at the end of life."
Subtheme: Facilitating connection between patients and families	"It was a tough time for the patients' families… they were broken … I worked to help them too."
Theme 3: Acknowledging emotional responses	
Subtheme: Handling of emotions	"I was scared to death, but my patients were more petrified than me."
	"I had so many feelings that I decided to journal … I do not want to forget my feelings, my experiences, what I learned, the people I met, and the patients that I worked with …"
	"I try to do selfcare to help me when it feels like the walls are closing in … and you can't do anything, and you just feel helpless."
Subtheme: Coping through self-care	"I think it was really important to self-reflect … and be intentional about my own mental health."
Theme 4: Learning opportunities	
Subtheme: Ongoing learning about the needs of patients (with COVID-19)	"We can deal with a lot of things now because we have been challenged to the nth degree to just figure it out."
	"…it was a constant learning process, but now we have a good idea about the best treatment …"
	"I was emotionally invested in learning about COVID and COVID complications."
Subtheme: Dealing with new learning challenges	"We were trying to learn about the effects of the chemicals used in reprocessing our N95 masks."
Theme 5: Facing community undercurrents	
Subtheme: Misunderstanding of the pandemic	"My patient's wife somehow broke into the hospital … got past security … so I put a mask on her and called my manager."
	"The media was not educating the public, and our national leaders weren't doing a good job either."
	"…it felt like thank you so much, you are heroes, thank you for doing this, but keep to yourself …"
Subtheme: Challenging personal experiences	"Nursing colleagues kept reminding me … 'you don't need to feel like you're wearing that scarlet letter when you go into a store' … but people just backed away from me, … and I felt exiled from the community."

Nurses felt respected and developed rapport with physicians who considered their safety and resource availability when writing orders. Attending physicians were described as "trusting nurses' opinions." One nurse described a physician's response: "Whatever you think is right, you let me know, and I will write for whatever you need. You are the ones with patients all the time." Another stated, "I think communication between people was strengthened…our infectious disease doctor…is our favorite doctor because he appreciates what we do. He is right there with us in the thick of it."

Other nurses were distressed when physicians stated, "I am not doing this consult." Another nurse said, "I was told to give the patients the physician's business card because he didn't want to go into patients' rooms." However, nurses noted that interdisciplinary teamwork positively evolved as knowledge, standards of care, and experience increased, and fear decreased.

Nurses' assessment of the administrative team ranged from positive to disheartening. Most nurses were grateful for the education, support, and resources provided, while some expressed concerns about reusing PPE, being understaffed, and feeling uncertain if clinical concerns were heard.

3.2 | Theme 2: Managing death and loss

Death and loss were common occurrences addressed by all study participants. Multiple nurses indicated they had "more patients with COVID-19 die than in all my previous years as a nurse." The patient deaths were described by nurses as "sudden and unexpected," "prolonged by complications" of "severe respiratory failure," "sepsis," and "cardiac failure." All participants acknowledged losses associated with a lack of family presence, communication, support, and comfort behaviors.

3.2.1 | Subtheme 1: Experiencing patient death

Many nurses returned to work expecting to care for patients from the previous day, and "…found new patients because those we cared for yesterday had died." One nurse stated, "I cannot even count the deaths I saw. I think I had maybe fifty deaths, but it could be more…" Adult patients of all ages were critically ill and dying. Young nurses expressed horror caring for patients their ages who were dying. Nurses were distraught by the way patients often died. A nurse remarked, "Some of the hemodynamic changes were scary… there was never going to be a meaningful recovery." Many nurses spoke about their first patient with COVID-19 who died. One nurse explained, "He was young, awake, and having difficulty breathing. He looked at me and I tried to speak Spanish and tell him it was going to be okay, not knowing if he was. He smiled at me…we intubated him… later he died."

Nurses explained, "Patients were alone with no family members present because of hospitals' policies prohibiting people at the bedside even when patients were dying." The nurses recognized the value of having family at the bedside at the end of life yet felt powerless given the restrictions put in place to minimize risk of COVID-19. One nurse summarized: "I got to know families well… talking to them four times each day depending upon how the patient was doing…and knowing their family had seen them only once before they died… has left me with the heaviest heart."

3.2.2 | Subtheme 2: Facilitating connection between patients and families

Often, nurses were the only healthcare providers in patients' rooms, and families relied on nurses for information and support. Most families expressed gratitude to the nurses caring for their loved ones. However, nurses' reliance on electronic devices to talk with patients' family members or to enable dying patients and family members to communicate was "inadequate, not a substitute for real human connection." Since patients who died early in the pandemic were on ventilators, the ability of patients and families to interact was severely limited. Nurses felt like surrogate family members as patients lay dying. For nurses caring for patients at the end of life, the change in protocol, exclusion of family members, and isolation of the dying patients were "disturbing." Nurses shared, "The hardest thing was holding an iPad and realizing this was not enough for the family member that was saying goodbye." Nurses were not assisted by clergy who did not or could not enter patients' rooms. On occasion, clergy stood outside patients' rooms directing nurses to anoint dying patients.

People trusted nurses to convey messages of love and support to their hospitalized family member. Yet, this was a dilemma if patients and family were not fluent English speakers.

3.3 | Theme 3: Acknowledging emotional responses

All the nurses expressed feelings of anxiety, fear, sadness, and of being scared and overwhelmed during the early months of the pandemic. Their anxiety centered on not knowing the best treatment approaches or acceptable standards of care because "…things were changing on a daily basis." They shared their emotions with other nurses, selected family members, and others. To assist with managing their emotions and stressors, participants focused on self-care strategies to sustain themselves during this turbulent time.

3.3.1 | Subtheme 1: Expressing emotions

Nurses discussed that even though they were feeling negative emotions, they persevered knowing "there was so much going on that we had to keep going." Many spoke about being physically and mentally exhausted. Everyone indicated that their anxiety made them feel vulnerable, and five spoke about feeling like they were on the

verge of a panic attack, while three others had panic attacks after going home from work. A nurse explained, "We were scared, upset and angry in the beginning." … "The manager told us, 'It was decided that you are the strongest team and take the greatest care of patients, and you have the privilege of being designated the COVID unit.'"

Nurses described high levels of work stress extending into their personal lives. One nurse shared the stress overload,

> Sometimes I was so stressed that all I could do was… lay on the couch when I got home…I was full of energy…I could not sleep…I was upset about what I saw that day. I felt anxious about going back the next day. Then the next day…I would come home so exhausted that I could not keep my eyes open.

Another nurse commented, "Nurses worried about everything." "It's stressful and hard to stay away from patients and be told to cluster care." One participant explained, "I felt great responsibility to my patients. I was the only person they saw. I clustered care…then I found I could not do that. The patient depended on me for everything, even for company."

Every nurse who participated in the study focused on the first wave of patients diagnosed with COVID-19. One stated, "I can't explain the emotional toll it took on me being in these rooms where patients were dying alone." Another nurse added, "It was emotionally draining to care for the dying patient and update and support the family at the same time." Several participants noted, "Taking patients to the morgue everyday was emotionally upsetting."

3.3.2 | Subtheme 2: Coping through self-care

Nurses utilized self-care coping strategies as the need for self-care was paramount. Feeling responsible to act professionally during this crisis, and then going home and needing to "act like everything's okay" created distress. Nurses were concerned about their family members and others living in a shared space. Participants highlighted effective habits and rituals to reduce risk to themselves and family members. They described decontamination rituals such as removing their work clothes before entering their homes and then immediately taking a shower. Many boosted their personal health habits, increased exercise routines, and accessed outside support systems. Others described "reading online," "doing yoga," "playing with the kids," and "taking a day off when there was enough staff." Several nurses mentioned "seeing a therapist to help handle my stress," "talking to someone other than family so I do not worry them," and "…questioning whether I wanted to be a bedside nurse…" Several reported having to alter personal milestones (e.g., postponing a wedding and changing their pregnancy plan).

3.4 | Theme 4: Learning opportunities

Despite the challenges associated with caring for acutely ill and often dying patients with COVID-19, the nurses acknowledged the learning opportunities afforded by the pandemic. All the nurses identified the opportunity for professional growth and increased autonomy. They realized that they have been providing care in what they hoped "is a once-in-a-lifetime experience." They further verbalized concerns about "keeping up with available knowledge." Nurses recognized their growing appreciation for evidence-based care in the absence of evidence about treatment and nursing care at the beginning of the pandemic.

3.4.1 | Subtheme 1: Ongoing learning needs about caring for patients with COVID-19

The nurses discussed how they "were learning as they provided care for patients," and seven referred to the initial learning process as either "trial and error" or "learning as we went along." One nurse expounded upon how "…the nurses decided to change from only wearing a mask in the patient's room to wearing the mask at the nursing station, and then to wearing an N95 mask all day…before it was mandated." The nurses also learned how to adapt to rapidly and constantly changing patient protocols. A nurse indicated, "We were trying to find ways to do workarounds…and kept adapting. It could be completely different things that we were learning and doing each week. People joked that everyday new emails told you to do something completely different." Another nurse explained: "I think it is just constant growth and change based on what is best practice showing."

It was common for the nurses to explain that they "couldn't learn important information fast enough," and that "the more questions we asked, the more we learned." The questions resulted from nurse-to-nurse discussions, clinical situations, and patients' rapidly changing health conditions. One nurse succinctly stated, "We just kept reading, researching, and learning."

3.4.2 | Subtheme 2: Dealing with new learning challenges

The nurses referred to being challenged to learn about the treatment and nursing care of patients with COVID-19, and procedures totally new to them. The two procedures most discussed were "proning patients on ventilators" and "performing CPR on patients in a prone position." A nurse recalled, "We flipped patients on their bellies in a swimming pose because they oxygenate better." Another stated, "Prior to COVID-19, I never knew how to do CPR from the back."

Others spoke about advocating for patients' psychosocial needs while attempting to maintain the mandate of clustering care. One nurse explained, "I was told go into the room, do not stay long, do

what you have to do, and come out, …but this was not the kind of care I wanted to give. Eventually, we figured out how to do this better."

The nurses addressed using opportunities to educate patients and their families, as well as friends and family members. Nurses found it "very challenging … to teach and reinforce the need to keep social distance, wear masks, and wash hands…" The more they learned about COVID-19, the more likely they were to share the information with others. "We can deal with a lot of things now because we have been challenged to the nth degree to where we just figure it out, learn how to do it, and go forward." After all, a nurse expressed, "I am making history here. I am in the room with our first COVID-positive patient, this is wild, this is pretty cool." "There was a level of excitement there as well."

3.5 | Theme 5: Community undercurrents

Each nurse expressed concerns about the lack of education, understanding, and often unclear information given to the community from national leadership. They spoke of the general public's misunderstanding of the pandemic. Several nurses recognized that the pandemic was a "life-changing" and "community-changing event" that members of their families and their communities minimized. The frustration expressed by the nurses centered on "the community not being truly aware of how bad the pandemic is."

3.5.1 | Subtheme 1: Misunderstanding of the pandemic

Nurses discussed the public's misunderstanding of the visitation restrictions, need for masks, and purpose of social distancing. One participant stated, "It's almost like people don't feel it's real." Another participant expressed frustration with family and friends by explaining, "It just didn't register with people even after a family member had COVID…and it's clear that this pandemic still isn't registering with people." One nurse affirmed, "They don't know how bad it is." Many explained how "patients' families were impatient and frustrated with visitation restrictions, and they frequently asked, 'Why are we still having visitor restrictions? This is ridiculous.'" The nurses stated the "media was not always realistic about the pandemic."

In the beginning of the pandemic, nurses acknowledged community support through "meals," "food," and "…cards saying thank you for what you do, and then that totally stopped." There was consensus that the public mindset shifted and "people are angry at us for doing the same thing we've been doing this whole time." Nurses working on hospital specialty units noted, "Many ill people were delaying and denying serious symptoms since they did not want to be admitted. The fear of COVID was so strong that people self-monitored at home …until symptoms were almost life-threatening… and then came to the hospital." Hospitalized patients who may have benefitted from homecare or attending rehabilitation facilities, choose discharge to home for fear of contracting the virus and the agencies maintaining no-visitor policies.

3.5.2 | Subtheme 2: Challenging personal experiences

All the nurses reported exclusion from events with family and friends. Although they understood the reason for being excluded, they felt they were better protected than people in the community. Nurses felt shunned and discounted. However, they recognized that people were scared and did not realize that "nurses are educated to care for patients who have infectious disease."

Some nurses spoke about maintaining distance from others to promote a level of comfort and safety. Nurses' statements reflected negative sentiments from others: "I do not think they wanted to outright ask me not to attend…" or "…I do not want to offend you, but I do not want to get sick." Most nurses cooperated with the boundaries set by others.

The nurses were distressed by being socially excluded. One nurse conveyed, "I was not invited because I was working with COVID patients." … "Then I got upset and said, 'You should be socially distancing not just from me.'" Another stated, "I wanted to explain that I wear an N95; I am safer than you are. You could be picking it up in the grocery store."

When nurses went shopping and were wearing scrubs, there were signs of disdain and stigma from people. A nurse explained, "It was like nobody wanted to see the nurse who was taking care of COVID-19 patients…and it felt like 'thank you so much, you are heroes, thank you for doing this, but also keep to yourself.'"

4 | DISCUSSION

This study adds to the growing body of research about the COVID-19 pandemic (Maiorano et al., 2020; Robinson & Stinson, 2021; Sun et al., 2020). The themes described in this study indicate that nurses experienced a level of uncertainty they had never before encountered, which they described as unique, unpredictable, and at times "unreal." Being put in a situation without their usual support systems and lacking information about best care practices further increased participants' sense of uncertainty and unpredictability. Their sense of being in control was eroded by the unprecedented number of acutely sick and dying patients, the shortage of PPE, and the need for nurses to take on responsibilities and tasks usually completed by other personnel. Lack of practice standards and the absence of protocols led to nurses' "self-doubting" and "questioning if we were doing the right things." The unpredictability, inadequate preparation, and lack of PPE were similar to the findings of Moradi et al. (2021) and Liu et al. (2020).

The care given to dying patients was contrary to facilitating end-of-life care with family members being present and saying goodbye

to loved ones. Yet nurses persevered despite their professional and personal distress experienced as their patients were dying. Nurses attributed the support from fellow nurses as providing the strength needed to care for patients who were deteriorating or being withdrawn from life support. In these situations, the participants did all they could to use electronic devices (e.g., tablets and cell phones) to enable families to connect and communicate as their loved ones were dying. The nurses found this process to be emotionally draining and inconsistent with the standards of care, findings also reported in other studies (Danielis et al., 2021; De Leo et al., 2021; Pariseault et al., 2022).

Nurses dealt with the varying degrees of team members' involvement and interactions with patients, as some providers elected not to enter patients' rooms, while others did not hesitate to do so. Because of changes in the work environment, nurses were working with interdisciplinary team members in a role somewhat foreign to them. The collaboration between nurses, physicians, and other healthcare professionals was strengthened because of changes in their working relationships as they provided care for sick and often dying patients. The unpredictability of the trajectory of COVID-19, the rapid decline and decompensation of patients' conditions from stable to critical, and death within a few hours further added to nurses' sense of uncertainty. These findings have also been reported by Arcadia et al. (2021), Sun et al. (2020), and Gordon et al. (2021). Over time, as knowledge and standardization of guidelines and protocols increased, unpredictability and fear of the virus decreased.

The ambivalent views of the administrative team described by study participants ranged from positive to inadequate and unavailable. This resulted in anger as well as disappointment among nurses. These findings are similar to those reported by Bennett et al. (2020), Moradi et al. (2021), and Smeltzer et al. (2022). The psychological toll from caring for patients during the pandemic was characterized by feelings of anxiety, distress, sadness, grief, and fear (Mental Health America, 2021). Nurses communicated among themselves, with selected family members and a few others who listened without judgment and provided both tangible and emotional support. Although nurses relied on an array of self-care strategies, several described developing new strategies, and effective and complex rituals for taking care of themselves (al Falasi et al., 2021). Others participated in psychotherapy for the purposes of processing and handling stress and traumatic experiences, addressing ongoing changes, rearranging their life plans and goals, and self-reflecting on their need to re-evaluate their careers (Hossein & Clatty, 2021; Mollica et al., 2021; Orru et al., 2021).

Although the greatest gap in information about COVID-19 occurred during the early stages of the pandemic, the participants reported an ongoing need for information because of the rapid changes in information about its management. Their appreciation for evidence-based care grew as they realized that little was known about the care of patients with COVID-19 infection. As they gained experience in providing care to patients during the pandemic, the participants viewed it as an opportunity for professional growth. These results are similar to those reported by Fernandez-Castillo et al. (2020), LoGiudice and Bartos (2021), and Yin and Zeng (2020), all of whom reported that their study participants were better prepared to care for patients in subsequent waves of the pandemic. Ardebili et al. (2021) reported growth on the part of healthcare providers as confidence increased over time and as the pandemic became part of their normal work life.

The study participants' stress and frustration were increased by the responses of community members to the pandemic and to healthcare professionals who provided care to individuals with COVID-19 infection. Community members lacked knowledge and understanding about the effects of COVID-19 infection on patients and the need for masks and social distancing to prevent transmission of the virus. Many dismissed its serious effects and ignored scientists' and authorities' recommendations to minimize their risk. Participants noted that many sources (e.g., television, Internet, social media), along with national leaders, were responsible for the dissemination of misinformation. Some study participants were socially isolated by members of their communities who looked upon healthcare workers with disdain, further increasing their stress and anxiety (Hooper, 2021). Similar responses were reported by Robinson and Stinson (2021), Gordon et al. (2021), and Smeltzer et al. (2022), all of whom indicated that nurses in their studies wanted to educate the public and individuals in the community who failed to understand the severity of the pandemic.

While previous studies have highlighted challenges faced by frontline healthcare providers, specifically nurses, this study highlighted some positive aspects of working at the bedside (LoGiudice & Bartos, 2021; Zhang et al., 2020). Although there have been several qualitative studies on the experience of nurses caring for patients during the pandemic, the interpretation of events differs from one study to the next based on country of origin, the perspectives of the researchers, and the events experienced and expressed by participants (Ardebili et al., 2021; Salina & Leena, 2021; Villar et al., 2021).

The nurses addressed the uncertainty and upheaval associated with their roles and responsibilities for managing the novel nature of the virus (Moradi et al., 2021). The ongoing variations in its clinical presentation and severity, the high mortality rate, and less than optimal patient outcomes for those who survived, contributed to overwhelming role strain and health provider stress levels. A significant burden for the nurses was the need to adapt to the evolving clinical practice guidelines, including constant changes in treatment protocols as new information and research became available. Nurses were vigilant and diligent in responding to these rapid changes.

Although this study's sample included only nurses, similar responses have been reported with other healthcare professionals (Bennett et al., 2020; Rebow et al., 2021). Because of the psychological effects of COVID-19 on healthcare professionals working closely with affected patients, Bennett et al. (2020) referred to these healthcare workers as “second victims” of the pandemic.

Women, who made up most of Bennett et al.'s sample, often play multiple roles such as mother and employee. They are often expected to meet the demands of work and home creating personal conflict and exhaustion while striving to maintain a sense of resilience and balance between both priorities. This need to be resilient was only exacerbated by the traumatic experiences nurses had during the pandemic (Turner et al., 2022).

4.1 | Strengths and limitations

Using this convenience sample can be considered a limitation in that participants were not typical staff nurses, since they were pursuing graduate studies. While previous studies have highlighted challenges faced by frontline healthcare providers, specifically nurses, this study complements other studies highlighting some positive aspects of working at the bedside (LoGiudice & Bartos, 2021; Zhang et al., 2020). Although there have been qualitative studies on the experience of nurses caring for patients during the pandemic, the interpretation of events differs from one study to the next based on country of origin, the perspectives of the researchers, and the events experienced and expressed by participants (Ardebili et al., 2021; Salina & Leena, 2021; Villar et al., 2021). The differences in perspectives and interpretation are strengths rather than limitations as frontline healthcare providers navigate the immediate and long-term effects of providing care to many patients during the COVID-19 pandemic.

5 | CONCLUSION

Given the duration of the COVID-19 pandemic, continued nursing research adds to the growing body of literature about frontline healthcare providers during pandemics (Ryan et al., 2022). Nurses have consistently proven to be a vital healthcare team member during previous pandemics. Their wisdom, tenacity, and dedication demonstrate their critical role in contributing to clinical practice, patient care, education, and research. As the pandemic persists, it is important to collect and analyze data and disseminate findings to inform the nursing profession, healthcare industry, and the public. The COVID-19 pandemic continues with ongoing waves and surges, as well as the appearance of evolving strains of the virus that break through vaccine immunity (Bergwerk et al., 2021). The variation in symptomatology and severity affirms the need for further research. Current evidence-based practice gleaned from nursing research about caring for patients with COVID-19 provides an ideal platform to educate current and new-to-practice nurses, and to revise and develop clinical practice guidelines. Nurses are the primary healthcare providers at the bedside and therefore influence the experiences of patients and families affected by COVID-19. Adjusting and reforming current practices based on research findings can help to stabilize the work environment by providing some predictability, minimizing the chaos and uncertainty, and ultimately improving patient care and outcomes.

AUTHOR CONTRIBUTIONS

Linda Carman Copel: Conceptualization; project management; methodology; supervision; data collection; writing–original draft and review. **Evelyn Lengetti**: Investigation; data collection; writing–original draft and review; methodology. **Amy Mckeever**: Investigation; data collection; writing–original draft and review; methodology. **Christine A. Pariseault**: Investigation; data collection; data curation; writing–original draft and review. **Suzanne C. Smeltzer**: Conceptualization; methodology; data collection; data curation; writing – original draft and review.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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.

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