LIVED EXPERIENCES OF NURSES WORKING IN THE CLINICAL SETTING DURING COVID-19 PANDEMIC IN EKURHULENI GAUTENG

A DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS

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DECLARATION

I declare that this dissertation titled "**LIVED EXPERIENCES OF NURSES WORKING IN A CLINICAL SETTING DURING COVID -19 PANDEMIC IN EKURHULENI GAUTENG PROVINCE"** is my own work and that all the sources that I have used or cited have been properly indicated or acknowledged by means of complete reference.

Sinethemba Nyandeni

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DEDICATION

I dedicate this study to my family

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ABSTRACT

Background: The Coronavirus 2019 (COVID-19) outbreak spread rapidly and caused increased strenuous impact on the healthcare systems. This resulted in a change of patient care being rendered in the clinical setting, thus affecting nurses working in Covid-19 wards during this period.

Aim: This study aimed to gain an in-depth understanding of the lived experiences of Nurses working in the clinical setting during the COVID -19 pandemic in Ekurhuleni, Gauteng Province. This understanding guided the researcher to propose recommendations in terms of Nursing practice, Nursing education and Nursing research.

Method: The study followed a qualitative, descriptive phenomenological approach. A constructivist paradigm was applied. In-depth interviews were conducted face to face and telephonically with 13 professional Nurses who nursed COVID-19 positive patients in hospital in Ekurhuleni. The Colaizzi (1987) data analysis method was followed to analyse the audio recorded interviews.

Findings: The following themes emerged from the analysis: (1) Nurses' emotional experiences of working during the COVID-19 pandemic; (2) Nurses' social experiences of working during the COVID-19 pandemic; (3) Nurses' own experiences of COVID-19 infection; (4) Nurses' challenging work experiences during the COVID-19 pandemic; (5) Nurses' positive work experiences during the COVID-19 pandemic; (6) Nurses' experiences of caring during the COVID-19 pandemic; (7) Nurses' experiences of coping during the COVID-19 pandemic; (8) Nurses' recommendations for working during the COVID-19 pandemic.

Conclusion and recommendations: The results of this study indicated that professional nurses who cared for COVID-19 patients suffered psychological distress and physical burnout. Having in-sufficient resources which included Personal Protective Equipment (PPE) and equipment exposed the Nurses to contract COVID-19. Lack of in-service training and managerial support aggravated the poor nursing care rendered to patients resulting in, confusion of policies regarding isolation of the patients. Therefore, further studies are needed to determine the effect on nurse's families and to improve procurement of resources. Working during the COVID-19 pandemic has exposed the nurses to identify the gap in their managerial support. Therefore, the researcher recommends that managerial support which

includes offering of professional counselling be done routinely for improvement of mental wellbeing of the Nurses. Regular in-service training must also be conducted to support the Nurses in clinical setting.

Key words: Lived experiences, Nurse, clinical setting, COVID-19, pandemic.

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LIST OF ABBREVIATIONS

BP	Blood Pressure
COVID-19	Coronavirus disease
CVA	Cerebrovascular accident
CEO	Chief Executive Officer
CPAP	Continuous Positive Airway Pressure
ENA	Enrolled Nursing Assistant
et al:	Latin term meaning “and others”
gyne:	Gynaecologist
HIV	Human Immunodeficiency Virus
HCWs	Health Care Workers
ICN	International Council of Nurses
ICU	Intensive Care Unit
LRTI	Lower Respiratory Tract Infection
N95	Face mask filtering at least 95% airborne particles
NCPAP	Nasal Continuous Airway Pressure
OPD	Outpatient Department
PPE	Personal Protective Equipment
Psych	Psychology
PUI	Patients under Investigation
RN	Registered Nurse
SATS	Oxygen saturation
TV	Television
TB	Tuberculosis Bacterium
UK	United Kingdom
WHO	World health Organisation

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CHAPTER ONE OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

A highly infectious type of pneumonia, Coronavirus disease (COVID-19) originated in and was confirmed in Wuhan City, Hubei Province in China. The origin of COVID-19 was linked to a seafood market, in Wuhan City (WHOa, 2020). This virus is said to affect the respiratory system of the host and is transmitted from person to person via touching and droplets when coughing or sneezing. The virus will undergo an incubation period of approximately 5.2 days. The infected person can present with symptoms which may vary from cough, sneezing, sore throat, fever, haemoptysis- vomiting blood, headache, diarrhoea and difficulty in breathing and acute respiratory distress which can be fatal and result in death (Rothan and Byrareddy, 2020).

The outbreak of this novel COVID-19 has spread to different countries and led to overwhelmed health care services. The World Health Organization declared COVID-19 a global pandemic on the 11 March 2020. Measures and guidelines were put in place to manage and curb the spread of COVID -19, leading to lockdowns of countries, and the ban of travelling to contain and manage the spread of the outbreak (Khanna, Cicinelli, Gilbert, Honavar and Murthy, 2020). As the infection rate continuously rose, the healthcare sectors needed to respond quickly. In South Korea, the hospitals designed to admit COVID-19 patients reached their full capacity resulting in 2300 clients awaiting admission in early March. As they waited for admission, 2 succumbed to the virus. Reports of fatigue among Health Care Workers (HCWs) continued to rise (Tanne, Hayasaki, Zastrow, Pulla, Smith and Rada, 2020). Furthermore, the possibility of the COVID-19 pandemic resulted in scarcity of hospital beds, intensive care beds, and doctors and Nurses as they got ill and some were quarantined. Patients were admitted according to a priority criterion. This implies that younger patients and those with fewer comorbidities got first preference (Emanuel, Persad, Upshur, Thome, Parker, Glickman et al., 2020). Similar incidents were seen in countries such as India and Madrid as they faced lack of hospital beds, inadequate intensive care beds and ventilators, (Tanne et al, 2020). At the time of compiling this study, there were approximately 23 000 HCWs in more than 50 countries reported to have tested positive for COVID-19 (WHO, 2020).

The International Council of Nurses (ICN) reported that there were more than 100 Nurses that lost their lives to the Coronavirus by 20 April 2020. According to Madarasz, (2020) one of the risks factors for this infection was due to the lack of Personal Protective Equipment (PPE) which the Government has to provide to the Nurses and other HCWs. The COVID-19 infection required the correct protective measures to be in place as the shortage of PPE directly affects Nurses and other healthcare providers duties as they depend on PPEs to protect themselves from contracting the COVID-19 virus, (WHOb, 2020). In addition, ICN through its Chief Executive Officer (CEO) urges all the governments to be accountable and act on the deaths of the Nurses due to the COVID -19 by capturing accurate data on the infection and death of healthcare workers not to underestimate the cases (Madrasz, 2020). Findings from a study conducted in a designated Hospital of Wuhan in China asserts that the risk factor for HCWs in hospitals includes the lengthy hours of working with the COVID-19 infected patient and lack of hand hygiene (Ran, Chen, Wang, Wu, Zhang and Tan, 2020). Ferioli, Cisternino, Leo, Pisani, Palange and Nova, (2020) agreed with the findings of the study done in Wuhan City as they highlight that spending more time with the COVID-19 infected patient in the same room without enough space and negative pressure was a risk factor for being infected. Furthermore, lack of adequate hand hygiene and correct PPE was another risk factor.

Nurses are front liners of healthcare and their role is not limited to caring for the basic needs that promote health, they carefully control the patient's environment to reduce health risks and keep patients safe (Royal College of Nurses (b), 2020). Nurses scope of practice allows them to assess, diagnose, plan the needs of patients, implement care and evaluate the effectiveness of their interventions. While doing their other duties they should also prevent the spread of infection (Act No. 33 of 2005). Nurses also have direct close contact with the COVID -19 infected patient as they are responsible for initiating mechanical ventilation or taking throat swab samples. These, results in increasing their vulnerability to infection (Wetsman, 2020).

The World Health Organization (WHO) in association with the International Council of Nurses and Nursing Now, recognises the global shortage of Nurses as the COVID-19 pandemic continues to strain the healthcare system. Thus, they made recommendations to fill the gap (World Health Organisation (c), 2020). These are among the recommendations: governments must speed up the process of training more Nurses and facilitate their employment and leadership posts; Improve working conditions including through safe staffing

levels, fair salaries, and respecting rights to occupational health and safety; The COVID -19 battle will be lost without Nurses, midwives, and other HCWs. In an empirical phenomenological study that was done in Hubei, China on the HCWs experience with COVID -19, nurses revealed that they sometimes find themselves not getting enough time to eat or use the bathroom in order to save time and PPEs. Shortage of staff contributed to being overworked as there was no relieve among the staff to offer quality care. At the end of each shift the staff would be exhausted (Liu, Luo, Haase, Guo, Wang, Liu et al., 2020). Another study conducted in the First Affiliated Hospital of Henan University of Science and Technology in China revealed that Nurses experienced fear, anxiety and discomfort as they started to work in negative pressure wards and working longer hours than normal. They were also expected to reuse their PPEs as they did not have enough stock. Nurses also reported that they lacked coping mechanisms and end up feeling helpless as the pressure increased (Sun, Shi, Jiao, Song, Ma, Wang et al., 2020).

In addition to lack of PPEs and shortage of staff and resources such as testing kits for early testing of nurses and tracing contacts, the stress resulting from the COVID-19 led to staff burnout. This is evidenced by the reporting of 100 Nurses who resigned due to being overworked and fatigue at Pahang Medical Centre in South Korea (Tanne et al, 2020). In China the report showed that an estimated amount of about 3 000 healthcare providers were infected and 22 died due to COVID-19. Recommendations about conversations which are supportive and have clear guidance with front-line care givers may assist them to cope and to decrease their anxiety. Promotion of self-care was also deemed vital (James and Adams, 2020). Huang, Lin, Tang, Yu and Zhou, (2020) recommended that provision of psychological counselling and workable shifts to the Nurses would improve their wellbeing. The authors also encouraged giving education and training to HCWs regarding the proper donning and doffing of the PPEs as a good strategy that will help to avoid contamination and reduce to risk of exposure to COVID -19.

The statistics of the 26 July 2020 revealed that Africa had 828 219 COVID-19 cases with 483 847 recoveries and 17 528 confirmed deaths, South Africa had 445 433 confirmed cases, putting it on top of the list in Africa, with 265 077 recoveries 6 769 confirmed deaths these statistics does not isolate HCWs (SA coronavirus website, 2020). In addition, the study highlighted that Africa might have an increase in COVID-19 as they were approaching winter season (Czernin, Fanti, Meyer, Allen-Auerbach, Hacker, Sathekge et al., 2020). This is in

relation to the poor health system; more people having weak immune system and being overcrowded in their families. These might impact badly on the healthcare service.

In contrary, some countries safety measure and incentives to protect and encourage nurses have been put in place. In Scotland, Nurses are provided with special leave to accommodate parental guidance as schools were closed due to lockdown. They are however not allowed to take planned annual leave in order to ensure enough staffing. Risk assessment of health comorbidities of nursing staff were determined to avoid exposing immunocompromised nurses to COVID-19. More Nurses have been recruited to cover the shortage and provision of essential services, (Scottish government, 2020). Similar actions are seen in the Zimbabwean government and Ghana were incentives were offered to encourage and support nurses. In Zimbabwe there was a call for the government to award all healthcare workers risk allowance and have tax exemption as a way of appreciation. Meanwhile in Ghana, their President announces 3 months of free water supply to the Ghanaians and 3 months tax relieve to health care providers, (media reports NewZimbabwe.com news); (Favour, 2020). Nurses in South Africa expressed dissatisfaction regarding lack of incentives such as danger allowance, salary adjustment and tax breaks (Denosa website, 2020).

Nurses in South Africa are at the frontline and they are responsible for managing the COVID -19 patients. They are therefore at risk of being infected. There were several cases in South Africa where health institutions such as Duduza Clinic had to be closed and disinfected as Nurses and other healthcare provider's tested positive for COVID -19 (Molelekwa, 2020). Although the experience of Nurses during this pandemic has been reported in different parts of the world through media and studies conducted, the settings are different. This study aims to explore and describe the lived experiences of nurses working in the clinical setting during COVID-19 pandemic in Ekurhuleni Gauteng Province.

1.2 PROBLEM STATEMENT

The World Health Organisation (WHO) guidelines on rights, roles and responsibilities of HCWs include key considerations for occupational safety and health during the COVID-19 pandemic. The guidelines clearly state that the employer and managers are accountable for ensuring a safe environment to minimise health hazards, most importantly they should provide enough PPEs of good quality. Ensuring the provision of training and support on infection control and the donning and doffing with correct disposal of PPEs. The guidelines

also stress the vital aspects that the employee (e.g. Nurse) be given time to self-isolate if their health is threatened and to be compensated and the infection be treated as an occupational disease. Lastly the HCWs should be emphasised to use the provided PPEs, self-monitor for COVID -19 symptoms and report to the supervisor if noting any symptoms (WHOb, 2020).

However an online survey done to explore the Nurse's experience of PPEs in the United Kingdom by the Royal College of Nursing revealed shocking practices that are a source of spreading the infection, such as the inability of the employer to provide PPEs, it was reported that 40% of the nurses did not receive training on what type of PPE is needed and when to use it, 46 % lacked training on how to wear or take off the PPE and their disposal. Furthermore 39% were asked to re-use once -off equipment while working with COVID-19 patients, (Royal College of Nursing (a), 2020). O'Halloran (2020) shared of administration oppression existed which subjected her to work in specialised units while she lacked the required skills, it has also been reported that the majority of Nurses were overwhelmed as they start and end their shifts in tears, that they were afraid of making mistakes and thus compromising patient quality care. In certain circumstances they are expected to bath, do pressure care and administer treatment to COVID -19 patients in ventilators without changing PPEs as they are not enough while doctors are instructed to limit their exposure to the COVID-19 patients. In this hospital leaders did not care how they were coping and surviving instead offered makeup wipes to use as the Nurses are expected to reuse their N95 masks. In Italy Nurses and doctors are finding it difficult to cope with the COVID-19 pandemic as they are afraid of the risk of infecting their loved ones at home (Kaniadakis, 2020).

The clinical setting conduciveness depends on the availability of resources whether human or material. The COVID -19 pandemic has worsened the already overburdened system which resulted in disproportional ratio of health resources which failed to meet patient demand, (AA News, media reports, 2020). Zimbabwe's Nurses and doctors in the public hospitals resulted in striking to demand protection from the deadly COVID -19, (DW News, media reports, 2020). While this act compromised patient care, it seemed to be working at resulted in getting the Governments' attention. Masina (2020) a journalist from Malawi reported on the discrimination, stigma and insults healthcare providers were subjected to as the community assumed that they are transporters of the COVID -19. The journalist further highlighted that Nurses were prohibited to use public transport and were being chased away from the homes they were renting. In Bamenda, Cameroon it was reported that HCWs lacked professional

and in-house training on PPEs and that some empowered themselves through searching the internet. The morale of the nurses is low as there are “no extra pay or no extras financial support, coupled with constant power cuts at some hospitals” this resulted in making it difficult for them to render quality health care (Sawlani, 2020).

In South Africa, the public working conditions were already overwhelmed even before the COVID-19 pandemic due to shortage of physical and human resource. The unions such as the Democratic Nursing Organisation of South Africa (DENOSA), National Education, Health and Allied Workers’ Union (NEHAWU) and Young Nurses Indaba Trade Union (YNITU) reported that Nurses were faced with struggles such as shortage of staff, lack of adequate supply of PPEs, transportation of Nurses to work as taxis are on lockdown and the opening of hospitals for isolation with no new staff appointed resulting in further shortage of Nurses. The Nurses’ psychological wellbeing, need for continuous counselling and early screening and detection of COVID -19, was cited as a concern (Shabangu, 2020 and Mahlokwane, 2020).

Newman (2020) reported that lack of PPE, stressed the HCWs as they were concerned that some of the doctors were treating confirmed COVID- 19 patients without protection as they were not wearing correct PPE. These workers feared that they might get sick, quit or even die while serving the community. This study aims to explore and describe the lived experience of Nurses working in the clinical setting during COVID -19 pandemic in Ekurhuleni Gauteng Province.

1.3 SIGNIFICANCE OF THE STUDY

This study brought insight of the daily experiences that the Nurses are facing as they fight this pandemic through the disclosure of their experiences. The experiences in the workplace of the nurses may assist in improving their clinical setting for optimal patient care to take place. Furthermore, this study explored the meaning and the value Nurses have attached to their nursing duties in relation to the experience they have in their clinical environment during the COVID- 19 pandemic. This study also attempted to reveal how this experience has contributed to the way Nurses view their profession and whether there are any service delivery gaps they have noted in their workplace. Their experience may also be used as a baseline for identifying challenges and appraisal of improving the clinical setting.

1.4 RESEARCH QUESTION

What is the lived experience of Nurse's working in the clinical setting during COVID -19 pandemic in Ekurhuleni Gauteng Province?

1.5 AIM OF THE STUDY

The aim of this study was to gain an in-depth understanding of the lived experiences of Nurses working in the clinical setting during the COVID -19 pandemic in Ekurhuleni Gauteng Province. This understanding guided the researcher to propose recommendations in terms of Nursing practice, Nursing education and Nursing research.

1.6 PURPOSE OF THE STUDY

The purpose of this study was to explore and describe the lived experiences of Nurses working in the clinical setting during the COVID -19 pandemic in Ekurhuleni Gauteng Province.

1.7 CONCEPT CLARIFICATION

The concepts used in this study are stated as follows:

Clinical setting

Any setting that accommodates patient care (California code of Regulations). In this study clinical setting refers to the COVID-19 wards where the patient infected with COVID-19 are being managed.

Lived experiences

German word referring to the immediacy of experiencing which provides the raw material to be shaped through interpretation, reinterpretation and communication into its lasting form, the experienced, (Gadamer, 2004). In study lived experience referred to the meaning, perceptions and interpretations attached by the COVID nurses to the experiences.

Nurse

A person registered in a category under section 31(1) to practise nursing or midwifery as stated by the Nursing Act 2005 (Act no. 33 of 2005). In this study a Nurse is the professional nurse who is nursing the COVID-19 infected patient in COVID-19 wards.

Pandemic

The Centre for Disease Control (2012) defines it as an acute rise in a disease attacking a population a particular area that have spread to other countries, mostly affecting bigger population. In this study in refers to the COVID- 19 outbreak affecting most countries and people, including South Africa.

1.8 PARADIGM

Morgan (2007) describes a paradigm as a belief system that contributes to the method used by the researcher to collect the accurate data required for the specific study and how to interpret it. The researcher followed a constructivist paradigm. Constructivists are flexible and focus on understanding the human experience as it is lived, through the collection and analysis of qualitative data (Polit and Beck, 2018). In this study the paradigm assisted the researcher in making a sensible decision to choose the research method, collect data, scrutinise and interpret them.

1.9 PHILOSOPHICAL ASSUMPTIONS

In this study, the researcher embraced phenomenology as a philosophical framework. Phenomenology is a design of inquiry in which the researcher described the lived experiences and perspectives of individuals about a phenomenon, through direct interaction between the researcher and the participants (LoBiondo- Wood, Haber and Titler, 2018). This study followed phenomenology which was originally developed by a German philosopher Edmund Husserl (1859-1938) as a philosophy, which were used as a qualitative research approach. Phenomenological knowledge reforms the understanding and lead to a more thoughtful action through constructivism (Polit and Beck, 2017). The constructivist paradigm has its roots in the philosophy and the human science (Halloway and Wheeler 2010). It acknowledges the existence of many socially constructed, subjectively- based realities that consist of stories or meanings grounded in natural setting (Hessel–Biber, 2010). Constructivists do not subscribe to the existence of a social and physical reality ‘out there’

separate from the individual. They emphasize the relationship between socially engendered concept formation and language and believe that the understanding that the human experience is important as focusing on the explanation, prediction and control (Halloway and Wheeler, 2010). The ontological, epistemological and methodological assumptions guiding the constructivist paradigm were discussed below:

1.9.1 Ontological assumptions

Van Rensburg, Du Plooy, Gelderblom, van Eeden and Wigston, (2010), describes ontological assumptions as the researcher's thoughts and reality view. As a result, the phenomenon of "multiple realities" exist (Polit and Beck 2017). "The lived- world" is a central theme of phenomenology that manifests itself as a structural whole that is socially shared and yet apprehended by individuals through their own perspectives (Polit and Beck 2017). Furthermore, language pervades the meaning of our surroundings and forms part of what makes the world a collective place than the product of an individual isolated subjectivity. In this study the researcher seeked to gain an in- depth understanding of the lived experiences of Nurses working in the clinical setting during the COVID -19 pandemic, in Ekurhuleni, Gauteng province. The researcher had set aside her own values and experiences and through empathetic understanding of the participant's meaning of the life- world allowing the multiple realities of the persons experiencing a phenomenon to emerge (Polit and Beck, 2013).

1.9.2 Epistemological assumptions

Epistemology is the theory of knowledge concerned with the question of what counts as valid knowledge (Holloway and Wheeler 2010). The researcher pursued authority knowledge from the Nurses who worked in the clinical setting during the COVID-19 pandemic. In doing this the researcher followed the constructivism approach. According to (Flood 2010), epistemology of descriptive phenomenology focuses on revealing the meaning of the perceptions of lived experiences rather on arguing a point or developing a theory. The researcher as a phenomenologist constructed texts or narratives about the world of her participants. This was a suitable approach as the research aimed to create knowledge based on the lived experience of the working in the clinical setting during the COVID -19 pandemic, in Ekurhuleni, Gauteng Province.

1.9.3 Methodological assumptions

Methodological assumptions refer to the way researchers obtain knowledge (Polit and Beck, 2017). In this study, a descriptive phenomenological inquiry was used as it focuses on the description and the understanding of the phenomena as experienced by individuals who have lived through them (Giorgi, 2012). Researchers using a descriptive phenomenological approach should have evidence of any “reductions” or “bracketing” being attempted (Polit and Beck, 2017). During this process, the researcher had set aside prior thoughts, conceptions and judgements and was open to the descriptions as provided by the participants (Flood, 2010). In this study, the researcher conducted in- depth interviews with the Nurses working in the COVID -19 wards, making use of probing questions to gain an understanding as the researcher gets absorbed in their experience of working in the clinical setting during the COVID-19 pandemic, in Ekurhuleni, Gauteng Province.

1.10 DELINEATION

The focus and scope of this study was based on the exploration of lived experiences of the Nurses working in the clinical setting during, the COVID -19 pandemic in Ekurhuleni District, Gauteng Province.

1.11 QUALITATIVE RESEARCH DESIGN

1.11.1 Type of qualitative research design

This research study followed descriptive phenomenology as a philosophical design. The qualitative, descriptive phenomenological research design was utilised on the basis that it described a specific phenomenon or things as they appeared. This type of design was relevant to this study as the researcher aimed to explore and describe the lived experiences of Nurses working in the clinical setting during the COVID -19 pandemic, in Ekurhuleni, Gauteng Province. Descriptive phenomenology includes the following four steps: bracketing, intuiting, analysing and describing (Polit and Beck, 2013). More information on the study design and methods was discussed in chapter 2.

1.11.2 Trustworthiness

Rigor refers to the ability of the research design and exact research method in responding to the research question. Truthfulness is the degree of quality in the truth value and the accuracy of the qualitative research results, (Cypress, 2017). The researcher has ensured to maintain the truthfulness of the study from the beginning of the study throughout the data collection phase and the analysis by referencing all the authors of the different data sources. More details of how the trustworthiness of the data was achieved has been discussed in chapter 2.

1.12 LAYOUT OF CHAPTERS

This study report consists of five chapters. The layout of the chapters is listed below:

Chapter 1: Overview of the study

Chapter one discusses the general overview of the study, to orientate the reader to the entire study. The problem statement, aim and objectives, research question, introduction to research design and measures to ensure trustworthiness were discussed.

Chapter 2: Research design and methods

In this chapter, the research design and methods used in the study were discussed. Details of the description of the study population, sample and sampling techniques, data collection, trustworthiness and ethical consideration are discussed.

Chapter 3: Presentation and interpretation of findings

The analysis and the interpretation of the findings were discussed in this chapter.

Chapter 4: Discussion of findings

In this chapter findings were discussed

Chapter 5: Summary and conclusion

This chapter addressed the summary of findings, conclusion and discussions.

1.13 SUMMARY

This study intended to gain an in-depth understanding of the lived experiences of the Nurses working in the clinical setting during the COVID-19 pandemic in Ekurhuleni, Gauteng Province. The use of descriptive phenomenology design helped the researcher to explore and describe the lived experiences of the Nurses as they work in the COVID-19 wards. The findings of this research had not only shared the lived experiences, but they also helped the researcher to propose recommendations in terms of Nursing practice, Nursing education and Nursing research.

CHAPTER TWO RESEARCH METHODOLOGY

2.1 INTRODUCTION

The previous chapter dealt with the overview and introduction of the study. This chapter includes research design and method with the research setting, population, sampling and recruitment of participants as well as data collection and data analysis. Measures to ensure credibility, confirmability, transferability, dependability and authenticity were also discussed. Ethical considerations are also described.

2.2 RESEARCH DESIGN AND METHOD

Polit and Beck (2017) defines “research design” as the plan for addressing a research question including specifications for enhancing the study’s integrity. This research study followed descriptive phenomenology as a philosophical design. Descriptive phenomenological research design is grounded in Husserlian philosophy and this philosophy also was used in this study. Husserlian philosophy insists on the description of the participant’s experiences as they experience them in their everyday life. This includes their feelings, believes, their memories, what they are hearing and seeing.

Phenomenological reductions were applied during data collection and analysis. This method was utilised on the basis that it describes a specific phenomenon or things as they appear. This type of design was relevant to this study as the researcher aimed to explore and describe the lived experiences of Nurses working in the clinical setting during the COVID -19 pandemic, in Ekurhuleni, Gauteng Province. Descriptive phenomenology includes the following four steps: bracketing, intuiting, analysing and describing (Polit and Beck, 2013).

- *Bracketing*

Bracketing is the act of recognising existing knowledge and believes that the research has about the studied phenomenon prior to conducting a study and putting them aside (Polit and Beck, 2013). In conducting this study, the researcher had put aside pre-existing information about the studied phenomenon to prevent polluting the data collected. The use of reflexive journaling is helpful in maintain bracketing (Polit and Beck, 2013). Through data collection and data analysis process, the researcher wrote down all opinions, ideas, and believes

possessed in relation to the studied phenomenon. This was done to prevent them from influencing the study.

- *Intuition*

Polit and Beck (2013) describe that intuition is when the "researcher remains open to the meaning attributed to the phenomenon by those who have experienced it". The researcher remained endorsed and explored the meaning the participants attached to their lived experiences and understand their point of reference. During the interview process the researcher listened attentively and got absorbed to the lived experiences of the participants to gain access to their world.

- *Analysis*

In this third step in which the researcher grouped statements with important information, placed in categories and got an idea about the important meanings of the phenomenon, (Polit and Beck, 2013). The researcher repeatedly read the responses of the participants to note vital statements made by the participants and create categories of the similar statements and lastly assign meaning to them.

- *Describing*

The researcher concluded the steps by being able to understand and define the formed phenomenon, (Polit and Beck, 2013). The researcher found some understanding of the phenomenon made from the responses that would lead to the explanation of it. Direct quotations from the participant's responses were used to provide clarity of the meaning.

2.3 RESEARCH METHOD

Polit and Beck (2017) defined research method as a technique used to structure a study and to gather and analyse information in a systemic fashion. The research method includes the following: research population, research sampling, data collection and data analysis.

2.3.1 RESEARCH SETTING

The research was conducted in a hospital in Germiston, Ekurhuleni. The hospital was initially not designed to nurse COVID-19 infected patients. They started nursing the COVID-19

infected patients in March 2020. The patients were seen in casualty and were nursed in the wards on the 4th floor. Two step down units were prepared for COVID-19 infected patients, one for patients under investigations (PUIs) and one for confirmed COVID-19 cases. However, as the influx of patients' increases the whole hospital was dedicated to nursing COVID-19 patients. The interviews were conducted in the offices inside the unit for participants who preferred face to face interview. All the necessary precautions to prevent the spread of the COVID-19 virus were followed. On entrance temperature screenings were done, hands were washed with soap and water with continuous sanitization throughout the interview. Face masks were always worn and social distancing of 1.5m maintained. Windows were kept open to allow for ventilation. For participant who preferred to be telephonically interviewed the researcher called them and interviewed them at their convenient time and comfort. Zoom and WhatsApp interviews were not conducted as it was stipulated on the research proposal as participants were not comfortable with them.

2.3.2 POPULATION

Alvi (2016) has defined "population" as all the participants that will be included per criteria in the research study. The population of this study consisted of professional Nurses who have nursed a patient who tested positive via Polymerase chain reaction and nasal swabs for COVID-19 in any of the units of the hospital. The professional Nurses who were in the study are working in casualty (three Nurses), surgical A (one Nurse), medical ward (two Nurses), labour ward (one Nurse) and step-down wards (six Nurses).

2.3.3 SAMPLING

The researcher presented herself to the COVID-19 Nurses, in the hospital in Ekurhuleni where she introduced herself to the potential participants. During the session the researcher introduced the study and explained its purpose in the language best understood by the potential participants. This helped the researcher to identify eligible candidates to participate in the study, as stated in Polit and Beck (2017). Purposive sampling is defined as a method of selecting participants based on the purpose of the study and only including who meet the inclusion criteria for the study (Alivi, 2016). Although the researcher used purposive sampling was used to recruit professional nurses who had direct contact to the COVID-19 patients while working in the COVID-19 wards, the researcher struggled to get enough participants due to the attitudes of the nurses. They were uncooperative and not keen to participate in

the study. However, due to difficulty in accessing the participants, the participants who met the criteria referred the researcher to other nurses who had similar experiences within the hospital and who were willing to be interviewed. Known as snowball sampling (Alivi, 2016) used to gain access to hard to reach participants. The researcher got 22 participants who met the inclusion criteria of having nursed a patient who tested positive via Polymerase chain reaction and nasal swabs for COVID-19 in any of the units of the hospital, during day and night duty. The researcher then interviewed 11 participants for the study who met the inclusion criteria which reached data saturation. The researcher added two interviews after data saturation was reached. The sample size was thus 13 participants in total

2.3.4 DATA COLLECTION

The individual interviews were unstructured phenomenological interviews, as it gave the Nurses an opportunity to elaborate their lived experiences as they live them (Holloway and Wheeler, 2010). Zenobia et al (2013), entails that broad open–ended questions are structured according to the aim of the study. Van Rensburg et al (2010), agrees with the use of open–ended questions as they allow the participant to freely express their emotions, ideas and opinion. In addition, the used of probing questions to gain more accurate data.

2.3.4.1 Conducting Interviews

After the researcher and the participants had agreed on the convenient venue to conduct the interviews, informed consents were signed before conducting the interviews and each participant was given their own copy. The interviews were conducted by the researcher alone. The interviews were audio recorded with the participant's consent. The researcher also took field notes during the interviews which lasted between 30-60 minutes. The interview were conducted between February 2021 and June 2021. In certain instances, the participants were not talking as freely as expected. Some would just answer in one word despite of the efforts of trying to probe more. Interviews which lasted less than 30 minutes were not included in the study.

Most of the interviews were conducted in English and others in isiZulu as other participants felt comfortable expressing themselves in isiZulu. The interviews were translated by the researcher. The main research question posed was as follows: "What was it like to work in the COVID-19 wards during this pandemic?" Probing was done to elicit more information

from the participants. The researcher expected that some of the participants may be emotional during the process and a psychologist was on standby to assist. However, all the participants remained calm during the process.

2.3.4.2 Reflections and observations of the researcher

The researcher observed that the nurses felt angry, unappreciated and felt they needed to share their experiences on their current challenges nursing a COVID-19 patient. The Nurses had expectations for support from their management which were not fulfilled. The lack of support affected their experiences. The participants needed professional debriefing offered by a professional counsellor. However, they all rejected the psychological referral offered by the research and the hospital, regarding it as coming too late. Some of the Nurses were reluctant to share their stories to the researcher. As the researcher resorted in conducting short interviews which are not included in the study, some interviews were conducted with the enrolled nurses who did not meet the inclusion criteria for the study. This was done to attract the professional Nurses to participate in the study. At some point the researcher was emotionally hurt due to the rejection the researcher got from the nurses. However, some of the participants were willing to be interviewed and they shared their experiences with the researcher. The researcher ensured to bracket all ideas and own perceptions about the prior experiences had with nursing the COVID-19 patients. The researcher ensured to remain open to the experiences of the Nurses even though the participants were aware that the researcher was also a professional Nurse.

2.3.4.3 PILOT INTERVIEWS

The researcher had the main research question posed as follows: “What was it like to work in the COVID-19 wards during this pandemic?” The researcher then constructed probing questions in an interview guide which helped in the formatting of questioning during collection of data. The researcher conducted two pilot interviews with two participants who met the inclusion criteria. The two interviews were transcribed and submitted to the supervisor who approved the interview guide and the pattern of probing that was followed. In qualitative studies, data collection and data analysis occurred concurrently. The researcher also analysed the interviews which determined that the pattern of questioning yield the relevant themes. No changes were made to the interview guide. Moreover, the researcher learnt to use probing questions to gain more insight to the participant’s response. The two interviews

were not included as part of the findings of the actual study as the main aim was to learn how to interview and probe. During the pilot study the researcher was not comfortable conducting the interviews due to poor interview skills and fear of asking leading questions or questions that would offend the participants that were not sharing more information. After transcribing the first two interviews which were the pilot interviews the researcher submitted the results to the supervisor and the interview skills were refined and the interview skills improved every time.

2.3.4 RECRUITMENT OF PARTICIPANTS

The researcher obtained the ethical approval needed before approaching the potential participants. On the introductory interview that the interviewer had with the potential participant the interviewer explained and handed a copy of the informed consent to them. The interviewer introduced the study purpose, what the study aimed to achieve, what was expected of the participant and clarified the study benefits. The potential participants were informed that participating in the study was voluntary and that they have a right to withdraw if they did not feel comfortable with the line of questioning. The researcher requested informed consent from the participants see (Appendix 2). Thereafter the researcher requested the contact details of the potential participants.

Through the process of snowball or network sampling, the researcher got 22 participants who met the inclusion criteria. However, due to the working hours, off-duties and at sometimes isolation of members of staff and sick leave for the staff members that was being experienced during the period of data collection it was difficult to get access to some of the staff members. The nature of the work and the difficult circumstances that nurses were finding themselves in during the period, also exacerbated the problem. In the end, out of the 22 that agreed to participate only 13 staff members were interviewed.

2.3.5 DATA MANAGEMENT

The transcribed interviews are stored on a USB memory stick and locked to safe in a facility at Prinshof Campus, at the University of Pretoria for a minimum of 15 years. Only the research team will have access to this information. The informed consent and transcribed interviews were stored in different formats to ensure that no one can trace the connection between the participant's audio record and the signed informed consent. The interview

records in the portable audio recorder were deleted to ensure the interviews and confidentiality could not be lost.

2.3.6 DATA ANALYSIS

Data analysis was done at the same time with data collection. Colaizzi's phenomenological method was used to analyse the interviews and helped the research learn more about the Nurse's lived experiences (Polit and Beck, 2017). The researcher repeatedly listened to the interviews and had made understanding and general sense of the lived experiences of the Nurses. The researcher then transcribed the interviews using Microsoft word verbatim.

These were steps in Colaizzi's phenomenological data analysis that the researcher used to analyse the data. The researcher worked with an independent coder to ensure all the findings of the study were analysed accordingly.

2.3.6.1 Read and write all the participant's description of the experiences

After the in-depth interviews with the participants, the researcher transcribed the interviews word to word in a Microsoft word document. The researcher together with the independent coder and the supervisor read the transcribed interviews and made an understanding of the participant's experiences. Descriptions of the participants lived experiences were written down.

2.3.6.2 Extracting significant statements

Statements which were significant in describing the participant's lived experiences of working with COVID-19 patients in the clinical setting during this COVID-19 pandemic were extracted. These statements were extracted from the transcribed interviews from all the participants. To support the participants description of their lived experiences.

2.3.6.3 Formulation of meaning of the significant statements

When the statements were fully described the participant's description of experience were extracted. The researcher formulated meanings relevant to the statements. This was done by grouping of the statements/ quotes into categories and themes generated according to the statements having the same meaning.

2.3.6.4 Organising formulated meanings into clusters of themes

Themes were formulated by grouping the meanings of the statements according to the description of the participant's experience.

2.3.6.5 Exhaustively describing the investigated phenomenon

This was done by discussing the meaning and understanding of the participant's lived experiences with what is already in the research data base. The phenomenon studied in this study was described against a similar phenomenon which was previously studied by other researchers to bring it to reality.

2.3.6.6 Describing the fundamental structure of the phenomenon

A clear description of the studied phenomenon was discussed in detail to ensure that the experiences of the participants were not polluted but described as the participant's lived them.

2.3.6.7 Returning to the participants

The researcher went back to the participants with the analysed interviews to confirm that the researcher had correctly analysed their lived experiences.

2.4 MEASURES TO ENSURE TRUSTWORTHY OF THE DATA

In maintaining the truthfulness of the data collected the researcher applied the following measure namely credibility, confirmability, transferability and dependability.

2.4.1 Credibility

Credibility is the ability of the study to measure what it is intended for and it should be the true reflection of the participants lived experiences (Maher, Hadfield, Hutchings and de Eyto, 2018). The researcher had ensured the truthfulness and accuracy of the results and interpretation of the data. The researcher had ensured credibility through lengthy in-depth interviews with the participants. The interviews lasted for 30-60 minutes. Furthermore, the researcher had built trust and rapport with the participants to gain their trust. The researcher

ensured the participants felt safe and comfortable to share their perceptions and meaning attached to their lived experience.

Member checking

Member checking is a technique which requires the researcher takes all the collected data, transcribed interviews, field notes, analysed data and the conclusions to the participants (Amin et al, 2020). This process can be done during data collection and analysis for participants to assess, validate and correct mistakes. The researcher listened attentively to the participant as they shared their experiences. The researcher made use of clarification and summarising interview skills to ensure that the participant experiences were being correctly reflected as the participant shared them.

2.4.2 Peer debriefing

Debriefing of the participant happened simultaneously with data collection. The researcher was aware of the participant's psychological impact resulting from the pandemic. As some have lost their loved ones and still working without being psychological supported. The researcher demonstrated empathy and allowed the participant to share their part of the story. Sharing their stories lightened the burden of the nurses in the study. The researcher also experienced debriefing as she shared with her supervisors the interviews with the participants.

2.4.3 Confirmability

Confirmability is ascribed to the extent of un- biasness, and neutral manner of the in describing the participants experiences (Kyngäs et al., 2020). The reflections of the researcher on how the researcher could have influenced the findings were noted down by the researcher. Through data collection and analysis, the researcher had bracketed all thoughts and journal all ideas to prevent contamination of the study.

2.4.4 Transferability

The researcher employed the use of purposive and snowball sampling methods and gave full description of the findings on the lived experiences of the Nurses working in the COVID - 19 wards during this pandemic. The researcher ensured that all the participants met the

inclusion criteria in order to participate in the study. In–depth interviews were conducted until data saturation is reached and no new data is collected (Cypress, 2017).Additional interviews post data saturation were also conducted to confirm that really there was no more new information.

2.4.5 Dependability

Dependability is seen through the study's ability to produce similar findings if repeated in another context, (Kyngäs, Kääriäinen and Elo, 2020). The researcher had provided full description of the research method used to collect and analyse the data.

2.4.6 Authenticity

Authenticity is defined as the researchers' ability to be fair about the differences that exist it the data that has been collected from the prospective participants, (Kyngäs et al., 2020). The researcher had used the same interview guide to all the participants to ensure they all had the same opportunity to describe their experiences.

2.5 ETHICAL CONSIDERATIONS

The study proposal was submitted to the in-house committee in the Department of Nursing where the researcher got permission to proceed with the study. The researcher then submitted to the Post Graduate Committee and to the University of Pretoria's ethics committee and got ethics approval (No: 583/2020) See (Appendix 5). The researcher then applied for permission on the National Health Research Database for permission to conduct the study in a hospital, in Ekurhuleni and she received approval (GP_2020-041) See (Appendix 5). When the researcher approached the hospital, the acting CEO who granted the researcher permission to go to the units and do the study.

Confidentiality

The researcher maintained confidentiality by not disclosing or mentioning the participant's names and sensitive information on the study findings. The researcher did not share the participants responses with anyone.

Beneficence

The researcher asked the participants not to respond to sensitive questions that they find uncomfortable. Water and toilet paper were present during the interview to comfort participants who expressed themselves emotionally. None of the participants wanted to use the hospital provided social worker and psychologists due to personal reasons.

Autonomy

The participants were not forced to participate either given false information. The researcher respected the opinions and ideas of the participants as the aim was to gain their lived experiences on the phenomenon.

Justice

There was no discrimination or any form of violence observed during the researcher's interaction with the participants. All participants were treated equally with respect.

2.6 SUMMARY AND CONCLUSION

In this chapter the research design and research methodology were discussed. The research population, sampling and recruitment of participants were discussed in detail as well as the data collection and data analysis. The measures to ensure trustworthiness, namely credibility, confirmability, transferability and dependability were dealt with in depth. The ethical considerations were also presented.

CHAPTER THREE PRESENTATION AND INTERPRETATION OF FINDINGS

3.1 INTRODUCTION

The previous chapter dealt with research design and methods, the trustworthiness of data and ethical considerations. This chapter presented the findings of the study which were answering the main research question: "What was it like to work in the COVID-19 wards during this pandemic?" Data analysis was done at the same time as data collection. Colaizzi's phenomenological method was used to analyse the interviews and helped the researcher learn more about the Nurse's lived experiences. The researcher repeatedly listened to the interviews and had made an understanding and general sense of the lived experiences of the Nurses. The research then transcribed the interviews using Microsoft Word verbatim. The researcher worked with an independent coder to ensure all the findings of the study were analysed accordingly.

3.1.1 Demographic information of the participants.

Of the thirteen professional Nurses who were interviewed, one was a male and 12 were females. All the participants were Africans speaking Tshivenda, isiZulu, Sepedi and Setswana. Their ages varied between 24-55 years. They all worked with COVID-19 positive patients. Of the 13 professional nurses eight tested negative and five tested positive for COVID-19. See Table-3.1.1 Below.

Table-3.1.1 Characteristics of the participants

Participants	Gender	Age	Type of COVID Ward	Experience as a Nurse	Results for COVID test
Professional Nurses	Male 1 Female 12	20-35yrs 4 35-40:4	Step down A and B: 6	5-10 years: 3 10-20 years: 8	Negative: 8 Positive: 5

		40-50:4	Medical: 2	20-30 years: 2	
		50-55:1	Casualty: 3		
			Surgical: 1		
			Maternity:1		

Eight themes were identified from the collected data. Themes were formulated by grouping the meanings of the statements according to their description of the participant's experience. Sub-themes were developed to support the themes. The researcher went back to the professional nurses with the analysed interviews to confirm if the researcher had correctly analysed their lived experiences according to the steps in Colaizzi's phenomenological data analysis method, See Table-3.1.2 below. The participants were assigned pseudonyms to maintain confidentiality. The females were addressed by sister and a random alphabet next to the word Sister for example Sister K. The male was addressed as Mr and a random alphabet next to the word, for example, Mr T

Nurse's emotional experiences of working during the COVID-19 pandemic was the first theme that emanated from this study. The participants expressed nurses experience emotional strain by working during the COVID-19 pandemic. It had six subthemes: Stress and fear, empathy and sympathy with patients and their families, emotional experiences related to death and dying, (Hyper) vigilance, feelings of being powerless, lastly, depression and burnout.

Table-3.1.2 Themes and subthemes

THEMES	SUB-THEMES
1. Nurses' emotional experiences of working during the COVID-19 pandemic	Stress and fear
	Empathy and sympathy with patients and their families
	Emotional experiences related to death and dying
	(Hyper)vigilance
	Feelings of being powerless
	Depression and burnout
2. Nurses' social experiences of working during the COVID-19 pandemic	Social isolation
	Stigmatisation
	Effects on nurses' family members
3. Nurses' own experiences of COVID-19 infection	Nurse's experience Family members tested positive
4. Nurses' challenging work experiences during the COVID-19 pandemic	Healthcare system related challenges

	Support related challenges
	Ethical dilemmas
5. Nurses' positive work experiences during the COVID-19 pandemic	Managerial support
	Psychological support
	Sufficient resources
6. Nurses' experiences of caring during the COVID-19 pandemic	Humane patientcare
	Ineffective patientcare
7. Nurses' experiences of coping during the COVID-19 pandemic	Internal coping strategies
	External coping strategies
8. Nurses' recommendations for working during the COVID-19 pandemic	Psychological support
	Managerial and organizational support

3.2. Theme 1: Nurses' emotional experiences of working during the COVID-19 pandemic

The first theme: Nurses, emotional experiences of working during the COVID-19 pandemic had six subthemes: Stress and fear, empathy and sympathy with patients and their families, emotional experiences related to death and dying, (hyper)vigilance, feelings of being powerless and depression and burnout .

3.2.1. Subtheme 1.1: Stress and fear

Stress and fear were the first subtheme that came up. Participants indicated that Nurses are stressed and full of fear which can be related to the unknown factors, fear to get infected and fear to infect others. One participant, sister L said

"*It was scary, it was very scary I think I can tell you about my first experience with a COVID patient. And it was with the team that am with now. I was working at night when I first saw that lady. She, apparently when she came I wasn't in the department I was going to another department to ask for something. So as I was walking along the passage I saw people running away. I did not understand why people were running away. It was security people*

running away, it was nurses running away, it was even relative just running away. So coming into casualty am seeing still the same pattern of people running away. And I don't understand what is happening. I was on PPE so coming to pass by here I saw all my team locked up in this office and am like I don't understand why, I don't understand why (interruption) are they all locked up here. Then one of them comes out and explains to me that there is a lady who has presented herself at the door. With positive results of COVID but she is wearing a mask and she came with her family. The husband and the two kids and so far, it is only her who was tested and got the results. There are three members of the family they were never tested so we don't know anything about them. But all of them eventually when I met them they had masks on. She had that proof on herself that she was positive. She had tested in the private hospital. So, what worried me was why now you are cooked up in an office. So they were like scared to assist because they don't know, first if they would be exposed, themselves. They were scared to even touch the person or come close to the patient because they don't understand how else to handle the person…….It is less likely that you will be infected at that particular moment. But you see because it was a new disease with no confidence at all from the people on the ground"

Some of the fear was related to the first-time exposure as the nature of the disease was new and the environment had to change. Sister F added

"*it's stressful I can say that. The first reason for me to say that it's stressful because we entered under the COVID not knowing what to expect. You know it's like the biggest challenge for us as Nurses for COVID. I start working here last year, my contract started last year*".

Others experienced frustration due to the lack of knowledge they had about the disease as Sister H said

"*Well it was so frustrating number one, because eh we were, a lot of us including the doctors did not understand the process of how COVID-19 affects the body. So, now what was frustrating is that sometimes even the treatment you find that you had to change to a different type to sort of manoeuvre the virus and to manipulate it because we have established that for most patients who are diabetic it they get severe COVID pneumonia. That would be because they are immune compromised so now eish it was a bit frustrating because we had to treat each and every patient as an individual according to the treatment and also the nursing care*".

She further added

"*When I remember during the first wave, when we had COVID positive patients we had a patient was severely distressed and that patient was a known diabetic on her fifty to sixty years she had type one diabetes. So, the first time when the patient was diagnosed with COVID-19 when the doctor explained the results to the patient my psychological, I don't know how to explain it but I was so scared number one I don't want to lie. I was so scared*".

Sister P feelings of being overwhelmed by the fear of contracting the COVID-19 virus resulted due to the lack of information

"*Overwhelming actually, like there is, I don't actually know how to describe it. But it was so overwhelming it actually almost drained me up just emotionally and physically draining. That is how it has been cause like you just to expose to this virus that no one has complete information about, yes*".

Other stress and fear were related to own exposure to COVID-19 as the Nurses continued to Nurse the infected patients. This had the nurses wanting to protect themselves from the patient as they feared dying from the COVID-19 virus and experienced a negative psychological impact. This was voiced by Sister F

"*So COVID hurt us as Nurses it's not that it hurt those families who have lost their loved ones but us as nurses. It has damaged our minds, our thoughts because we were thinking if I am going to touch this person let's say I contract COVID today I will die and leave my family. They won't be able to see me, what about my children you see that. So COVID is scary. Even though now we are starting to adjust but that fear is not over, it's not over. Because every day, you know COVID every time a patient coughs as they pass you feel like you are having a sore throat, you feel like having shortness of breath. When you having shortness of breath you ask yourself whether you are having COVID or not. At that moment you don't wish to test because you know that you might test positive you see. You find that sometimes you are coughing and sick, it's the signs but you find that you are negative.*"

Some of the fear was due to the lack of clear directive of how to care for the COVID-19 positive patients, this was said by Sister L

"*So with accident and emergency it causes a challenge in such a way that when someone comes in. Remember it was said that when someone comes in they have to have mask so up would give people a mask. But you must understand that people were not yet used to*

using masks. You would have them put on mask but you would have initially you put them outside because there wasn't anything or clear direction as to "how to handle them". So, we would put them outside and deal with them outside".

The same feeling being stressed and fearful was experienced by Mr T

"*What I can say is that it was very stressful. When the COVID-19 arrived because we were all surprised we were scared we didn't know what kind of a disease COVID-19 is. So, it was actually very stressful like to the point where we were even scared of coming to work. Because we have seen people on TV and we have heard that, hearing different stories about people dying in different countries, so I must say it was very difficult for us to nurse those patients*".

And he continues to share how this fear contributed to the poor treatment the patients received from the nurses who were scared to come near them

"*I think everyone was scared, the staff was very scared that's the reason everyone was too scared to take responsible to go and assist that patient. That was the only reason, before COVID-19 people go and see the patient even if as an … was not there in the ward. When the COVID arrived, everyone was distancing themselves from assisting the patient because they were scared. Fear of the unknown was the most scaring factor that resulted in delayed response. Ja*".

3.2.2. Subtheme 1.2: Empathy and sympathy with patient and their families

Empathy and sympathy with patients and their families was the second subtheme that emerged. In spite of their fear, Nurses still felt empathy and sympathy with patients' suffering from COVID-19. The Nurses put themselves in the position of the patients and their families that were unable to enter the hospital. Although there was nothing the Nurses could do to fill the gap between the patient and their families they remained empathetic and sympathetic to the patient and their families. This was shared by Sister F

"*If there is something I don't understand, I don't rest and my heart is not at easy. The first thing I think of is what if it's my own Mother will I like it if she is treated this way? If its brother or my sister will I love it even if they die in this way?*".

She continues to highlight the stress and pain that was experienced by the patients due no visitors allowed during hospitalization

"…*You find that they have that low pressure if they were told they can't see their families. You know not seeing your family, or someone close to you or your children is very painful. Some of them, what I have notice is that they die due to that, that they can't or are not allowed to see their families. You find that a person would die while stressing about their children or wife or husband you see that. You know it's painful to stay without seeing your children or how painful is not seeing a family member. So COVID caused a gap among many families, a person ends up dying at the end of the day. It's not allowed to that they see the patient it is said that when they see the patient, they will get infected with COVID so at the end of the day we end up not knowing if the person being buried is the right one or no*t".

The same experience was shared by Sister H

"*Because now the relative and family members were not allowed to come in the hospital because of what not and what not so the relatives were a challenge a very big challenge especially when like you find they have accompanied their patient who was very sick and all of a sudden the patient is dead. Yo it was a problem because they could not understand. They could not understand……a person being sick for a long time that is when a person can just die. So now it is COVID-19 it was an abnormal situation for all of us. Now you find that a person is talking, now the person is deteriorating, distressed plus, plus and the patient dies. So, for them it was a bit hard for the relatives during this time*".

As the Nurses spent more time with their patients, they began to have empathy for them as this was related to how the patients have been observed to long for their loved ones. Sister F stated

"*So it's painful not being able to see a family member. I think that is something the government must review at least there must be that time even if it can be one person to come and visit. That will give hope, you find that others have their husbands here who have COVID others it's their wife and they can't see their partners and the end of the day they think their families have deserted them because of COVID. So it has separated families a lot so it's painful. We are living for God's grace*".

Sister Z also shares the same experience

"*You see if you put yourself into those people's shoes, those are mothers and you will find the families are phoning now they want to know how is my Mother doing. You are telling them*

"Mummy is getting there, getting there, tomorrow morning or before the morning you are phoning them Mummy is no more.

She further stated that family members asked the question

"How come, because they told me that Mummy is getting better" and remember with this COVID they were not visiting. No visiting hour and now what I've seen they open visiting hour again".

As much as the nurses were empathetic there was not much they could do for their patients. For instance, if the family cannot accommodate the patient in their homes and patient is not for admission

"*And you will find that the very community comes with an expectation that we would be admitted even when the doctor will see the person because one of the protocols was that see the patient if the patient doesn't warranty hospital. Because of the level of symptoms, the person has, then the person can go home and quarantine themselves at home because now you have to take a swap first before you release them to quarantine home. But the community will come and say that with that patient "no, no we can't also accommodate this person at home, this and this". So, we end up now having to try and sort the social issues which I have got nothing to do with at that particular moment. And some of them you feel for them because at the end you find that there is a lot of them in a small house*."

Sister M found it more difficult to inform the news of the death of a patient to the family, who in some cases was the bread winner and subsequently also felt pain for the loss of the family member

"*Eish, it's not easy but as HCWs the families were coming and then bringing the patient and at the patient end up dying. We try to resuscitate but at the end telling them is another story another part. Like "How am I going to tell this people that we lost their family member?" so I don't know how to explain it but it's a situation where you can say you are brave. Cause you never know what that person holds in the family I a bread winner or what? So sometimes telling them that you have lost their patient is not easy... You find that you can't even tell them that k lets go and sit down and try to explain. Though you know that they came alone with this patient who is having difficulty in breathing they can see that this patient is dying or that patient died already. So, telling them is not easy, telling them is not easy.*"

Nurses had to put themselves in the patient's position to be able to feel for them and treat them in the manner befitting them. This was also shared by Sister A who stated

"*And for us that thing "it leaves a bad picture of" translated from isiZulu, what if tomorrow it's my family, what if tomorrow it's me, you understand*."

3.2.3 Subtheme 1.3: Emotional experiences related to death and dying

Emotional experiences related to death and dying was the third subtheme that emerged. The exposure to multiple, sudden and unexpected deaths led to different emotional experiences and left Nurses traumatized. Sister K describes a situation where they witnessed 10 patients dying in one shift as being as scary as the deaths happened so fast and unexpected

"*People were dying like flies. They were dying like flies we had, I remember at one time we had 10 corpses at one night. Most of the patient were like were getting in. like we admit the patient now in the morning or around mid-night they were gone. When the family bring their toiletries in the morning that patient was talking to them but in the morning the patient is gone. So, it was so scary but this second wave it was not like first wave. First wave was so scary because people were dying like flies*".

The same incidence was witnessed by sister F in her case there were eight corpses and Sister Z case was ten corpses. She describes the experience as being strenuous and depressing "

No, there were a lot, I mean in day, at one stage we were laying more than ten corpses in one night. In one night and you talk to the person and after few minutes you are greeting the patient was dead the one you just spoke to. So, it was just chaotic".

Mr T and Sister H shared the same experience and concluded that the deaths of the patients were caused by anxiety and depression more than COVID-19 infection

"*And after a few minutes that patient condition deteriorated drastically and after it deteriorated drastically we had to resuscitate the patient unfortunately we lost that patient. And only to find out that we lost that patient due to anxiety. Anxiety is the one that was a big measure problem during COVID-19 because when people were diagnosed with COVID-19 the started having panic attacks, they started having anxiety disorders, they started being severely, severely distressed because now they were stressed, they were panicking and they thought*

"…am going to die, you don't have a cure…" you know all those things. So, it was a bit of a challenge because on that very same day I think we lost closed to seven patients. Because of the anxiety, you can see that it's anxiety it's not that COVID is really killing people in most cases but because of the anxiety the stress the panic attack. You know when you are having a panic attack your body's response, you understand. So ja."

Sister H continues to share how this abnormal situation had disturbed her psychological and led to her absenteeism from work

"*Honestly, I was so drained to a point where I thought is this (network disturbances) if people are dying like that, it brings frustration to say what will happen the next day. I expect this to happen because death is not normal and we cannot normalize death. It has never been normal. So, seeing people die at such an instead for me it was quite disturbing, very much disturbing because there were days where I could not go back to work, you understand*."

3.2.4 Subtheme 1.4: (Hyper) vigilance

Hypervigilance was the fourth subtheme that emerged. Nurses reacted different to the experience of working with the COVID-19 patients. Nurses responded with vigilance to protect themselves and their families while others experienced hypervigilance, expecting the worse. The feelings of hyper vigilance. Sister G stated

"…*it gets to be totally different in a sense that you come you see the patient you end up seeing things that are not there. You find like the patient sitting when you try to communicate with the patient "sis how are you doing, any short breath? then as much as she says I don't have a shortness breath you end up seeing things that are not there like but sis you seem like you have short breath, I noticed that now you were coughing and you are not coughing you know those things and yet the patient is telling you am not coughing sis and am breathing fine then you have to put the machine just to be on the safer side to check the oxygen saturation of that patient. Cause you feel that maybe the patient doesn't want to exaggerate the symptoms that she is actually experiencing so you end up seeing thing that the patient is not actually experiencing*".

This resulted in the Nurses taking precautionary measures when nursing diabetic patients who had COVID-19 as to prevent complications, were reiterated by Sister K who said "*Especially the diabetic patients. We knew, we already know that if the patient is diabetic in*

the morning or during the night we must go to the bed and check the patient because you might find the patient not breathing".

What worried the Nurses most was how they were exposing themselves to the infection and knowing Nurses that have died due to the infection. As they cannot not stop worrying about what would happen next. Sister Z stated

"*Even now you just ask yourself because, now we are receiving patients and they are saying k they are patients under investigation (PUIs) because they are swapping each and every patient who is coming to the hospital but after few days out of those patients you will find two are positive what now. By then now they are saying don't wear a PPE as we used to wear you just wear your gown only. So we Nurses are not protected if I can tell you my dear one we are still going to get a problem. Lot of Nurses died from this disease because when it started, and I think even now they are too reluctant saying no we don't have. I keep on asking why they are saying that because we are getting positive still*."

Thoughts of having community taking care of their own health might prove to help prevent unwanted complications and empower them about owning their lives. Sister L stated

"*Another point would be I think this time around, we were shocked in such a way that the community now has to start realizing they also need to be proactive on a daily basis. Where self-health care is concerned you know. As much as at the end of the day they can clarify with a professional person rather than wait for a things to happen and then start reacting from there, you know. People need now to be proactive so that we work hand in hand. It's not that hospitals will always have the solution to the diseases which are there but humans to start looking into their life styles. And start trying to make sense of what is happening and minimizing to a greater extent unforeseen, unwanted consequences which may be befall them*".

3.2.5. Subtheme 1.5: Feelings of being powerless

This subtheme related to the feelings of being powerless. Having the intention to assist which was not successful, and external help being impossible left the Nurses with experiences and feelings of being powerless. During a difficult resuscitation with a patient who was not responding to oxygen therapy it was sad that the patient could not be transferred to the ICU or other big hospitals for the right care due to lack of beds Sister P stated

"*I would still give an example with the desaturating one, desaturating regardless of fowler's position, double oxygen still desaturating and you have to nurse the patient there is nothing you can do. There is no ICU bed available, bigger hospitals can't take the patient we the only ward that can nurse the patient and there is nothing you can do. You've actually exhausted all the options you have. It was bad*". One of the hardest situations Nurses had to experience was failing to save a patient's life when all the needed resources were available. It made them to feel helpless and scared as shared by Sister A "*It was killing people and it was sad because remember a person dying in front of you while you are trying everything, everything that you know it will help, gasping for help "saying" translated from isiZulu "sister help me" watching that patient die. There is oxygen and "everything but they are not helping they are working" translated from isiZulu, but they don't reach where they are supposed to, you understand, it was very scary*."

The Nurses went through difficult time where they had to let a patient die as there was nothing they can do to help the patient as one participant said "*it was just that when it's time for the patient to die it was time there was nothing we could help with*" (sister F). The same feeling of being powerless was echoed by sister Z who at some point felt like quitting as she was experiencing a lot of deaths in the hospitals "*It was bad shame. I felt like quitting in nursing to quit and not knowing what to do because all the hospitals were like, nursing COVID positive patients. And you know what it was just chaotic. Because I tried when I was part time I went private hospital thinking that maybe there they are not experiencing the same thing we are experiencing. I was lying to myself it was the same. This disease was not choosing whether you are educated or not, whether you are black or white or Indian or whatever. It was killing each and every one even though sometimes we don't talk about it because you know its confidentiality and what so ever*."

3.2.6 Subtheme 1.6: Depression and burnout

The sixth subtheme was related to the depression and feeling of burnout the Nurses suffered as a result of working in the clinical environment during this COVID-19 pandemic. The behaviour that Nurses display is due to the psychological suffering and the feeling of not being cared for as echoed by Sister F

"*You can see that we are suffering psychological this is the reason why you sometimes hear Nurses saying "oh it's done, there is nothing we can do". That is from that negligence of*

providing counselling for the Nurses….you find that others have lost empathy. They cannot empathize with the patient even if the patient says something they would say it's because you are naughty". The patients are the ones who are suffering as the Nurses don't care as much due to the low motivation of working associated with the exhaustion and anger they are carrying from the inside this is reiterated by Sister Z "*that's why nurses to be honest they are short tempered now. Remember they don't give that holistic nursing care, they are short tempered they just want to work and go home and keep quiet even there will be like. If the patient is doing a wrong thing like the drip is pulled out "My sister you will see to finish am not going to put it up you can have the tablets". What if that person is unable to swallow? I am done, I am out you see because the drip will assist also with those who are unable to drink. My sister I don't know what this nursing is all about now*." She goes on to add that she even had to go and consult due to the physical symptoms of depression she was experiencing "*Till to date I cannot forget you know at one stage I had to go the doctor whereby the doctor said "I think you are depressed" and she gave me anti-depressant medication and I said to her I don't understand when people are dying like this. This disease it terrible*."

The experience of being infected with COVID-19 had scared other Nurses as they had suffered from pain, stigmatization and social exclusion. This was made worse due to lack of support and care resulting to the Nurse not seeing a need to help the next person

"*I would say I am bitter because one time I wish like, I don't care anymore, you see whatever happens must happen but a lesson I wouldn't say there is a lesson I have learnt I would be lying there is nothing, nothing. Instead am just dealing with this bitterness of mine of at least how can I, last week we had a psychologist if I book a session with him I feel like I personally have a problem. I once reached a time where I don't care anymore*" (sister C)

For others burnout resulted from the lack of teamwork which when there is a situation of being short staff which led to the professional Nurse carried all the burden and frustration alone. Sister M stated the following

"*And you know there would be a burn out because some would say no I won't do this and then it seeks you. You will end up being frustrated because you can't even push that person to do it if they say that they can't, it's too much for them*."

The feeling of demotivation and discouragement resulted in poor patient care as the nurses due the Nurses demotivated in carrying for the patient Mr T said

"*There is no motivation people will always be discouraged and they won't really work hard or put all their effort to assist the patient. The quality of care rendered to the patient will always be poor because people are demotivated. Ja one of the things people need motivation especially these days people struggling everyone was affected by this COVID-19. People in different sectors they lost their jobs so. Ja on top of that other staff members lost family members, other nurses they also passed away because of COVID-19 so people we so discouraged*."

The above theme discussed the emotional level Nurses felt about the pandemic with fear of the unknown. Due to their prolonged exposure to infected patients, they feared being infected themselves, infecting their families and other patients. Despite of their fear, Nurses still felt empathy and sympathy with patients' suffering from COVID-19. They put themselves in the position of the patients and their families that were unable to enter the hospital. Nurses bore witness to patients' dying from COVID-19. This exposure to multiple, sudden and unexpected deaths led to different emotional experiences and left Nurses traumatized. Nurses responded with vigilance to protect themselves and their families while others experienced hypervigilance, expecting the worse. Some nurses felt powerless against the situation, while others were left with symptoms of depression and burnout.

3.3. Theme 2: Nurses' social experiences of working during the COVID-19 pandemic.

The second theme: Nurses' social experiences of working during the COVID-19 pandemic had three subthemes: social isolation, stigmatization and effects on Nurses' family members.

3.3.1. Subtheme 2.1: Social isolation

Social isolation was the first subtheme that emerged. Nurses felt isolated from their circle of socializing because they feared infecting their own families as infected they tested positive for COVID-19 Sister T stated

"*Obviously they were uneasy for some time, very uneasy because now you have to go and visit but now you can't even go because you are worried that you might go and infect the kids and just go and infect your grandmother. So now you must stay in one place because you are very scared of infecting anyone at home, you know. So now you can only talk to them over the phone because I am scared what if I go home and I am already infected and it becomes a problem*".

Sister C suffered the stigmatization to a great degree as she felt that she failed to bury her own Mother, as she was not allowed to attend the funeral after being tested positive with COVID-19 she stated the following:

"*And as for me another thing that makes me bitter is that I failed to bury my Mom neh, because my family was saying no you are not coming home because of this COVID*." Nurses had a duty to help the patients while exposing themselves.

Sister M felt not being welcome at home due to her kids fearing touching her

"*They were even scared you know for themselves scared even to touch you. Scared to come close to you, you must, when you come you must just take all the clothes and bath first. No hug nothing just you go straight to the bathroom, wash yourself you know. So ja you know even that thing changed because normally if you come home you kids come to hug you. Kids now have to stay away, now they are running they are scared you know even you*." Being in isolation after being infected with COVID-19 further prohibited contact with friends and family members.

Sister P left lonely during this time as she needed a hug to feel better. She compares these situations as being in jail and that she felt depressed

"*… remember during the isolation period because you in that room and you can't go out. It's like you are in prison being locked in a cage. That wasn't nice that was hard. That was a period it became depressing*".

3.3.2 Subtheme 2.2: Stigmatization

Stigmatization was the second subtheme that emerged under this theme. The Nurses who nursed the COVID-19 patients were subjected to stigmatization by colleagues from the same ward and in the hospital Sister C stated

"*that when you arrive at work you must bring two pair of clothing there one you will wear when you enter and the moment you enter you wear PPE we were the only ones wearing jumpsuits, when going out everyone you could see that everyone even though some would try but they were running away, running away from us*".

Some Nurses had to remove their name tags to protect themselves from being stigmatized "*also there was stigma. When we arrived here, because we are under COVID contract, when*

you enter the lifts, we have name tags like I was against that even now am against that. We have our name tags they have COVID picture which is yellow then it says COVID nurse so and so on that name tag. So you see entering in the lift they all get out and you are left alone in the lift and you ask yourself what is happening. When you approach the passage, you will see all the people moving away from you and ask yourself what is happening. I wore the name tag for only one month and never again until today" (Sister F).

The impact of stigma was believed to be the cause of the death it was shared by most of the participants. In the quote below

Sister A share how her patient feared knowing that they are infected with COVID-19 as they feared being stigmatized and dying "*And stigma, stigmatization it kills our people it does kill some people remember "a person, COVID when it arrived people were fearing that I have COVID I am going to die of which these are some of the challenges we once had you find that a patient does not die because they have got COVID but from being" translated from isiZulu, anxious, you understand…. We must learn "the feelings of our patients that no person gets pleasure from being hospitalized, no one enjoys to sit on that bed, you understand, to annoy you, there is no person who enjoys that. They are here because they are here seeking for your help, so if we can treat patients as individuals and not discriminate them" translated from isiZulu*."

Unlike other Nurses Sister P also suffered stigmatization from her own family, other colleagues and their management when she got infected with COVID-19. However, she got support from her colleagues

"*Am still much stigmatized not only, k stigma wise it's not only at home. Stigma wise also happens with our very same colleagues. You know it was hectic even at work the colleagues from different wards would actually stigmatize the COVID ward. It's like when you in a lift with them it's a problem so you must use your own lift, you must use isolate the ward was actually just isolated it was much stigmatized, much stigmatized. In the beginning of this it was stigmatized it wasn't nice hence I said I survived because of my colleagues that I worked with it the ward. We were left we no choice but too actually to be there for each other. Because colleagues are stigmatizing you, I mean you want to get into the lift they say "No it's COVID, its COVID ward" that's what they were saying "it's a COVID ward staff" everyone is just scared. People were scared to come to our ward in the beginning even the same management was scared to get into the ward. They were literally just standing in the door*."

3.3.3 Subtheme 2.3 Effects on Nurses' family members

Effects on Nurses' family members was the third subtheme that emerged. Nurses were going back to their families after nursing the COVID-19 patients and their families responded differently to that. Some families remained supportive as in Sister C's case whose husband was supportive even though she tested positive and although she was emotional drained after being infected

"*Since I tested positive, I become too emotional and I don't have a heart at all. It even involves and affected my family. I just thank that my husband was kind and understanding but I no longer have that heart I used to have like before*."

Nurses' family members had to understand as their time spent with their loved ones was not the same, some days were tough on the Nurses. The same was experienced by Sister Z, she shared that sometimes she would come home in tears and depressed due to the situation she witnessed at work

"*Ja so am the one who is suffering with my kids because the people who are suffering it's us and our families. Because am coming home being depressed I would cry sometimes not even eat because now am tearful I just want to go to my room and cry and then sleep the following day am going to work again*."

Some families had uncertainty and were scared to be infected by their loved ones. Sister G had to be strong for her kids as they were worried about her and reassure them to relieve their anxiety levels

"*No, there was no additional support. I had to support myself because I had to be stronger my kids as well. Because every day when you come back home, from work you come home you get the kids the first thing they ask you is "hi Mama how many patients with COVID did you nurse today? No don't touch us, please go take off your uniform, you know those things. I had to be strong for them because as much as I understand they didn't have anybody, like in the family we didn't have somebody that was actually affected by COVID up to so far. Because they are listening to the news the numbers are going up and blah, blah they know mama is exposed on a daily basis. They will ask "Mama did you test? When last did you test? No guys, now you have to explain, you know what you only get tested we tested once when*

we started and then after that we will only going to test when we actually show the symptoms. The one moment you clear your throat there by the kitchen, you will hear ohh COVID."

The above theme focus was on the effects of working in the COVID-19 ward on their social life. Fear of infecting others and social stigmatization contributed to Nurses' experiences of social isolation and how their families were affected.

3.4. Theme 3: Nurses' own experiences of COVID-19 infection.

Nurses shared their own experiences when the contracted the virus and their family member contracting the virus under the third theme: Nurses' own experience of COVID-19 infection. It had two subthemes: Nurses' experience and family members tested positive.

3.4.1. Subtheme 3.1 Nurses' experience

Nurses' experience was the first sub theme that emerged. The Nurses were sharing what it meant to them to be infected with COVID-19. It was so unfortunate for Sister C to be the first Nurse to test positive in the hospital while she was doing her duty. She reflects to the experience as being tough, she had disbelieved of how she could have contracted the virus as she did her best to protect herself and feelings of self-blame

"*Yes, am the first Nurse in this hospital to test positive, so, yo (takes a deep breath) it was tough for me. It was very tough and at the end of the day, you ask yourself, that I have been doing everything that we were told to, k as long as I wear PPE and try that other things you do them by yourself, if maybe I do like this I will reduce the chances of getting it, I did my best I did my best but at the end of the day I had it am the first one. What went wrong? You will always ask yourself that question of what went wrong. I keep on blaming myself, why you see, why I was trying to be a hero, like all those things it was tough, it was tough.*"

She continues to share how the infection had affected her memory. It is very emotional and stressful situation for her

"*So He said, you know what? There still research being done on people who tested positive but we think that there is a damage done to COVID patients. As of now I forget a lot of things, I put something there the following day I don't even remember where I have put it. Like I wouldn't say am intelligent or something but am clever according to me. I can understand things simple right now I don't even remember my daughter's cell phone number. Since I had*

COVID you understand. (Continues to cry). So, he referred me, he said no there are other people that you could see who can help you because he can see that this thing is deeper, you see."

Nursing patients who were infected with COVID-19 hit different when Nurses were the ones tested positive this was echoed by sister K as she expressed her reaction to her positive results. She did experience symptoms and she is glad they survived

"*Yo, I thought am dying to be honest but I had no signs but when I test and the results came back positive then I had the signs after. I developed the signs after but it was just, we were not presenting with the same symptoms. So, me I was presenting with painful joints and severe headache that I went to the doctor they gave me tramadol, Panado, everything but it was not working. Others they presented with the shortness of breath, but they survived in the ward no body died with COVID we all survived*".

Other Nurses regard themselves lucky as they survived the COVID-19 infection considering the experience they had of nursing patients with similar infection. Sister P stated

"*To be in this situation to be going through that I considered myself to be lucky because I wasn't admitted I only had mild symptoms. So, it's like now you want to be there for the ones that are going through the most because you have also got the pain of those mild symptoms. The headache that doesn't go away regardless of taking analgesia that was painful*".

Most Nurses were infected which meant they had to stay at home and quarantine, this resulted in the shortage of the Nurses on the floor. Sister L stated

"*It was not a very comfortable situation, not at all. I remember there was a time where it hit hard to an extent that the majority of the workers were laid off. The majority of them in a short space of time that was last year around July, August, September. So those months they suffered a lot because I think about fifteen of us, were all laid off days after each other. And initially it started being a quarantine of fifteen days so you can understand that with that amount of people being laid both doctors and Nurses being laid off. All the fifteen days they actually went like an on and on basis and that exposed us in a sense that on the floor we would suffer*".

To some Nurses getting infected was not a surprise as they are working with the COVID-19 positive patients. Mr T was calm when he learned about the infection however, he did have symptoms of COVID-19

"*No I was actually prepared and expecting it though physically I was experiencing the symptoms coughing, sore throat, and I was having fever, my body was a bit weak. I couldn't sleep well at night I didn't really experience shortness of breath, but I was actually blocked. I had nasal congestion so I knew immediately when I experienced those symptoms it could probably be COVID-19. I was actually expecting it because I was working in the COVID-19 ward so it was not a surprise to me instead I told myself that I would be calm am just gonna treat myself.*"

3.4.2 Subtheme 3.2: Family members tested positive

Family members who tested positive was the second subtheme that emerged. Sister J personally experienced the COVID-19 symptoms however did not test positive. She continues to share how her daughter suffered from stigmatization when presented herself to the hospital

"*So when she gets to the hospital, yo yo! the stigma that she gets there, the stigma at the entrance with those ones that are screening the patients they said …"you are seven days tested positive, no, no don't touch us, take your envelop and put your things don't come close to me please, please go and sit outside" her husband found her sitting on the stoup outside the hospital. Her husband was fuming he called the CEO of the hospital they decided to sit down with her and she was having shortness of breath because of the… he found her outside crying that why must they treat me like this? They don't know anything about the COVID, it's like COVID is the death sentence I don't know what to do if people, I don't know" she was trying to tell them she was seven days tested positive yo! It was bad*."

The above theme dealt with the Nurses' own experiences of COVID-19 infection. The Nurses who inevitably became infected with COVID-19, shared the unique meanings they attached to the experience; also, of living through their family members being ill with COVID-19. Nurses got infected and were sick. During that unfortunate moment the Nurses who were on duty suffered on the floor. Some Nurses succumbed to COVID-19.

3.5. Theme 4: Nurses' challenging work experiences during the COVID-19 pandemic

The Nurses share the challenges they had to deal with during the pandemic was the fourth theme that emerged. It had three subthemes: healthcare system related challenges, support related challenges and ethical dilemmas.

3.5.1. Subtheme 4.1. Healthcare system related challenges

Health system related challenges was the first subtheme that emerged from this theme. Nurses' experience was influenced by the challenges that they came across while nursing the COVID-19 positive patient. Their stress was complicated health system related challenges. Inadequate infrastructure posed another challenge for the Nurses and the donning and doffing was done in one cubicle which was described as totally wrong by Sister H according to infection control precautions. And the shortage of ICU bed compromised patient care

"*Yes we had the challenge because we had to use a cubicle for the donning and doffing which is totally wrong with regard to the infection control precautions. You don't don clean PPE and doff out dirty PPE in the same room, you understand but there is nothing we can do.... Yes, yes because our ICU is small so, some patients could not be accommodated due to limited bed capacity and some were not being sent to ICU because it was full*".

Some Nurses felt that the hospital infrastructure was not therapeutic for mixed genders and for isolating infectious patients as there was sharing of the toilet among the infected patients. Sister K stated

"*I can say the infrastructure because the hospital was not made for so many isolations, because we were mixing males and females. And the toilets, the cubicles they don't have toilets inside … the males and the females must somehow use the same toilet. So, the male patient maybe will be inside the toilet and the female one is knocking wants to come in. so that was the challenge that we came across with because we only had one isolation room now it was like females must be isolated in the same room and males must be isolated in the same cubicle. And the toilets they must use the same toilet*."

Mr T also echoed the same incident of sharing the bathrooms might have worked to facilitate the spread of the virus through the surfaces

"*OH actually I can say we had a challenge with, the patients sharing the same bathroom that was a challenge.Our ward was mixed all the patients both genders they were in the same*

cubicle I mean the same ward then they were using the same toilet. All the PUIs as well as the ones who were confirmed they were sharing the same toilet and bathroom. It was a challenge because according to what we were taught or what we were told even on the surfaces the virus could still remain in there so if the patients were actually sharing the same toilet the one who are negative would also contract the virus. I think that was the challenge there was no control on how to prevent the spread at that time. The hospital was just accommodating every patient who was coming through. All the patients who were see at casualty were swapped for COVID-19 so ja everyone was just using the same toilet that was on the things it was difficult to deal with."

Although the Nurses wanted to adhere to some of the precautionary measures of COVID-19 transmission the infrastructure made it impossible for them to do so as there was limited space to maintain social distancing among themselves

"*Social distancing and so on but like I said sometimes the unit do not allow for social distancing. Like you can say social distancing then you find that you working with plus minus five people per shift. The nursing station is very tiny the push is how are we going to work when there is limited space in general in the ward you know*"(sister T).

The infrastructure for casualty seemed to have caused some of the nursing obstructions as there was not enough space to do certain procedures such as nebulizing a patient instead the patient was taken out to the cold to be able to be given nebulization and prevent spreading the infection to other patients, sister M had had the same experience to this. In some instances, the patient will be resuscitated in a room without adequate ventilation and light which was not ideal and compromised patients

"*The other thing which also affected structurally was the issue that we could not even give them nebs in the same situation. We had to pull them outside then have an oxygen tank to be pulled outside for the person to get nebulized outside. The weather conditions were another thing. Remember last year it was around winter time, its' cold and now they have to sit outside and get nebs*".

Sister L agrees with sister M

"*remember I said there is two ventilators, meaning now we have to split to me in the now what we call COVID one ventilator to be in the non-COVID area. Under they may shift to resus, those were challenges we were faced with. You end up resuscitating with the*

frustration that it's not the best or ideal room which is well ventilated, well-lit and somewhere along the line when you want something it's not there. Now you have to go and run and get it elsewhere but initially the system was running smooth. Now babies as well are compromised because we resuscitate all the kids down there. With COVID still this child might come with maybe fever but" (Sister L).

At some point the Nurses had to nurse critical patients on the floor and on wheelchairs due to insufficient space, beds and not enough food. Sister M stated the following

"*Ja, definitely it has a negative impact because sometimes you will come on duty you will find the patient lying down on the floor because the is no space there is no beds. Normally we didn't know we were going to nurse the patient on the floor you don't leave a patient on the wheelchair, a critical patient. At some point you have to nurse the patient on the wheelchair and then it was just challenging because even to tell the family that we don't have a bed you see. They don't understand, they are expecting us to give them food, clothes, everything and sometimes you sign incidents where they complain about us saying there is no food*"

In some cases, insufficient medical resources and equipment were not available as a result the patient would suffer. Sister P stated the following "*The challenges we had was lack of resources especially with desaturating patients at times we had desaturating patients. Like the SATS would be low, the would have low we didn't have high flow, we just had high flow this year the whole of last year we didn't have high flow. ICU, we make arrangements ICU doesn't have ICU bed, bigger hospitals don't have space for patients. So, we still have to nurse those patients in the ward on double oxygen*".

When Nurses didn't have the immediate resources, they need to work they would borrow from other units. In the day with sister G lost a COVID-19 patient, she did not have the body bag used for COVID-19 patients

"*as much as I could not preserve the life. So, like my day was something else because I had to be there until around I believe eleven am to twelve am. Now the challenge is k my client passed on. Now there is a story of now how do I wrap my client and prepare my client for the last offices. Now they said there is a special umm shroud I don't have it in the ward I know that for sure. Now I have to call the medical ward they are the ones that they actually are used, deal with the cases. "Guys when this happens what to do you use" they tell me about a body bag. Now you are like "a body bag?" the only thing that I could think of, the body bag that I know is the one that they use at forensic. So you go there now you have to come out,*

you have to take off the protective clothing now you have to run around try to get everything to prepare, to actually prepare your client now for you're the last"

Sister A shared how they had a challenge with the dissolving clear bag to put their infectious linen as when they are not there the people who are supposed to take it would refuse to take it

"*Our linen was not mixed with the linen from other wards, you understand our linen on one side. We had a challenge that with linen we are using clear bag, there is that clear bag that dissolves, like they don't want to hold line they just want to put it in there. Sometimes we facing a challenge not ha ving plastics, those clear bags we had to put our linen in the yellow one, when you have put the linen in the yellow bag they would refuse to take it who must handle it now" translated from isiZulu.*"

To the struggle of oxygen another life saving device that was not available to use was the NCPAP device

"*In that unit of COVID we don't have CPAP masks, nothing and CPAP mask was helping lot of patients in other hospitals. You understand that those are the gaps"* (sister Z).

Sister L shared how they were struggling with insufficient ventilators, and blankets to keep the patients warm during cold days

"*Some don't have blankets and we also did not have enough blankets to go by. So those were the challenges that we had physically, structurally I mean. And equipment wise we didn't have*".

Other things were beyond the Nurses' abilities however they were still expected to do their best. There was a time where there was not enough wall oxygen and the use of oxygen cylinders posed a dangerous risk of injuries said sister H

"*We had cylinders but the problem is that the cylinders oxygen isn't enough. You can use it for plus minus hour even if it's a full tank so we used the ones that are mounted on the wall at least they are effective enough more than the one of cylinders. Cylinders are very dangerous because we can put them on the patient's bed side because they are flammable, number one you may never know when a patient has matches or anything, and they are a hazard because now yes it stands but what if it falls on the patient's foot or anything. So, we can't put such dangerous equipment on the patient bed side*".

Availability of, and procedures related to PPE, posed its own challenges. Nurses were faced with a situation of not having enough PPE to protect themselves from the deadly virus. The concern for most of the nurses was the challenged posed by shortage of PPE as they had to reuse them which posed a risk of infection. This was echoed by Mr T, Sister M, Sister C, Sister T

"*Yes, when the COVID starts we had the challenges of how are we going, if you are going to go inside the cubicle and nurse the patient when coming out what am I going to do to this PPE. And when am supposed to go lunch, tea time so what am I going to wear when am going back so but, in the wards, let's say when you go for lunch or tea time you have to remove your PPE. Remember there is a jumpsuit outside there is a gown inside or maybe you remove the gown on top and just go to the kitchen with a jumpsuit. You go and have tea and come back and wear again the same gown but though you don't know because some of your colleagues may get infected and when you go for tea. We are using same room, you see same room and you end up sitting next to one of your colleagues not knowing what is their status…*" (Sister J).

Sister P felt drained by the difference in the PPEs worn to prevent being infected and to learn that her hospital system actually exposed them instead of offering protection

"*No, we were not protected we were wearing plastic aprons. It was plastic aprons and N95. We also, after that we were sent for training, at that training its where you see jumpsuits, gowns, double gloving and you go back to the situation. It reminds you to go back to the situation where you were just only nursing with plastic apron. So, it was actually totally draining*" (Sister P).

Nurses worked in difficult circumstances amidst staff shortages exacerbated by absenteeism and fear of nurses to provide care to patients with COVID-19. Nurses had to work under difficult and tough situations with disproportional nurse to patient ration due to staff shortage. Sister F nursed 22 patients alone for three days and all she managed to do was to give medication and nothing else:

"*As I am telling you it was hectic. What I told myself was that if I gave them medication then paper work is not that important they will see, the important thing is medication. If I can start giving medication at nine until three pm still giving medication because at the end of the day this person is not getting one medication. Some they get a lot of medication because some have got BP their medication is a lot and some are diabetic and so on. Not only antibiotic but*

other medication. As I am telling you that I nursed alone twenty-two patients for three days. It was hectic I wished for a hole to open so I can enter but what can I say the staff was knocked by COVID and they were really sick."

Some Nurses had to stretch themselves to ensure patients are looked after this meant Sister G will work in two wards at the same time as she was the only professional Nurse on duty. The two wards were non COVID and COVID wards which also posed risk of cross infection "*So, far they only hired one RN and that I know of, that I have met because when I met her she was asking sister I hear you normally work this side am gonna have to go to theatre with you whenever you are in the theatre so that I can acquire myself with, the only RN that I know up to so far when she is off there is no one to relieve her so it goes back to the normal way of saying am gonna be nursing in the ward and then come back and nurse on the other side.*" Sister H had described the frustration that befallen on the professional nurse due to staff shortage as she had to do all the work that her subordinated could not do:

"*Like human resource, human resource we are having a huge shortage you will find that the ward accommodate thirty patients yet there are only four nursing personnel of which maybe one is a professional Nurse and you find out that the three are enrolled Nursing assistant so can understand the frustration because now find that all that work falls under the professional Nurse, the other category cannot do other things, you understand. So ja human resource is one thing that is a challenge and if ever I would change that unfortunately there is nothing I can do to change that*".

Sister J had to be the only nurse on duty while her colleague were on quarantine and she came across multiple challenges which made it difficult for her to work. For instead when she had to take out a scheduled drug no one was available to countersign, had a lot of patients coming in the unit, she was overwhelmed

"*When I get there most of the nurses ninety nine percent of the Nurses had tested positive for COVID they were on quarantine. I remember one day coming on duty I was alone, ….When you go to the drug cardboard you have to be two so who is gonna counter sign for me because I was alone? On the other side the challenge is when you are alone and the patients are coming in like this, you have to triage and you have to nurse the patient and on the other side you still have to do one to three it's a lot*"

Nurses had to work under stress due to staff shortage and Nurses from other wards did not want to come and help out, said Sister K:

"*Under stress with thirty-four patients. It was hard really. We were short staffed and the COVID ward, nobody wants to work in there unless this contract because they were hired for COVID they are the ones who will come and help. The permanent staff they didn't allow, they didn't want".*

According to the COVID-19 protocols Nurses were not allowed to spend more than 15 minutes with a patient. On the day sister P was the only professional Nurse on duty she approximately 3 hours administering medication to 23 patients and she strongly believes that is where she got infected

"it was hectic and it's a dilemma you can't just leave the patient without giving treatment. So where you can you re insert so that's how exposed I was. I think we gave treatment that day for plus minus three hours".

Despite the insufficient staff on duty Nurses had to adapt to other roles to ensure patient care is rendered as the other personnel were scared to enter the ward. Sister M shared how she had to become a clerk when there was a new admission in the unit, become a cleaner, a social worker and a nurse at the same time

"*Even now instead of working we work but on the other hand you have to answer all these questions on the phone so you become a cleaner, you become a social worker, you become a clerk. On nursing side because even clerks sometimes, they are scared to come and open file on COVID side you have to go there and give them the information… So, you become a clerk you take all the information the gross and everything while I was supposed to nurse the patient who is having difficulty in breathing and you have to give treatment other one is taking information you see*".

Nurses found themselves working under situations which they described as tough and challenging by Sister T, as difficult by sister A and sister M lastly as strenuous by Sister Z and Sister Q in the following quote

"*Exhaustion does contribute because by then we were not able to relax like this. One minute there is influx of patients, while you are busy with a patient who demises there is a new patient for admission, so it was strenuous I don't want to lie. Now it's better …*"

Some Nurses felt their struggles we complicate by the organizational structure as they mixed patients lacked clarity of the procedures to related to certain specific procedures. Sister G's

unit she felt their department accommodated positive cases without being given the guidance of how to go about nursing them

"*I feel somehow maybe when they were doing it, according to the information you know the hearsay from some of the other units, and there is a ward that was said it will only accommodate the cases. The challenge that came about to actually came to be clarified, I had to nurse. It was a case to say, because it was a maternity … I feel when they did the in service training to say this is the body bag that we are going to use. We are not going to use the normal shroud and everything, they only focused on the medical side excluding the obstetric area and the obstetric cases now are not nursed together with those patients they are now nursed separately which made it a challenge because now when you call the normal other units … now it's your first case you are having a loss now you don't know what to use and what not to use you have to go and ask from the medical areas where they are used to dealing with the positive cases*".

Some Nurses feared the consequences of nursing conditions that they know less about their management as they were not trained for them.

"*To add on that, the psych, not psych only even pregnant woman, we are still nursing patients at this moment we are not being asked, they just, I remember I think three weeks back we had this lady she was thirty weeks pregnant, we were told that she has COVID she has to come here. Am not a.. Am just a general nurse, you see. So, for us we felt we are not safe if she comes here because am not even psych specialist if something happens at the end of the day I will be responsible for that, you see*" (Sister C).

Nurses experienced a delay in the transferring of the patients to other hospitals where they need to get further management and they were not sure whether they were fully protected during the waiting period. Sister M stated

"*That ja. Sometimes you have to wait with the patient in casualty while waiting for a transfer to other hospitals. And the other hospitals are also full so you have to wait with the patient in casualty. Waiting for transfer not knowing that are you protected or not because it sometimes maybe not be in the full PPE*"

3.5.2 Subtheme 4.2: Support related challenges

The second subtheme that emerged was support related challenges. With regards to support, Nurses felt disappointed by the lack of managerial support at times when they really needed it. Sister G had a tough time escalating matters that needed management as no manager wanted to take responsivity for her area. Despite reporting her concerns remained unattended and continued to disturb her work

"*I think there was somebody who was supposed to be responsible for that but according to my own experience or should I say my own small opinion. I think that the managers as much as they are not too much close to the patient some of the things they tend to overlook because even when you go to them you tell them what's your concern this is what concerns me then you later think maybe in the next two days or so you gonna get maybe a resolution to that but you find out this one is thinking that so and so was supposed to attend to that. So, there is no specific person that you can say I need to go to this person that is the person that is responsible for area with those clients*."

Nurses felt a lack of effective communication from their managers which contributed to their unpleasant experiences in their work place.

"*The space where and nobody told me that am going to take you from medical now you are going to work in casualty. They just phoned me when I was off at home and tell me that the changeover says you are going to casualty. So, I decided you know what it's not good because they were supposed to call me and sit down with me and tell me , because of one two three we have decided. If there is a shortage in casualty, because we have decided to take you to casualty. Nobody told me that. Some body called me when I was at home telling me*" (Sister J).

As the COVID-19 was a new infection which was still being studied. The Nurses had confusion related to how they need to protect themselves while nursing these patients. For Sister P the communication line complicated their confusion

"*The confusion on how to protect yourself, the communication of how it was actually communicated. Let's take it back to how I told you we were given no choice but to have patients in the ward, yes*."

Nurses felt the absence of the manager's support in their difficult times. They were expected to nurse the patience without guidance and clarity. The difficult thing was the managers and the infection control sisters not coming in the ward to give the support the Nurses needed

"*At first we did not have support at all. I wouldn't lie to you we didn't have support because this thing. "As you know" when it started it was coming from other countries, coming to us it had that thing that COVID "kills". "So, when it arrived this side" I remember our first patient, "when it arrived" we nursed that patient I think for a period of three weeks. It was one female, so by then that is why I say everything was difficult because no one wanted to come to the ward not even management, not even infection control sisters. And by then we didn't even know "what to do at that time". Support system was very poor*" (sister C).

Other Nurses echoed the same challenge, Sister P, Sister T, Sister Z and Mr T had complains that needed management support were ignored

"*We didn't receive any support or additional support from any other unit or other wards. Like everyone was just scared including the management themselves, they were nowhere to be seen. They used to come to the main door maybe ask for the statistics without actually getting inside the ward as to find out to how we are coping, how we are doing, how are the patients because they were also scared so we didn't actually receive help. But we were actually complaining to them that we are not coping, we are scared and people are absenting themselves because they are not really k. so there was no help that we received from anyone*." (Mr T)

Insufficient psychological support was echoed by most Nurses as they felt they were supposed to be mentally prepared and supported. Nurses felt the psychological support came late as the damage had already aspired

"*I remember the day we had the counsellor to talk about this whole thing on how it's affecting us so she gave us the opportunity to express how we feel about we feel about the situation and staff and staff. Actually they told us that if you want you wanted a one on one you can contact her at the end of the day I don't know if this was enough I don't know if taking about it was enough …….Like for instead I think as much as I think as a staff we were on panic mode everyone was on panic mode and then when we were all on panic mode so who was going to alley anxiety. Like I feel like when the counsellor came to talk to us at that particular moment it was too late*".

The nurses would have appreciated counsel sessions from their managers as they faced with daily challenges not to continue working as if nothing was bothering them at that time: "*Yet we are not even receiving that counselling to say as HCWs that are facing these challenges every day. So, they is no time that they would say let's now sit and talk "how are*

you feeling, how are you doing?" you just work as work as usual and then, that's it" (Sister M).

Nurses also felt that they were not sufficiently orientated and trained to manage the pandemic, but some acknowledged the situation as unexpected and unfamiliar. The lack of preparedness exposed the nurses as not enough stock was at hand. Sister G mentioned a sad incident that she had to assist the COVID-19 patients with bare hands as she had an allergy to latex glove

"We were not prepared the only thing that we had, in fact we were partially prepared not completely prepared the way it was being said that this is how you are supposed to dress and all that. And having me with an allergy to latex glove it was something else. Cause at some point I had to go there without the gloves".

Nurses needed the educational session that will prepared and empower them to be able to render effective care to the patients and some did not get it

"*I won't lie in-service training was so limited some got it some did not get it. We had to use our own infection control measure that we learnt, yes. So ja, it was…not to all of us*" (sister H)

Sister J and sister A faced the same situation where they needed to be orientated into the unit as the environment, procedures and equipment used was unfamiliar to them

"*I have never worked in casualty since to me to use the what you call the ventilator machine it was a challenge. To me to do what else there are so many things and the environment, I was not familiar with the environment you don't know if you need this thing where must you find it. So the environment*" (sister J).

Some of the nurses did not receive the important training of how they were supposed to don and doff the PPE and how to use it effective to yield the needed protection shield *"nothing, nothing sister nothing. Nothing I can tell you it was like, you see the donning and the doffing nobody came and tell us about the PPE how to wear them how to doff, how to don how long must we use that PPE*" (Sister K).

3.5.3. Subtheme 4.3: Ethical dilemmas

Ethical dilemmas were the third subtheme that arose. Nurses experienced ethical dilemmas related to distribution of resources and the unusual situation the healthcare system was confronted with. Nurses had to be caught in dilemmas during their carrying for the patient. Patients were discharged and their families were refusing to take them home as they were scared to be infected regardless of being tested negative. However, the doctor planned to keep the patient in the hospital

"*Because even some that we had here, you find that the patient is discharged but at home they are refusing to take that patient if three months is not finished. And we would tell them that it is no longer effective, he is fine now completed quarantine and they would refuse. One lady was crying when she was supposed to fetch her husband saying but he has not finished three months if it lasts for three months it means he will infect us. And we would tell her there is no such thing because he has been quarantined for ten days to fourteen days so it's no longer effective he is fine now. Now he is walking and doing everything by himself and she said no I cannot he will kill me and my children no and she left we stayed with the patient*" (sister F).

One of the COVID-19 protocols included not to resuscitate the COVID-19 patients as it was believed the risk of spreading the virus was more during this procedure. It must have been the biggest decision to leave the patient to die and not do any intervention as a nurse. Sister Z was caught in between as she could not help but think what would she have done if it was her mother

"*…Yes and people were left to die others they were going to make them survive you know my sister. But what if it was your mother was lying there then they don't resus and you know it that if I can give oxygen or more. Bag this patient or do maybe CPAP or*".

The shortage of ventilators resulted in another dilemma were a decision had to be made whether to keep the patient who is already in the ventilator and disadvantage the new patient who is also in need of a ventilator or take out the one who is already in the ventilator

"*well we had two ventilators in a time you know. At any one particular time someone has to be ventilated and it's occupied. Someone else comes in it will now be a dilemma as to much more time can you give to one person as compared to the next person. Because you would be caught up in a situation where you give some people oxygen but at the end of the day it would not give or yield the positive that you would want to see happen*" (Sister L).

Another incident was witnessed by Sister L where a patient died in front of other patients while waiting for a bed

"*So they will all be mixed you know and we will somewhere along the line have unfortunate cases whereby you would lose some patients in that situation. When other patients are there looking and now you don't know how to hide this situation. You don't know how to handle it better because if someone loses a live in that situation. It simply means that to the person who is looking after that it might me, you know or these people are careless you know or don't know what they are doing. It raises up a whole lot of questions, a whole lot of anxiety as well. But we went through it as just as we can*"

As visitors were not allowed come in and see their loved ones. Nurses found themselves answering calls of the relatives. The dilemma arose when the relatives want to know the condition of the patient which the nurse cannot do

"*Sometimes they shout at us the families on the phone because they want to know what is happening. Sometimes you don't even have time even to explain to the family, they want you to explain the condition and staff and the doctor is in even around to explain. And sometimes ethically you are not even allowed to the patient's condition and staff through and on the other hand this patient is COVID so these were the challenges*" (Sister M).

The above theme dealt with the stress experienced by Nurses was complicated by challenging work experiences. Hospitals lacked the required infrastructure to accommodate multiple admissions and social distancing. Some organizational issues were experienced such as management of and spaces to accommodate patients awaiting testing. In some cases, sufficient medical resources and equipment were not available. Availability of, and procedures related to PPE, posed its own challenges. Nurses worked in difficult circumstances amidst staff shortages exacerbated by absenteeism and fear of Nurses to provide care to patients with COVID-19. With regards to support, nurses felt disappointed by the lack of managerial and psychological support at times when they really needed it. Nurses also felt that they were not sufficiently orientated and trained to manage the pandemic, but some acknowledged the situation as unexpected and unfamiliar. Nurses experienced ethical dilemmas related to distribution of resources and the unusual situation the healthcare system was confronted with.

3.6. Theme 5: Nurses' positive work experiences during the COVID-19 pandemic

The fifth theme: Nurses' positive work experiences during the COVID-19 pandemic had three sub themes: Managerial support, psychological support, sufficient resources.

3.6.1. Subtheme 5.1: Managerial support

Managerial support was the first theme that came up. Opposed to the previous theme, some Nurses appreciated the availability managerial and psychological support. Sister F and Sister J benefited from their supportive managers when they were stranded their managers joined the team and nursed the patients together

"*I went to report to the night super that am alone in casualty and I don't know anything. I don't know anything about casualty because I have been working in a medical ward for fifteen years since I came in to this hospital. So the night super said to come down sister I will try to get one of the Nurses from the ward to come and help you. As a result, we end up being three even the night super was with us to help us*" (Sister J).

Sister K is also appraising her manager as she shared their burden through their difficult time "*yes, she was also stressed. You can see she is not sleeping she is also stressing with us. Only her but other no. we had her because she is the one who even buy the cake……it was only that area manager used to come even in the weekend when we were short. If you can call her, tell her I remember one time I worked with her during the day. I worked with her, I called her that am alone she came and worked with me"* (Sister K).

Some Nurses applauds the efforts of the infection control team for being supportive and providing them with clarity when they needed

"*It I can say they were trying the people from infection control side they would come in the morning just to check on us to say "are you still coping? Or maybe they will teach us another method if something new came up to say "you are supposed to wear gloves like this and the mask wear it like this, how do we discard ? How do you wear it? The donning and diffing site, do we have been we having the doffing are we having the doffing pace? And wear our PPE". They were trying even the manager to send us to Joburg Gen, Charlotte Maxeke for in service training to see how we are …. They were supportive, ja*" (sister M).

3.6.2. Subtheme 5.2: Psychological support

Psychological support was the second subtheme that emerged. Unlike the other Nurses Sister G benefited from the general counselling offered by wellness as she was feeling overwhelmed "*The only thing that made me cope the wellness people from work they had to come they told us that if you feel like the stress is getting to much like you are overwhelmed by the stress then you need to also go to them like they do that general counselling*". Sister H felt like enough psychological support resources were made accessible to the Nurses however she did not utilize them for own personal reasons "k*, at work they tried to give us, to offer us support because we have a social worker side for the staff and now we have a clinical psychologist who is there for such things. So, I can say at work place there is psychological support even though some of us did not utilize it and then with regard to my personal psychological support was there. So ja, I guess I was fine*."

The hospital did offer psychological support to the Nurses however some Nurses preferred not to use it as it came late when they had accepted the situation. Sister P stated

"*Even after some time it was only when psychologists were sent but then it's like now they sending psychologists to come talk to you, speak to you already your mind is made that you are here you belong there, you belong in COVID ward."*

Some Nurses got debriefing sessions from their managers to reassure them in the difficult time they were facing

"*The minute they came they called us for debriefing so that they can reassure us. We are all new in this, you mustn't be scared as you wearing PPE so you must also eat healthy. That was the debriefing that they told us they even brought us the cake just to, you see*" (Sister K)

3.6.3 Subtheme 5.3: Sufficient resources

Sufficient resources were the third subtheme that emerged. Some Nurses enjoyed having sufficient resources which enabled them to render effective care. They had access to PPE to protect them from contracting the COVID-19

"*They provided the jumpsuits, the shoe covers, then in the middle of that because they said we must wear the overall, they shoe covers the mask was there then at some point there is another type of N95 which is white that whitish one*" (Sister G).

The Nurses had got relieve when the hospital hired extra Nursing staff and doctors under the COVDI-19 contract which relieved some of the burden

"*And it became a little bit of a thing of once they started hiring nurses and doctors who we specifically working under the COVID contract. Then it increased the level of the team on the floor you know. Because at least now not necessarily mean that we could cope but we could at least share the work load which would have been done by six people now you will find that we are eight or we are nine as Nurses. And having four doctors or particularly have three doctors. At least there is some sort of balance when it comes to numbers but with casualty being what it is naturally it is unpredictable"* Sister L).

The above theme focused on the positive experience the Nurses had during this pandemic. Nurses appreciated the presence of managerial support, psychological support and sufficient resources.

3.7. Theme 6: Nurses' experiences of caring during the COVID-19 pandemic

Nurses were expected to render quality patient care to the COVID-19 patients regardless of the pandemic. The sixth theme that emerged: Nurses' experiences of caring during the COVID-19 pandemic. It had two subthemes: humane patient care and ineffective care.

3.7.1 Subtheme. 6.1: Humane patient care

The first subtheme under this theme was humane patient care. Nurses thrived to maintain the quality of patient care to the patients. Some Nurses were encouraging their patients to fight to live and they were deeply wounded if the patient dies

"*It was painful you are crying, you run to the….. you cry, you cry with the patient but at the end of the day you don't tell the patient if the patient is dying you understand. You just talk to the patient "Baba fight" you talk to the patient fight please, don't give up now, you understand even though you see that it's difficult"* (Sister A).

Some Nurses gave their best care even more to their patients as they adapted roles to ensure the holistic needs of the patient were taken care of

"*I guess am the only thing that I can say I ended up having to be more like a social worker to my clients because some of them they are concerned no body explained anything to them. They are just told "sisi we moving you, you are going to this side and nothing else that is said*

to them, what to expect and what not to expect. No one they are actually allowed to vent their fears as the client now as a client. So, now you have to be the next of kin, you have to be there as a social worker, so now you have to be the nurse as well so I ended up to learn that k fine if I have to be a social worker in between my nursing career so be it. So, that I can allay the anxiety for my clients. In order for them to recover because what I realized as much as they are there they are not much fit even though sometimes you get those ones that you can see that this is the one actually need my full attention but the more reason for them to be more sick, it's just anxiety that all" (Sister G).

Sister F had witnessed patients who got the strength to live through the positive words of encouragement that were preached to the patient

"*You find that a person lives because of the words we have spoken. We tell them no you will be all right think positively think about your family, your children when you die. You speak with that person and you see that patient picking up at that time it was concluded that the patient won't make it. You can even see that the oxygen is not helping, sats will be dropping and going down but after talking them, at sometimes I don't want to lie, I would sometimes use my phone and borrow the patient to call their family member if they know their cell numbers. You find that when I come in the patient would say "Nurse thank you it helped to hear their voice*"

3.7.2 Subtheme 6.2: Ineffective care

Ineffective care was the second subtheme that emerged. Patients suffered as they received poor hospital due to personnel being scared to come in and assist the patient. Patients were not given food and they had to struggle to get help when they needed it

"*Because now they end up being forgotten they end up being forgotten even if it comes to meals that is one of the cases that I usually have to fight with. Then you go there you greet your clients "hi cc how are you are you still doing fine?" then the next complain that you are going to get is "sisi I didn't have tea, I didn't have no bread, I haven't even see the food, what time are we actually having lunch here?" now you have to run around trying to look for the ward assistant who is the one that is responsible to actually give lunch to the client, was the client even on the diet list? And where did the delay get to be, you know those I think if affects the healing of our clients because now they say "we are being neglected now that we tested COVID positive*" (Sister G).

Sister H felt the working strategies of certain individuals compromised patient care

"*At the end of the day the patient care depends on an individual you know we have various and different strategies on how work, right. And we don't work the same way.so now at times the patient will be compromised obviously because there is no way you can do everything alone, you understand. Yeah the patient care would be compromised but at least minimal care has been delivered*".

For other Nurses like sister P, felt that the COVID-19-time limit protocol disadvantaged the patient as the Nurse had to spend less than 15 minutes

"*Sister P: Like you just actually be limiting the movements and the working with the patient part it was hard. Because you there for work like you basically there for the patients you try your level best to help the patient and at the same time you must self, you must protect yourself. So the nursing care I wouldn't say the nursing care was as good as nursing a patient that is not COVID positive."*

Sister Z witnessed a neglect of other diseases as the focus was on COVID-19 which also disadvantaged the patients

"*I've seen that they were neglecting lots of diseases like TB I can say. They were concentrating on COVID only and other patients were from other different diseases you know you will hear from them when you are talking to the patient. And the patient will tell you "no I've been having this and that, and that" but now we are concentrating only the COVID side of it*". Some Nurses pointed at short staffing as a contributing factor to patient neglect as there were many responsibilities for one person to attend to " " (Mr T).

Some Nurse believed that the negative attitude of their colleagues resulted in the patient receiving poor quality care

"*For me, as for me, I would say it is because when they arrived even the staff amongst ourselves, you know we have got different categories? When it started, we, like there are RNs, and other subordinates, they were saying that they are not going to nurse the patients as COVID is for the RNs, the sisters. Unfortunately, I was the one who was nursing the patient. As I have said our first patient was a female patient who stayed for a period of three months. So, specifically for me it was tough because I knew that every morning when I wake up am going to nurse that patient. Because no one wanted to help me you see. If not by other sister, but dedicated myself that I wanna nurse the, I will nurse the patient because at the*

end of the day things were not done, you will find that when you are about to knock off maybe medication was not given and food. Another challenge was, at first it was said that you are to give the food, medication is ours, if there is a mess inside we were given a mop that if there is anything that need to be cleaned up, you will take the mop and clean up as a RN, so no one else. All those things, I did all those things alone, you see" (Sister C).

The above theme looked at humane patient care that was rendered by the Nurses with acts of kindness and words of encouragement they practiced. Related to many challenges, some Nurses observed, or were involved themselves, in instances where patients were neglected with ineffective care.

3.8. Theme 7: Nurses' experiences of coping during the COVID-19 pandemic.

Nurses' experiences of coping during the COVID-19 pandemic was the seventh theme. Where Nurses shared their different coping strategies that they used to cope during the pandemic. This theme had two subthemes: Internal coping strategies and external coping strategies.

3.8.1 Subtheme 7.1: Internal coping strategies

Internal coping strategies was the first subtheme that emerged. Nurses needed to find a way to cope and continue working. Some Nurses managed to cope through their love for nursing and caring for the patient

"*When I went to do the course, I came back and when they asked for people who will be vaccinated I was the first one and they asked me why. I said no it's better I get it knowing. I love helping people and I love spending time with them because having conversations with a person you are comforting that person giving that hope even though you can see it's bad*" (Sister F).

Regardless of the fear Sister G had she took courage and helped the patients as she had commitment to nurse without discriminating the patient whenever a patient is in need of her help

"*As much as I was scared but I had to tell myself that the patient is here and is looking for help from us as the nursing care profession as much as it might have …to contact the virus let me rather treat the patient the same way that I will be treating somebody with HIV.*

Because remember with the HIV we still having that stigma around it now am nursing this patient am so concerned about the blood thing and all those funny things. If there is a hole on your glove and all that. So, I had to take it that way. To say as much as she is positive but it's not something that she asked for and she still needs the care like everybody else, she doesn't need to be discriminated against the condition now because she is not actually the condition as much as she is affected but she still needs the nursing care in totality".

To some Nurses nursing is regarded as a calling, Sister K was scared but she believed that she was called to help the patient

"*No, it didn't affect because when this is a calling, when being a nurse is a calling you become scared but when the patient comes the person that you are, you have to nurse the patient still, help that patien*t".

Some Nurses still had the commitment to nurse the patient even after they were sick of COVI-19 themselves. Sister P shares that because she now knows how it feels like to be a patient she had a positive attitude to help the patients

"*then it was only towards the final days where I was like this is hard hence I went back to work with a positive mind. I knew how it felt for the patient so I went back with a positive mind maybe again because I was a survivor I knew how it felt like*."

Sister Z witnessed the commitment displayed by the Nurses to care for their patients as they sacrificed having lunch to ensure all the patients' needs were taken care of "*Seeing Nurses working without having your lunch, your tea time and go home your lunch nobody sees that but you come home and eat your lunch because what can you do because you cannot go and sit leaving the patient suffering and without medication you have to. You have to help the patient because you are there for them you know*".

Some of the Nurses understood that they were there only ones who can help the patients, if not by them by who? And they had expected such situations like this might cross their paths "*As I have mentioned at the beginning anyway, I am a nurse things like were knew or I knew that they would happen, one day we might we come across conditions similar to this I just had that thing that at the end of the day the patient had to be nurse if not by me then who else, you see. That was the only reason*" (Sister C).

Some Nurses possess the true love for nursing as they nursed the patients without full protection and still have that desire to help the patient

"*Knowing that this is not the full PPE so it was challenging. At the end of the day we have to work and you are thinking if I don't work, who will work also. And these people need help. And then sometimes you find yourself saying "eish, I don't have a choice here*" (Sister M).

Nurses had to respond fast to the challenges they were faced with in order to help the patients. Nurses found themselves improvising for the resources that they needed to use and were not available

"*yo, there was a time we were in a situation where we were short of oxygen points. So, we were short of oxygen points we had to improvise to say who has the highest demand for oxygen now at that time because the oxygen points were short and we had a lot of patients who needed oxygen. So, we had to assess a patient thoroughly to say who needs oxygen more than this one, this one can cope for some time and this one cannot cope. It was an abnormal situation*" (Sister H).

For some Nurses like sister P improvising meant to adapt and continue to work as a shift work even if there are members who are not there

"*And make sure that we give the patient holistic care at our outmost best at all times. Because if you see a challenge you already become discouraged you know and you won't be able to do anything that's the only thing you gonna be thinking about but if you decide that no we can do this we can work this was we can try and you know alternative ways this can really work because actually there work is not gonna stop because the shift is missing two people. You have to make sure that everything is done at the end of the day you know*".

Some Nurses took the initiative to manipulate their environment to protect themselves. Sister C and her team took out the file from the cubicles to minimize exposure and developed cubicle nursing

"*if you could see this side, no one told us how to put the patients. We decided ourselves as you can see outside each and every cubicle there are two tables, one for the doctor to use and the other one we put files on it, you see. Before, the patient's files would be inside the cubicles we sat down as nurses and decided to try this idea. We didn't even tell them they just saw the change and came to ask us what is happening. We told them we find it better. Our files were not even labelled outside but we decided to number them according to bed numbers for example 5A it works for us. K, another strategy we are using, is a strategy to focus on, remember we have cubicles, to focus on your people like if maybe in this shift I will*

focus on this cubicle I should know those people better by doing that we feel like that you are even limiting yourself from going different cubicles, you see".

Some Nurses refused to see a challenge without solution so they tried their outmost best to create solutions to their problems

"*And because what made me I think push on with that first patient was understanding one fundamental issue when it comes to the department of health. Regardless of the situation that you are faced with you have to try and come to a solution. So, ignoring the situation or giving into anxiety it's not going to give you the end results that you hoped for, you know. Rather get the negative result at the end of the day but having done something towards preventing the negativity from happening in the first place, you understand. That was one thing that governed me*" (Sister L).

Other Nurses used rationalization, a way of thinking about the threatening situation in a different way. As they had to find a way to cope and adjust with the current situation, the nurses compared this infect as any other infection that they are at risk of contracting as they nurse different patients

"*Well, I adjusted because we are dealing with a lot of viruses and a lot of diseases. We have got meningitis, we have got HIV, and you can have a needle prick anytime. We dealing with TB, we are dealing with klebsiella we have got a lot of diseases that I can contract at any time so it was easy for me to adjust and treat it as any other virus or like any other disease*" (Sister H).

The same was echoed by sister J "

As normal patients especially, the TB patients I end up telling myself you know. I have patients with COVID is the same with a patient with TB".

Some Nurses treated the COVID positive patients and those with other respiratory infection the same as both need supplementary oxygen.

"*So ja other than that the needs are the same like n any other patient, like any patient with LRTI or pneumonia maybe they a battling to breath obviously you all gonna give them supplementary oxygen same thing with the COVID-19 patient. The only difference is that this one is COVID positive and the other is negative. But ja its almost the same that the only difference*" (Mr T)

Enhanced knowledge and understanding about COVID-19 also helped nurses to cope. Nurses empowered themselves with learning more about the deadly virus to be able to nurse the patient and relieve anxiety

"*A whole lot, eish, I have learnt a whole lot because now it made me go back to the book again. It made me go deeper and find out as to how this COVID-19 affects the human body. What really, really happens, you understand what really, really happens and it became very easy for me because I could easily see, have a provisional diagnosis to say k this patient might have COVID because is presenting with this and this and that so I could have a provisional diagnosis k this patient might be having COVID only to find out that the results come back positive has COVID. It was a bit, a learning curve a huge challenge but with at…*" (Sister H).

Other Nurses echoes that the knowledge gained helped them to cope and chased the fear way

"*Either than that I would say it was a learning curve, we learned a lot about COVID while working with COIVD so I can say now I know a lot about COVID and it doesn't actually scare me anymore. I know how to deal with it, I know how to deal with the patients, I know how to deal with the challenges am very much at easy*" (Sister T).

The same was echoed by Sister L "*Then from there ja I guess we started becoming slowly, slowly educated and our anxiety levels as well started becoming a bit more, a little bit more comfortable and calmer. We made peace and life went on*".

Nurses had to reach a state of acceptance to be able to cope with the situation before them. As Sister H continued to nurse the patients saw a need for to adjust to reality of people dying and others being contracting the virus

"*And emotionally I had to pull myself to say k now we are dealing with this virus and I have to find ways to adjust to it because it was not one patient now it was a lot of patients, who were diagnosed with COVID0-19*". For others they had to accept and prepare themselves that they might contract it "*So I only accepted that now the COVID is here so I just told myself I must expect anything at any time. I can't say I won't get COVID, I was expecting that COVID*" (Sister J).

Some Nurses wanted to quit but felt forced to continue working and accept the situation as they had to work to provide for their families

"It was bad. It was hard, actually it was hard, very hard but because you must put something on the table so were forced to work. Because our hospital is COIVD hospital so we are not like you can choose that am going to "I want to go to OPD." Because OPD also they are seeing new patients that they swap everyday even in fact every like casualty they have new patients that they swap, medical wards they, and like every ward we had COVID. So, there is no way that you can unless you resign" (Sister K).

Nurses had to go pass the stress zone and find a way to work regardless of what they have been through. Some Nurses had a regroup session where they discussed and rethink their actions to know where could they have done wrong

"*K, sorry I was saying, you know with this situation it was so abnormal so we had to regroup to our senses and think … must I do now, everything go wrong. More like a reflective cycle to say what have we done wrong? How can we cure this and how should this be tackled sort of like, I don't know how to explain it but it's sort of like first wave, like, yeah*" (Sister H).

Some Nurses didn't want to give into stress as they decided to counsel themselves as they did not see any choice but to do so

"*The first day coming here, I just you know what, am just that person I don't want to be stressed too much. So, I decided you know what everybody was… because I don't want to be killed by stress before I am killed by COVID. (Sister J loughs) I decide to counsel myself on my own. So, anyway I don't have a choice at the end of the day I had to do it*" (Sister J). Sister P was one of those nurses who had to be strong for themselves and is driven by positive mind-set as she echoed that there is selfishness in this world but one needs to do what is right and always document it as evidence

"*Always stay true to yourself, do what you can do, always put it down you know again as a nurse I will always say that "what is not written is not done". Is that sometimes know that "it's one man for himself" regardless. There is selfishness in this world in such situations that actually expose a lot. So that you know sometimes you just have to be strong for you. Go to work cause you there for the patients. And ignore all others and focus on what is important. Jeh it just makes it one step even it takes a long time*".

As for Mr T the experience of nursing COVID-19 patients helped him to discover himself the strong qualities that helped him to cope through this pandemic

"*Like about myself I am a very courageous person, like am not easily terrified even though I have seen, experienced some horrible things throughout my carrier as a professional nurse but now I have reached that state where there is nothing that can scare me. As long as am fine, got good health I will always be ready for anything or any challenge then I can take care of the patient*."

Most of the Nurses overcome the stress by focusing on their children as Sister Z, she was driven by the desire to provide for her kids

"*Hence am saying you know we are working because we have to cater for our kids I had to say it is well if am going to die I will die like one of the nurses who are dying of this COVID but I have to work for my kids because there is nothing I can do. There is no where I can run to I came to that stage that ja its fine let me just go back and work, I worked till now am working there." For some nurses possessing the ability cope with any situation that come your way made it easy for them to adjust to the situation "Yes I was saying I have learnt a lot during this COVID because lot of things have been changing in our lives you know. You have to learn to cope with all the situation because you never know what tomorrow will bring for you. Always be ever ready for anything that can happen you know. Because we never knew*" (Sister M).

Some nurses managed to stay hopeful and found strength in spiritual coping.

"*We thank Jesus shame. I said it, last year I didn't even have flu. And I ask God how is it possible because I spend time with the patient and I make sure…… But we did manage as you can see now we have two. Who would have thought that COVID ward would have two patients*" (sister F). Sister K agrees that her team would pray every morning and night to be strong in spirit and with stand the challenges they were faced with "*the I don't know what I can do each other and pray" every morning we would pray even in night we pray so that we can be strong in spirit*".

Some nurses got hope that the diseases were at least manageable when their patients recovered and don't die "*And another thing that made me to go on is because at that time I didn't lose any of my patients that tested positive. So, I had this hope to say at least it's manageable*" (Sister G).

Sister Z shared how she have learnt to thank GOD for the strength he gave her to be able to help the patient who cannot help themselves

"*I have learnt to you know what to thank God for my life really, for his protection. I have learnt that you know what every day I thank him for keeping me going because other people didn't see the day. And am able to help people and when I finish my work you know I just say you know God thank you I've made it through the day and now am going home. And I thank you to give me strength of helping the poor patients who are unable to help themselves*" (Sister Z).

Some Nurses got the encouragement to continue working from believing that God loves them "*And I can say God is good all the time because I never had COVID and I keep on working each and every day. People like they were having COVID most of the staff. I keep on testing, I tested four times and I was negative. That was my encouragement to say God loves me*" (Sister M). Nurses lived with fear that tomorrow they might lose their family member but knowing that God's grace and prayer will still be there helped them to cope

"*Knowing that it might happen tomorrow you lose your family that you love but by the grace and prayers we are still here*" (sister A)

3.8.2 Subtheme 7.2: External coping strategies

External coping strategies was the second subtheme that emerged. Social coping was accessed by some nurses, support provided by their families as well as the strength they gained from teamwork with colleague. Sister K believes that nurses having contracted COVID-19 increased their team spirit as they were able to give fast response to patients in need.

"*Here I cannot say there was a gap because we are a team even the permanent staff as I have said that there are contracts and am under contract with the permanent we were working together. When we do something, we are doing it for the patient because we were are all affected by this thing, some staff was infected by COVID they also knew that we don't know what they had experienced so when someone walks in everyone jumps to assist because they know how painful this thing is. So are working well as a team there was no gap*"

Some nurses were appraising the encouragement they got from their fellow team members as it pushed them to go on

"*And as I have said that we supported each other as staff, we would pray together encouraging each other that you know what this also shall pass" translated from isiZulu*" (sister A). Mr T is also echoing the support his fellow team mates gave home when he contracted the virus "*but I only got the support from my colleagues those people we were on the same shift with. They used to check up on me because they heard that I contracted the virus there was a time when everyone was checking up on me if am going well and fine, am I k*". the same was echoed by Sister T "*To meet the patient's need so, ja I just feel like the support that we had as a shift made it easier for us to get to stand to the challenges that came when our colleague or our staff member was not at work due to being infected with COVID*".

Nurses belong to families which they are financially and emotionally supporting. It helps some Nurses' to cope knowing that their families were supporting them

"*And you have a family that looks up to you and a family that you must also support. So that is actually what kept me going"* (Sister P). Some Nurses found strength through their families " *But it's not nice even to be honest with you, even last night I came home I was just crying, I cried my daughter she is twenty-four she felt so bad she said it is well I will pray with you*" (Sister Z).

Most of the Nurse's family members had already prepared themselves that their loved ones might contact COVID-19 as they work and they remained supportive

"*And the funniest thing is that when I asked my some because I was with my son and he was the one who was taking care of me. That were you not scared that I might probably infect you with it. He was like "I just made peace the day you that I came home and told him that you already have come across someone who is COVID positive". And in his own words "you know what I knew that one day the chines are going to visit us, I was just not sure what day were they going to land." So those were his exact words*" (Sister L).

Some Nurses who are staying far from their families also experienced support from a distance which was enough for them to stay strong during the difficult times

"*I had no choice I had to come to work another thing I got a support from my Family so I used to call them inform them what is happening. They were asking me am I k, am I fine ja I told them am fine but then I also acquired the virus, I also got infected with the virus last year. Ja I got a support from my family. They used to check up on me, how am I doing so I took some*

ten days off from work at least I got to breath. I came back to work I was a bit better, ja" (Mr T).

The above theme dealt with the nurse's attempts to cope in different ways with the stress and challenges they encountered. Driven by a sense of duty and commitment, some Nurses persevered to show up for work and do the best they could. Some improvised and worked out unique and practical ways to cope, while others used rationalization, a way of thinking about the threatening situation in a different way. Enhanced knowledge and understanding about COVID-19 also helped Nurses to cope. Nurses realized the unavoidability of the pandemic, and responded with acceptance and resilience. Some managed to stay hopeful and found strength in spiritual coping. Social coping was accessed by some nurses, support provided by their families as well as the strength they gained from teamwork with colleagues.

3.9 Theme 8: Nurses' recommendations for working during the COVID-19 pandemic

Nurses' recommendations for working during the COVID-19 pandemic was the eighth theme that emerged. Nurses saw a need for giving recommendations on how a situation similar to this pandemic can be better handled to yield effective results. This theme had two subthemes: psychological support, managerial and organizational support.

3.9.1 Subtheme 8.1: Psychological support

Psychological support was the first subtheme that emerged. In order to maintain healthy mental status of the staff it was recommended by the Nurses that counselling will be more effective if done on early stages of the pandemic to prepare them for what is coming. This would have made understanding of the situation to be better

"*If they had allayed anxiety at the first go but people are gonna get infected that's the truth, this is what is going to happen we have ways that we can prevent it. Like I feel like that would have helped, you know. At some point you get to understand the situation"* (Sister T).

The same was echoed by Sister P "*Proper preparation especially mentally. Mental health is more important I think as staff members we need to be mentally prepared*". Some of the Nurses made a cry for counselling as witnessing dying people is affecting them mentally. They plead that at least every three months there must be counselling sessions.

"*I then asked the manager to speak on our behalf that every three months we get counselling because we really need counselling as nurses during this pandemic… wards because we are the frontlines everything happens here….. We need counselling because the death of a person is no joke, seeing a person dying knowing you can't give back breaths to that person it's not a small deed*" (Sister F).

3.9.2 Subtheme 8.2: Managerial and organizational support

Managerial and organizational support was the second subtheme that emerged from this theme. Nurses have nursed the COVID-19 positive patient for 12-hour shift and they have evaluated its effectiveness. Sister G thinks that getting more staff allocated to the COVID unit which they will work 6 hours shift might help reduce the exposure to the virus, reduce the work load and ensure quality nursing care is rendered

"*Though am not sure how we can actually do it or whether maybe by saying if you are a staff member that is nursing them how often can you go into that room if maybe there is a set of two members to say if maybe let's say I go in from seven o'clock when the shift starts. Let's say I go work like six hours even if am not going to be staying their full time but just to say maybe am gonna see the patient every hour then umm I have another staff member that is gonna take over the next six hours*."

Some Nurses pointed a need for more moral support and encouragement to boost staff motivation and morale. Further saw an appreciation gap that should be filled by giving staff who exposed themselves to COVID-19 through helping the patients' danger allowance

"*I think people lacked motivation to work because right now everyone is calm. Motivation is the only thing that they need so a thing like COVID-19 allowance because people are being exposed to danger. So, people should be given at least the allowances obviously everyone needs money so if there is money involved people would be encouraged to go and work. But then if people are still getting their normal salaries like every day they don't receive any allowances and they are very much aware that the management received some money from the department of health but still people are not getting what is due to them*" (Mr T).

Some Nurses felt the gaps and the challenges they faced were mostly related to the Nurses opinion being absent in the decision-making process. The need to involve Nurses was seen as crucial,

"*We saw that it is working so I think if they could involve us more than coming when they have already decided that they think this will work, they don't even suggest they just come and tell us. If they can involve us in decisions regarding nurses I think it will be the best way for me it will work best*" (Sister C).

Furthermore, sister Z cries for a manager that is actively involved in the operation of the unit "*A hands on manager is the one who sees and who can tell the better thing about what is happening really with the patient. You cannot hear from me and say "how many patients did die? How many?" no you must be involved. "Hey guys how are you feeling? I can see you its hectic, what we can do in order to help you guys?" you know the nurses will come out with some advises "no we think hire more staff, this and that and that*".

In the end, nurses did not ask for much, they only wished for managerial and organizational support, sufficient resources and psychological support to enable them to provide the care that many of them viewed as their calling to do. The nurse's recommendations were discussed in this last theme.

3.10. CONCLUSION

This chapter presented the findings of the study. The eight themes that emerged were discussed: Nurses' emotional experiences of working during the COVID-19 pandemic, Nurses' social experiences of working during the COVID-19 pandemic, nurses' own experiences of COVID-19 infection, Nurses' challenging work experiences during the COVID-19 pandemic, Nurses' positive work experiences during the COVID-19 pandemic, Nurses' experiences of caring during the COVID-19 pandemic, Nurses' experiences of coping during the COVID-19 pandemic and Nurses' recommendations for working during the COVID-19 pandemic.

CHAPTER FOUR DISCUSSION OF FINDINGS AND LITERATURE CONTROL

4.1 Introduction

Chapter 3 dealt with the presentation of findings based on the data analysis that was conducted. The objectives of this study were to explore and describe the lived experiences of nurses working in the clinical setting during, the COVID -19 pandemic in Ekurhuleni, Gauteng Province. In order to propose recommendations based on the findings of this study and with reference to Nursing practice, Nursing education and Nursing research. The participants responded to the research question asked which was: What is the lived experience of nurse's working in the clinical setting during, COVID -19 pandemic?

Findings were presented in the previous chapter which were analysed using the Colaizzi phenomenological method.

4.2 Discussion of sub-themes

In this chapter the findings were discussed supported by literature control. The discussion was based on the eight main themes that emerged from the study as follows:

- Nurses' emotional experiences of working during the COVID-19 pandemic,
- Nurses' social experiences of working during the COVID-19 pandemic,
- Nurses' own experiences of COVID-19 infection,
- Nurses' challenging work experiences during the COVID-19 pandemic,
- Nurses' positive work experiences during the COVID-19 pandemic,
- Nurses' experiences of caring during the COVID-19 pandemic,
- Nurses' experiences of coping during the COVID-19 pandemic
- Nurses' recommendations for working during the COVID-19 pandemic.

The first theme was:

4.2.1 NURSES' EMOTIONAL EXPERIENCES OF WORKING DURING THE COVID-19 PANDEMIC

Emotions are a big part of patient care and safety. The emotional state of a Nurse directly impacts the care that is administered to a patient (Heyhoe, Birks, Harrison, O'Hara, Cracknell and Lawton, 2016). It may hinder or promote patient care. Hence it is important for a Nurse to be emotionally stable to deliver optimum care to the patients in his/her care. In this research study the emotional experiences of Nurses during the pandemic was characterised by stress and fear. The Nurses were afraid of contracting the disease, infecting their loved ones and ultimately dying from the disease. Fear is described as fundamental survival reactions to threats, (Reizer, Koslowsky and Geffen, 2020). Another factor that added to their fear was the burden of treating patients without full understanding the COVID-19 pathophysiology. Furthermore, avoiding getting infected for the sake of their loved ones made the Nurses to be hypervigilant. Nurses were always afraid of making any errors which can result in them contracting the COVID-19 virus and thus leading to them infecting their families. In a study conducted at the Northwest of Amhara Regional State Referral hospital, Northwest Ethopia by Mekonen, Shetie and Muluneh (2020) came to the same conclusion that nurses were worried about their family members being infected which led to increased anxiety levels.

The level of anxiety might have been aggravated by insufficient knowledge regarding the COVID-19 virus among the Nurses and contributed to their fear. Which was exhibited in staying away from the infected person. Lack of knowledge was attributed to lack of training. Labrague and De los Santos, (2020) study findings on frontline nurses employed in five hospitals in the Philippines, showed that Nurses who have not attended COVID training showed increased fear, negative job satisfaction and psychological distress. Their study correlated with this study, namely that the Nurses shared similar emotions, e.g. that their fear related to new exposure to the infection, confusion regarding protecting themselves, negative emotions of being frustrated and how it resulted in the patients being disadvantaged. This study really shared the impact of fear the Nurses had in relation with lack of training, knowledge about the COVID-19 virus and psychological distressed. These findings are consistent with the findings of the study conducted by Raven, Wunie and Witter, (2020) among HCWs who worked during the Ebola outbreak in Sierra Leone. They highlight that insufficient data about Ebola contributed to fear of the disease and that stress resulted from their struggle for lack of resources.

Nurses who feared to contract COVID-19 resorted in avoiding contact with the COVID nurses and stigmatizing them. Stigmatization occurs when people are labelled based on situation(s)

they are experiencing or had experienced. (Schubert, Ludwig, Freiberg, Hahne, Starke, Girbig, Faller, Apfelbacher, Knesebeck & Seidler, 2020). People who experience stigmatization often have report low job satisfaction and social isolation. The nurses in the study experienced stigmatization from their colleagues who would rather not interact with them. This affected their work experience and led to lack of satisfaction and feelings of neglect.

In spite, of their stigmatization and social isolation from their colleagues, the nurses in the study had to carry out their professional duties which includes emotional support to the patients. The high rate of infections during the COVID-19 pandemic led to the implementation of restrictive visitation policy. Hence, the nurses in the study had to forget or lay aside their feelings of isolation and be emotionally strong and supportive for their patients. They empathised with their patients.

The empathetic feelings of the Nurses increased as they viewed themselves as a support system to the patients whose family members were not allowed to come and see them due to the COVID-19 protocol (Nelson, Murdoch and Norman, 2021). Empathy is defined as an act of commitment to understand what is felt by others by adapting their perspective, reacting supportively (King, Kamble, DeLongs, Sandman, Lenard et al., 2016). In the current research study Nurses in the study felt the pain of the patients due to the fact that they were daily confronted COVID-19 infections and the deaths. Xu, Tang, Lu, Fang, Dong and Zhou, (2020) reported that Nurses would run and cry alone after witnessing patients' death.

The pain of witnessing patient dies on a daily basis left nurses traumatised and feeling powerless. Liu, Luo, Haase, Guo, Wang and Liu, (2020) supports this finding as their study highlighted feelings of grief and powerless related to the patient's suffering and the quick deaths they had to experience. The feeling of powerlessness as the nurses witnessed the deaths of the patients further led to anxiety and depression among the nurses. The nurses in the study believed that their anxiety and depression might have caused or hastened their patients' death.

The depression from the deaths of patients and the powerlessness felt by the nurses led to burnout among the nurses. In addition to this, lack of basic resources that can help in resuscitating patients led to the nurses in the study to the desire to quit the nursing profession. Findings of this study were supported by a study done in Sub-Sahara risks for burnout amongst doctors, Nurses and other HCWs which were related to heavy workloads,

poor working condition, and staff shortage (Dubale, Friedman, Chemali Denninger, Mehta, Alem et al., 2019).

Similar findings were revealed in a study conducted by Halcomb, Mclnnes, Williams, Ashley, James, Fernandez et al., (2020) where it was reported that Nurses who worked in primary health care in Australia wished to resign from their current positions as they feared for their personal safety.

Demotivation and discouragement were common to nurses taking care of COVID-19 patients in the COVID-19 pandemic as reported by several studies (Fernandez, Sikhosana, Green, Halcomb, Middleton, Alananzeh et al., 2021). The demotivation and discouragement were worsened in this study by lack of teamwork which left Nurses both emotionally and physically exhausted. Bredicean, Tamasan, Lungeanu, Giurgi-Oncu, Stoica, Panfil et al., (2021) reported similar findings that the inadequate support in the professional environment was linked with higher anxiety and stress, less resilience and higher burnout scores among health care professionals

4.2.2 NURSES' SOCIAL EXPERIENCE OF WORKING DURING THE COVID-19 PANDEMIC

The second theme that came out in this study was the Nurses' social experience of working during the Covid-19 pandemic. Nurses felt a change in their social life as they return from work. Their interaction with their family, after work was filled with fear and as they were expected to first remove their uniform and then wash before contacting their families. Others had to stay away from home as they feared infecting their loved ones. Nurses' social life was negatively affected as they spent most of their time in the hospital working with COVID-19 infected patients. Having a balanced social and work relationship is essential for nurses' well-being. This balance was impacted by the experience of caring for COVID-19 patients as nurses were stigmatized and felt socially isolated.

The fear of infecting their loved ones led Nurses to self-isolate from their friends and families as an act to protect others but also felt incomplete without their loved ones. This study finding was supported by a descriptive phenomenon research study done in Turkey, which revealed that Nurses stayed away from social environment as they feared stigmatization and infecting their loved ones, they also felt lonely and isolated (Kackin, Ciydem, Aci and Kutlu, 2020).

The greatest source of strength for nurses in both studies, was their family support and understanding which enabled them to care and support the patient with no doubt.

4.2.3 NURSES' OWN EXPERIENCE OF COVID-19 INFECTION

Nurses experienced various reactions when they got infected with the COVID-19. Some were calm as they already anticipated, while some felt lucky that they survived the infection as they had to nurse and watch patients and their colleagues die from the infection. These responses were similar to the experience of a Nurse in Northeast of New York who spoke publicly in a radio interview that stating that she felt lucky and thankful that she was infected with COVID-19 and had no respiratory symptoms (WAMC Northeast Public Radio, 2021).

On the other hand, some Nurses blamed themselves as they tried unsuccessfully hard to protect themselves and their families from becoming infected. As a result of the family members infection some from stigma while others died from the infection. In a similar account Stent and Gontsana (2021) reported a nurse suffering from post-traumatic stress disorder from the death of her father from covid that he contacted from her. Memory loss was reported as the worse effect Nurses experienced.

4.2.4 NURSES' CHALLENGING WORK EXPERIENCE DURING THE COVID-19 PANDEMIC.

Quality patient care depends on the availability of infrastructure, adequate resources, and human resources. However, in the COVID-19 pandemic Nurses in this study had challenging work experience. The challenges were related to human and material resources in the health care systems, support and ethical dilemmas. Inadequate infrastructure and resources such as ventilators, oxygen and intensive care unit beds to facilitate patients' isolation and care were of major concerns for the Nurses. There was not enough space to accommodate multiple admissions and social distancing. This study finding is consistent with the study conducted by Raza, Matloob, Rahim, Halim, Khattak, Ahmed et al., (2020) among the Nurses working in government hospitals, in Pakistan as they reported poor conditions of the isolation wards, which they felt were contaminated and unsafe which made it impossible to follow standard operating procedure of COVID-19. Additionally, lack of PPEs and in-service training regarding donning and doffing of the PPE added to the challenging work experience of the nurses.

Shortage of staff because of the COVID-19 infection and absenteeism of the nurses from work added to the challenging work experience of the nurses in the study. The existence of Pre-COVID global shortage of nursing staff in patient care became exacerbated with the COVID-19 pandemic (Goodare 2017; Haryanto 2019). The fear of treating a COVID-19 patient made nurses to stay away from the hospital. According to Tujjar and Simonelli (2020) the absenteeism among the nurses during the pandemic shows the need for a support structure for the nurses. Some of the nurses in this study reported lack of support and guidance from their managers. The lack of support from the managers was due to lack of preparedness for the COVID-19 pandemic lowered the staff morale, confidence, guidance and support to provide high standard patient care. The pandemic caught them off-guard as highlighted by Labraque, Hammad, Gloe, McEnroe-Petitte, Frond, Obeidat et al., (2018) that educational gap and lack of preparedness can lead to strenuous working conditions.

4.2.5 NURSES' POSITIVE WORK EXPERIENCE DURING THE COVID-19 PANDEMIC

In spite of the report of lack of support from their managers by some nurses, others reported availability of managerial support as they shared their burden and provided clarity when need for the benefit of patient care. Nurses who were already suffering psychological effect of the COVID-19 pandemic found the psychological support offered by the hospital to be delayed. While others who utilized and benefited from this service reported confidence in treating and managing the patients. This argument was supported by the study done by Sheng et al., (2020) which report that Nurses received support from colleagues, public and hospital leaders and they felt safe and encouraged to work. This study found that some Nurses working in the specialized units felt protected as they were provided with enough PPE to protect them from contracting the virus. This finding is supported by study conducted by Robinson and Stinson, (2021) as Nurses appreciated their employers' efforts in providing appropriate resources to protect them.

4.2.6 NURSES' EXPERIENCE OF CARING DURING THE COVID-19 PANDEMIC

Nurses had the courage to continue fulfilling their responsibilities to nurse the patients despite of inadequate protection and struggles with limited resources. This act benefited the patients as they were vulnerable and depended on the Nurses. This study found that Nurses devoted themselves and encouraged the patients to live. The flexibility of the Nurses allowed them to

adapt to other non-nursing roles to ensure patient's needs were catered as opposed to other disciplines which distanced themselves from COVID-19. The same courage was reported by the study done in the United Kingdom, among the frontlines HCWs such as Nurses who nursed the COVID-19 patients. Frontlines continued to care for patients regardless of challenges they faced including inappropriate PPE supply, inadequate training and guidance (Barello, Palamenghi and Graffigna, 2020 and Hoernke, Djellouli, Andrews, Lewis-Jackson, Manby, Martin et al, 2021).

Fear of contracting the virus disadvantaged patient care as Nurses distanced themselves as an act to protect themselves. Nurses felt the COVID-19-time limit protocol compromised the patient as the nurse had to spend less than 15 minutes. There was no time to create rapport with the patient and attend to their holistic needs. The findings of this study are in line with those of the study conducted by Hoernke et al, (2021) as the Nurses felt wearing of masks prevented them from building rapport with the patients as the PPE limited facial expression, physical touch and time spent with the patient. These finding are consistent with the study done by Kok, Hoedemaekers, van der Hoeven, Zegers and van Gurp, (2020) as quality patient care was compromised by Nurses not taking responsibility for many COVID-19 patients. Being short staffed with high patients demands contributed to the neglect of patient needs. Furthermore, this study found that the negative attitude displayed by the Nurses due to frustration of being over worked and feeling exhausted which compromised patient care. This is consistent with the findings of the study conducted by Liu, Tao, Gao, He, Wang, Xia et al., (2020) as Nurses who provided care for a dying patient found the situation to be emotionally and physically draining resulted to their negative attitude. Additionally, nurses were heartbroken as they nursed patients on the floor and on wheelchairs as there was shortage of beds. This lowered the Nurse's pride and confidence of creating a conducive and comfortable environment for the patient.

4.2.7 NURSES' EXPERIENCE OF COPING DURING THE COVID-19 PANDEMIC

The ability of the Nurses to cope during the pandemic was determined by the individual ability to accept and understand the situation. When Nurses are unable to manage their intrapersonal skills patients will not be able to interact effectively with the patient. Resilience was defined as the ability to successfully cope, adapt or manage stressful or traumatic situations (Straud, Henderson, Vega, Black and Van Hasselt, 2018). This study found that Nurses' experience of coping during the COVID-19 pandemic was highlighted by Internal

coping strategies and external coping mechanisms. The following strategies motivated the Nurses and gave them a strong sense of duty and commitment as a Nurse; improvisation; rationalisation; knowledge and understanding; acceptance; resilience; spiritual coping and hope; peer support and family support. Enhanced knowledge and understanding gained by the Nurses about COVID-19 as they continued to be exposed helped them to manage. An online survey of Manyaapelo, Mokhele, Sifunda, Ndlovu, Dukhi, Sewpaul et al., (2021) among HCWs in all South African provinces, suggests that training programs can improve HCWs confidence as Western Cape Province increased COVID-19 exposure which resulted in an increased knowledge about COVID-19.

Nurses who were interviewed reported that they managed to stay hopeful and found strength in spiritual coping. In a study conducted by Egunjobi, (2020) encouraged humans to seek help from Jesus Christ as he had encouraged them with a Bible verse quoted in Matthew 6:25-34 as it state: “Therefore I tell you, do not worry about your life, what you will eat or drink; or about your body, what you will wear. Is it life more than food, and the body more than clothes?... Therefore, do not worry about tomorrow, for tomorrow will worry about itself. Each day has enough troubles of its own.” Support and encouragement received by the Nurses from their families despite the distance and team members gave them strength to overcome their challenges. Cao, Wei, Zhu, Duan, Geng, Hong et al., (2020) supports the current study finding as Nurses in their study coped by talking with their colleagues.

4.2.8 NURSES' RECOMMENDATIONS FOR WORKING DURING THE COVID-19 PANDEMIC

This study found that to maintain a healthy mental status of the staff, Nurses recommended that counselling will be more effective if done in the early stages of the pandemic. While some Nurses saw a need for counselling and debriefing as witnessing dying people affected them mentally. The study findings are consistent with the recommendations made by Markey, Ventura, and O’Donnell, (2020) as the study urges the Nurse Manager to consider ways of empowering, supporting and enabling Nurses to implement ethical standards on a daily basis. Furthermore, Galehdar, Kamran, Toulabi and Heydari, (2020) saw need to boost Nurses’ mental wellbeing for support from decision and policy makers and government during and after crisis. In addition, Nurses in this study strongly believe that nurses should be involved in decisions making process regarding Nurses. This study findings are well

supported by the recommendations made by Berello et al., (2020) for voicing of Nurses needs to the world in preparation for the next major health challenges.

4.3 Conclusion

The findings of this study found that the Nurses who cared for COVID-19 patients in Ekurhuleni, Gauteng Province and who nursed COVID-19 patients in the non-specialized units were negatively affected by the insufficient resources and infrastructure. Future studies to improve the procurement and distribution of resources and adequate infrastructure for effective management are required. The study acknowledges the negative psychological impact caused by the pandemic. Therefore, further studies to determine the effect on Nurse's families should be conducted. Working during the COVID-19 pandemic has exposed the Nurses to identify the gap in their managerial support. Therefore, the researcher recommends that managerial support which includes the offering of professional counselling be done routinely for improvement of mental wellbeing and that regular in-service training be conducted to support the Nurses within the clinical setting.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, RECOMMENDATIONS OF THE STUDY, LIMITATIONS AND CONCLUSION

5.1 INTRODUCTION

In chapter 4 the findings were discussed supported by the literature control. The aim of this chapter 5 is to present the summary of the findings of this study, conclusions, recommendations for further research and limitations of the study.

5.2 OBJECTIVES OF THE STUDY

The objective of this study was to explore and describe the perceptions of the nurses working in clinical settings during Covid-19 pandemic. The setting of the study was at Ekurhuleni in Gauteng Province. The rationale for conducting the stud was to propose recommendations in terms of Nursing practice, Nursing education and Nursing research based on the lived experiences of the COVID-19 nurses. The objective of the study was achieved as reflected on the summary of the findings of the study as stated in the next subsection.

5.3 SUMMARY OF THE FINDINGS OF THE STUDY

The findings of the study revealed that nurses working during the Covid 19 pandemic endured a lot of challenges as reflected in the themes and subthemes presented and discussed in chapter 3 and chapter 4. They suffered physically, emotionally and socially. They felt exhausted as they were experiencing shortage of staff due to colleagues that were exposed to the virus who were either on quarantine or isolation. They endured a lot of stress emotionally. They had to be over cautious as they were afraid of contracting the virus and die or spreading the virus in public transport and infecting their families. However, lack of enough PPE to assist nurses to protect themselves made the situation worse.

Nurses felt stigmatised in the community as people did not want to come near them or members of their families. They were perceived as carriers of the disease who were spreading it in the community. Nurses were also afraid of contracting the disease. In one of

the themes, nurses reflected their own experiences of suffering and dealing with Covid-19 infection. They felt that it was a lonely road that made them even more afraid as they watched colleagues dying due to the pandemic.

Nurses also indicated that the working experiences was very challenging during the covid-19 pandemic with both negative and positive experiences. It was also clearly described that for nurses to survive during this period they had to develop coping mechanisms which entailed verbalizing their fears and relying on peer support. In the last theme nurses described the lack of preparedness and lack of resources to deal with the pandemic as a factor that influenced the way nurses and the whole health fraternity dealt with the health education, preventive measures and the rate of the spread of the virus. In their recommendations, they emphasised the need for the health care system to have strategies and plans in place to deal with pandemics in the future.

5.4 STRENGTHS OF THE STUDY

This study was conducted in the COVID-19 treating hospital just after the first wave and during the second wave of the pandemic. Nurses who were interviewed had first-hand experience with the COVID-19 patients.

5.5 RECOMMENDATIONS OF THE STUDY

Based on findings of the study, the researcher made the following recommendations in terms of nursing practice, nursing education and nursing research. The recommendations were made based on the themes that emerged from the study:

5.4.1 Recommendation for nursing practice

- Recommends that managerial support including the offering of professional counselling be done routinely for improvement of mental wellbeing of the Nurses.
- Nurses to be prepared mentally and physically for upcoming waves of infection that will ensure that they can deal with challenges. Being empowered with information may lessen fears impairing patient care.
- Professional Nurses inputs to be acknowledged as they are immediate the care givers for patients and experience more challenges on the patients surrounding.

- Managers to offer immediate support to the professional Nurses during crisis and always available to give guidance.
- Department of Health should employ more professional Nurses whether contract Nurses or full time employed Nurse or overtime Nurses to ease the burden and improve patient care.

5.4.2 Recommendations for nursing research:

- Future studies should be conducted in order to improve the procurement and distribution of resources and adequate infrastructure for effective management required. Further studies should also include the determination of the effect on Nurse's families.
- Further studies need to be conducted to explore the Nurse's experiences in a clinical setting during this COVID pandemic, in remote areas is needed.

5.4.3 Recommendations for nursing education:

- Regular in-service training be conducted to support the Nurses in clinical setting and in-terms of new protocols.
- Clear development of guidelines for standard operating procedures relating to patient care and staff safety during an outbreak.
- Infection control personnel to give clear and appropriate health education on the donning and doffing, and discarding of PPE during and outbreak of COVID-19.

5.5 LIMITATIONS OF THE STUDY

This study was conducted in one hospital in Ekurhuleni Health District, Gauteng Province. Purposive and snowballing sampling methods were followed. The study took place in urban areas excluding those working in hospitals that are in rural areas, therefore the study may not reflect experiences of other professional nurses who nursed COVID-19 patients in small hospitals. The setting must be noted to avoid the factors that can affect the replication of the study.

5.6 CONTRIBUTION TO THE BODY OF KNOWLEDGE

This study had explored and described the lived experiences of the Nurses working in the government hospital in South Africa during this COVID-19 pandemic and how the emotional sufferings had affected patient care. Furthermore, shed light on how the shortage of material and human resources had influenced the quality of care rendered during this COVID-19 pandemic. This study had proposed recommendations to improve Nursing practice, Nursing education and Nursing research.

5.7 CONCLUSION

The aim of the study was to explore and describe the lived experiences of Nurses working in the clinical setting during COVID-19 pandemic in Ekurhuleni Gauteng Province. To offer recommendations in terms of nursing practice, nursing education and nursing research. Interpretative phenomenological analysis design was used in this study. The researcher collected data from 13 purposively and snowball selected professional Nurses who nursed the COVID-19 positive patient. They were interviewed using semi-structured individual face-to-face and telephonic interviews. The interview process was guided by an interview guide. Each interview was audio recorded and lasted between 45-60 minutes per participants on average. Fields notes were taken as a means of triangulating data collection method. The researcher transcribed the audio recorded interviews verbatim. Data analysis was done at the same time as data collection. Colaizzi's phenomenological method was used to analyse the interviews and helped the researcher learn more about the Nurse's lived. Trustworthiness of the study was maintained using the criteria of credibility, transferability, dependability, conformability, and authenticity. Ethical aspects such as protection of the rights of the institution. Permission to conduct the study was acquired and informed consent obtained. The objectives of this study were met as the researcher had managed to explore and describe the lived experiences of the Nurses working in a clinical setting during, COVID-19 pandemic in Ekurhuleni, Gauteng Province and made contextual relevant recommendations to improve nursing practice, nursing education and research with recommendations for further studies were identified limitations for this study were determined.

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APPENDICES

APPENDIX: 1

INTERVIEW GUIDE

The researcher is going to have in- depth interview sessions that will last for 30-45 minutes with the participants to explore and describe the lived experiences of working in the clinical setting during, COVID -19 pandemic. The researcher will use open-ended questions to gather the needed description of the participant's experiences. As they will allow the participant to express themselves accordingly.

What is it like to work in the COVID -19 wards during this pandemic?

Follow up questions:

- What impact is this experience having in carrying your duties as a nurse?
- How are you coping with the current situation?
- How is the support you are getting helping you to get through the situation?
- What are measures in place to ensure to you are safe and protected in the wards?
- What are the challenges you are facing in your clinical setting?
- How are you dealing with the things you cannot change and are affecting your duties as a nurse?
- Tell me more about the shortfalls you have identified in your department and how you think should be addressed?
- What lessons have you learnt from the experience?

Probing questions will be used as the need arise for further clarity, paraphrasing and summarizing will also be used to reflect on the participants. The interviews will be audio-recorded with the participant's permission. Field notes will be taken on the non- verbal responses of the participants.

APPENDIX 2

PARTICIPANT'S INFORMED CONSENT.

The lived experiences of nurses working in the clinical setting during, COVID-19 pandemic, in Ekurhuleni, Gauteng Province.

Principal Investigator: Sinethemba Nyandeni

Supervisor: Professor Mulaudzi

Institution: University of Pretoria

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S):

Daytime number: 072 2830 151

Afterhours number: 072 2830 151

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

date	month	year

:
time

Dear Prospective Participant

Dear Mr. / Mrs. .....……..

1. INTRODUCTION

You are invited to volunteer for a research study. I am doing this research for a master's degree purposes at the University of Pretoria. This document gives information about the study to help you decide if you would like to participate. Before you agree to take part in this study, you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we will be discussing during the interview.

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore the lived experiences of nurses working in the clinical environment during, COVID-19 pandemic in Ekurhuleni, Gauteng.

By doing so I wish to learn more about the challenges and service delivery gaps the nurses are facing during the COVID-19 pandemic. Also, to learn the meaning and value they have attached to their nursing duties in relation to their clinical experience.

You will be interviewed by the researcher in the presence of an assistant researcher. The assistant researcher will assist the researcher in taking of field notes on the non-verbal responses of the participants. The interviews will be conducted online using zoom and WhatsApp video call as a mean to maintain social distancing during this pandemic. The interviews will be recorded with the consent of the participant.

However, the participants without connectivity face to face contact will be arranged and appropriate preventive measures will be followed. These measures include hearing of masks covering both the nose and mouth, maintaining 1.5m distance during the interview, frequent sanitization of hands and pens during the session and temperatures will be monitored before the interview starts. Should the temperature the interviewer, assistant interviewer or the participant be higher than the normal body temperature the interview will be cancelled and re arranged. The interviews will be conducted in the venue chosen by the participant for his/her comfort and accessibility. However, for the online interviews the participant and the interviewer together with the assistant interviewer can be in any venue with no distraction. The venue chosen must allow the interviewer and the participant to be audible, both sides must be able to have eye contact to facilitate good interview skills.

3. EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM THE PARTICIPANTS

If you agree to participate, you will be asked to participate in an individual interview which will take about 30-45minutes. The individual interview will be a one-on-one meeting between the researcher, participant and the assistant researcher. I will ask you several questions about the research topic. However, an assistant interviewer will be present to assist in taking field notes on the non-verbal responses of the participants to ensure that there is no missing information. I will ask you several questions about the research topic. This study involves answering some questions such as: What is it like to work in the clinical setting during, COVID- 19 pandemic in Ekurhuleni, Gauteng province.

With your permission, the interview will be recorded on a recording device to ensure that no information is missed.

4. RISKS AND DISCOMFORTS INVOLVED?

We do not think that taking part in the study will cause any physical or emotional discomfort or risk. The only possible risk and discomfort involved is that during the interview you may find that some questions are sensitive; for instance, questions about how are you coping with the current situation. If questions feel too personal or make you uncomfortable, you do not have to answer them. The department of health provides extra psychological support for

covid-19 related problems. This is done in the wellness centres situated in government hospitals.

If you need psychological support or counselling during or after the interview, I will be able to refer you to a psychologist. Name and contact will be provided together with arranged means of communication preferred by the participant.

5. POSSIBLE BENEFITS OF THE STUDY

You will not benefit directly by being part of this study. But your participation is important for us to better understand the importance of improving the clinical setting in order to ensure occupational safety and respecting nurses' rights for positive working experience and quality care during a pandemic.

The information you give may help the researcher improve the quality of nursing care through the proposal of recommendations for nurses working in the clinical setting during, COVID-19 pandemic with reference to nursing practice, nursing education and nursing research.

6. COMPENSATION

You will not be paid to take part in the study. However, any cost you have because of taking part in the study, for example airtime used to call the researcher, data used to join the online interview and transport costs will be paid back to you (reimbursed).

7. VOLUNTARY PARTICIPATION

The decision to take part in the study is yours and yours alone. As a result of the COVID-19 pandemic preventative measures, online interviews using zoom and WhatsApp video calls can be used to promote social distancing. Informed consent will be emailed to the participants, and after they have responded, agreed and signed the consent form. However, the participants without connectivity face to face contact will be arranged and appropriate preventive measures will be followed. These measures include wearing of masks covering both the nose and mouth. Distance of 1.5m should be observed during the interview session.

Frequent sanitization of hands and pens during the session. Temperatures will be monitored before the interview starts. Should the temperature the interviewer, assistant interviewer or the participant be higher than the normal body temperature the interview will be cancelled and re arranged. You have the choice to choose any interview method that you prefer. You do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way.

8. ETHICAL APPROVAL

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides doctors on how to do research in people. The researcher can give you a copy of the Declaration if you wish to read it.

9. INFORMATION ON WHO TO CONTACT

If you have any questions about this study, you should contact:

Sinethemba Nyandeni, the researcher.

10. CONFIDENTIALITY

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report or other research output.

All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not possible for people to know that you were part of the study.

The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee. All of these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All hard copy information will be kept in a locked facility at Prinshof Campus, at the University of Pretoria, for a minimum of 15 years and only the research team will have access to this information.

11. CONSENT TO PARTICIPATE IN THIS STUDY

- I confirm that the person requesting my consent to take part in this study has told me about the nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read and understood the above written information about the study.
- I have had adequate time to ask questions and I have no objections to participate in this study.
- I am aware that the information obtained in the study, including personal details, will be anonymously processed and presented in the reporting of results.
- I am participating willingly.
- I have received a signed copy of this informed consent agreement.

_____ _____

Participant's name (Please print) Date

_____ _____

Participant's signature Date

_____ _____

Researcher's name (Please print) Date

_____ _____

Researcher's signature Date

I GIVE CONSENT FOR THE INTERVIEWS TO BE RECORDED

YES / NO

City of Ekurhuleni

GAUTENG PROVINCE
REPUBLIC OF SOUTH AFRICA

APPENDIX 3

EKURHULENI HEALTH DISTRICT
RESEARCH PERMISSION

Research Project Title: Lived experiences of nurses working in the clinical setting during, COVID-19 pandemic, in Ekurhuleni, Gauteng Province.

NHRD No: GP_202011_041

Research Project Number: 11/02/2021-04

Name of Researcher(s): Ms Sinethemba Nyandeni

Division/Institution/Company: University of Pretoria

Date of review by the EHDRC: 11 February 2021

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.
- Facilities approved for the research: Bertha Gxowa (Germiston) Hospital
- Participants' rights and confidentiality must be maintained throughout the study period and when disseminating the findings.
- No resources (financial, material and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.
- The study will comply with Publicly Financed Research and Development Act 2008 (Act 51 of 2008) and its related regulations.

Title: Lived experiences of nurses working in the clinical setting during, COVID-19 pandemic, in Ekurhuleni, Gauteng Province.

- The EHDRC must be informed in writing before publication or presentation of research findings and a copy of the report/publications/presentation must be submitted to the EHDRC
- The district must be acknowledged in all the reports/publications generated from the research.
- The researcher will be expected to provide the EHDRC with
  - Six monthly progress updates including any adverse events
  - The final study report in electronic format
  - Present the final research findings at the annual Ekurhuleni research conference if possible.
- The EDHRC reserves the right to withdraw the approval, if any of the conditions mentioned above have being breached
- The research committee wishes the researcher(s) the best of success.

THEMBANI MASINA

DEPUTY CHAIRPERSON: CITY OF EKURHULENI

Dated: 22/02/2021.

Dr. R. Wellerman

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI HEALTH DISTRICT)

Dated: 22/02/21

APPENDIX 4

Faculty of Health Sciences
School of Health Care Sciences
Room 3-75. HW Snyman North
University of Pretoria,
Private Bag X323
ARCADIA
0007
Tel: 012 356-3233
Joyce.mothabeng@up.ac.za

21 August 2020

Faculty Ethics Committee

Faculty of Health Sciences

University of Pretoria

To whom it may concern,

Evaluation of a protocol for the following student:

Student Nyandeni S - Department of Nursing Science (MNur); student number: 13294832

Title: Lived experiences of nurses working in the clinical setting during, COVID-19 pandemic, in Ekurhuleni, Gauteng Province

This letter serves to confirm that the above mentioned protocol was discussed by the Postgraduate Committee of the School of Health Care Sciences during the On- line meeting of 12 August 2020.The proposal was accepted with minor changes, and the corrections were effected. It is hereby referred to your committee for ethical clearance.

Sincerely yours,

Professor DJ Mothabeng

Chairperson: Research and postgraduate committee

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX 5

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

28 October 2020

Approval Certificate

New Application

Ethics Reference No.: 583/2020

Title: Lived experiences of nurses working in the clinical setting during, COVID-19 pandemic, in Ekurhuleni, Gauteng Province.

Dear Ms S Nyandeni

The **New Application** as supported by documents received between 2020-08-26 and 2020-10-21 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2020-10-21 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2021-10-28.
- Please remember to use your protocol number (583/2020) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers

MBChB MMed (Int) MPharmMed PhD

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
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Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

Emanuel, E.J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., et al. 2020. Fair allocation of scarce medical resources in the time of covid-19. Mass Medical Soc.