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ORIGINAL ARTICLE

'It was difficult, but our struggle to touch lives gave us strength': The experience of nurses working on COVID-19 wards

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Abstract

Background: Nurses are considered important healthcare professionals during the management of the pandemic process due to the considerable amount of time they spend in the face-to-face nursing of infected patients. To optimise the service of healthcare workers, it is recommended that the mental health needs of the health workforce are addressed.

Aims and Objectives: This study aimed to explore the experiences and coping strategies of Turkish nurses working in pandemic units.

Methods: A grounded theory design was applied. In-depth interviews were conducted with 15 nurses. The data were analysed according to the constant comparative method.

Results: The study generated a core category ('It was difficult working in the unknown, but our struggle to touch lives gave us strength'), showing that all nurses felt heroic via the satisfaction of touching patients' lives and uncertain. Four main categories emerged: being caught in the pandemic, empowerment for coping with the struggle, challenges during the coping process and effects of the pandemic on life.

Conclusions: Nurses felt that their profession was sacred and valued by society, and comprehensive support had facilitated the process. Nurses had difficulty in managing their fear of infecting others and adapting to many new elements, the learning process and a lack of understanding of their role as team members. The nurses attending to the pandemic have experienced the effects of COVID-19 on their lives, such as psychological growth, psychological symptoms and being labelled as high risk.

Relevance to clinical practice: Nurses would be further empowered by government and society's support and acceptance of professionalism in nursing. The findings suggest that the resources for the psychological support of nurses in the pandemic should be increased. Regular and intensive training for nursing is necessary to promote adaptation and efficacy in crisis management.

KEYWORDS
coping process, COVID-19, experience, grounded theory, nurses, pandemic

1 | INTRODUCTION

The coronavirus disease 2019 (COVID-19) has raised concerns about the healthcare sector due to the increasing number of confirmed cases worldwide (Shanafelt et al., 2020). According to a World Health Organization (WHO) (2020a) report issued on 28 June 2020, there were 9.843.073 confirmed cases and 495.760 confirmed deaths worldwide from COVID-19. Turkey is also affected by the ongoing pandemic with 195,883 confirmed cases and 5,082 confirmed deaths according to data from the Republic of Turkey Ministry of Health (2020). As in the rest of the world, a process of rapid transformation and adaptation was initiated in the Turkish healthcare system as soon as the first confirmed case was observed on 11 March 2020 in Turkey. Many inpatient units were converted to COVID-19 wards to expand bed capacity for patients; healthcare professionals from different specialisms and units were assigned to work in frontline positions; and all non-emergency leaves of healthcare workers were cancelled for three months (Elbay et al., 2020).

Nurses are considered important members of the healthcare professional community in many countries because of the considerable amount of time they spend in the face-to-face nursing of COVID-19 patients (Jackson et al., 2020). Nurses have undertaken important roles not only in patient care, but also in controlling the outbreak (Liu et al., 2020), and are reported in social media as superheroes devotedly coping with the COVID-19 pandemic (Williams, 2020). Nurses need to successfully manage the process and support patients, both in the short and long term throughout the pandemic (McPeake & Pattison, 2020). However, the highly contagious nature of COVID-19 has severe and negative impacts on the health, survival, emotional state and coping strategies of healthcare professionals (Huang & rong Liu, 2020). Nurses suffer intense stress due to the high risk of infection exposure, the fear of providing inadequate care, being labelled as high risk and the general uncertainty caused by the experience of the previous epidemics of SARS and MERS (Liu et al., 2020). They experience a process of adapting to and coping with the new living and working conditions (Jackson, Bradbury-Jones, et al., 2020{Xiao, 2020 #11; Xiao et al., 2020).

The healthcare workforce is defined as integral to an effective pandemic response. To optimise the service of nurses, it is recommended that their physical health is protected and their mental health needs are anticipated and addressed (WHO, 2020b). The CDC (2020) emphasised the importance of listening to and learning from the experiences of healthcare practitioners as they respond to COVID-19. Earlier disaster processes, such as the Middle East respiratory syndrome coronavirus (MERS-CoV), demonstrated the need to examine the needs of, and difficulties experienced by, healthcare workers when establishing a safe healthcare system to respond effectively to national disasters (Yujeong Kim, 2018). To our knowledge, the existing studies clarifying nurses' experiences of working in COVID-19 pandemic units have been conducted only in China (Liu et al., 2020; Sun et al., 2020; Yin & Zeng, 2020; Zhang, 2020). It is known that there are significant variations in acute and intensive care capacity, relevant skills, competencies and pandemic training across the WHO European Region (2020a). Therefore, it is important to develop an explanatory framework to gain insights into nurses' experience of working in pandemic units and to re-conceptualise and re-theorise this experience to contribute to increased sensitivity to nurses' experiences and needs.

What does this paper contribute towards the wider global clinical community?

- The present study shows that nurses have professional satisfaction and motivation from being at the forefront of the struggle.
- Social acceptance empowers nurses. Professionalism in nursing is presented as an important factor in facilitating the coping and learning process, having social acceptance and nursing philosophy.
- Support resources from management and peers are key factors in coping with working in pandemic units.

1.1 | Aims

This study aimed to explore Turkish nurses' experiences of working at COVID-19 pandemic units.

2 | METHODS

2.1 | Design

The present study was conducted using the classic grounded theory methodology (Glaser et al., 1968), which promotes a deep understanding of concepts and interprets the experiences of people. Grounded theory provides a conceptual framework that presents concepts about the phenomenon of interest and their relationships with each other (Glaser et al., 1968; Strauss & Corbin, 1998). It is described as the best qualitative design to clarify complex issues that require deeper exploration (Strauss & Corbin, 1998). Owing to its approach, this theory was considered the most suitable design to explore Turkish nurses' experience of working in COVID-19 pandemic units, which is a new and complex phenomenon. The recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist advocated by Tong, Sainsbury & Craig (2007) were followed (see Supplementary File 1).

2.2 | Participants and setting

Fifteen nurses working in COVID-19 pandemic units participated after providing informed consent and meeting the inclusion criteria.

No participants dropped out. A strategic sampling strategy was applied to interviews, using a combination of purposive sampling and theoretical sampling. Purposive sampling should be selected from purposeful cases that are 'information rich' to gain a broad spectrum of views and identify an emergent theory (Palinkas et al., 2015). In this study, to assure a range of responses, diversity in participant characteristics included sex, age, education level and years of experience as a nurse.

After the first six interviews were analysed, additional participants were recruited to guide the depth of the theory being developed using theoretical sampling. Theoretical sampling is a grounded theory strategy that is used to present and highlight gaps in the existing data set. Theoretical sampling includes new participants who provide additional information to saturate emerging categories (Bryant & Charmaz, 2010; Chun Tie, Birks, & Francis, 2019). Theoretical sampling was used to identify individuals who would shed light on the development of new categories about the effect of the learning process and professional status of nurses on the coping process.

The characteristics of the participants are presented in Table 1. The participants were 21 to 39 years old, and two out of 15 participants were vocational health high school graduates. Vocational health high school education, which was common in the earlier years, was provided to be specialised as a healthcare professional at the high school level. Three out of 15 had completed postgraduate education in nursing. The other participants (n = 10) had undergraduate-level education in nursing. The five nurses were married, while the others (n = 10) were single. The length of participants' clinical experience ranged from 7 months–22 years. Except for one nurse, other participants (n = 14) came from different departments and worked in the pandemic. The length of the pandemic clinical experience of the participants ranged from 2 months–5 months.

The present study was conducted at a public hospital in southern Turkey. This hospital has five pandemic units that were converted from different specialty units. Every shift was managed by the two nurses, and one nurse was responsible for five patients in one pandemic unit. Every pandemic unit had an average of 8–10 patients during the data collection period.

2.3 | Data collection

The data were collected through in-depth telephonic interviews in June 2020. Each interview was conducted only once by the second author (MO). The participant and the interviewer did not know each other prior to commencement of the study. Each interview spanned 40–60 minutes, was audio-recorded and followed a semi-structured format, focussing on the experiences and coping process of the participant (Table 2). To facilitate dialogue during the interviews, the researcher used open-ended questions, practised active listening and encouraged participants to talk freely. The data collection continued until theoretical saturation was reached, indicating that no new information was gained (Glaser et al., 1968).

TABLE 1 Characteristic of the participants.

	Age (years)	Sex	Marital status	Education level	Work experience (years)	Original Department	Day worked on COVID–19 ward before interview
Interviewee A	34	Female	Married	Undergraduate	12	Infectious diseases clinic	5 months
Interviewee B	39	Female	Married	Graduate	22	Operating room	3 months
Interviewee C	27	Female	Single	Undergraduate	7	General surgery clinic	4 months
Interviewee D	38	Female	Married	Undergraduate	19	Cardiovascular surgery clinic	2 months
Interviewee E	23	Female	Single	Undergraduate	2	General surgery clinic	4 months
Interviewee F	21	Female	Single	Undergraduate	2	General surgery clinic	4 months
Interviewee G	37	Female	Married	Undergraduate	17	Otorhinolaryngology clinic	4 months
Interviewee H	24	Male	Single	Undergraduate	~1	Neurosurgery	
Interviewee I	25	Female	Single	Undergraduate	2	Perinatology	4 months
Interviewee J	21	Female	Single	High school	~1	Orthopaedic clinic	4 months
Interviewee K	26	Female	Single	High school	8	Neurosurgery	3 months
Interviewee L	38	Female	Married	Graduate	13	Operating room	4 months
Interviewee M	35	Female	Single	Undergraduate	12	Cardiovascular surgery clinic	4 months
Interviewee N	33	Female	Single	Undergraduate	8	Operating room	4 months
Interviewee O	29	Female	Single	Graduate	8	Gynaecology clinic	4 months

TABLE 2 Interview guide.

Main question: What is the meaning of being a nurse working at COVID−19 wards?
Main question: Can you tell me about your experience working at COVID−19 wards?
Main question: What are the reasons why you have a positive/negative experience during working at COVID−19 wards?
Main question: What are the effects of working in pandemic clinic on your life?

3.1 | Data analysis

Data were analysed using open, axial and selective coding, representing a hierarchical, systematic approach recommended by Strauss and Corbin (1998) that involves a constant comparative method with iterative data collection and analysis (Strauss & Corbin, 1998). The constant comparative method develops a theory by considering all instances of variation in the data (Strauss & Corbin, 1998). Our analysis was conducted by moving back and forth between similarities and differences within the emerging categories using a constant comparative method. In the first step, that is framed open coding, the researchers conducted a line-by-line examination of each transcript for salient categories. Each statement that served their aim was coded with a keyword or phrase and guided by the question: 'What does the participant talk about here?', 'what category does this incident indicate?' and 'what is actually happening in the data?'. This coding process is iterative and builds up gradually, which provides theoretical sensitivity. The second step included axial coding, statement comparisons and categorisation according to

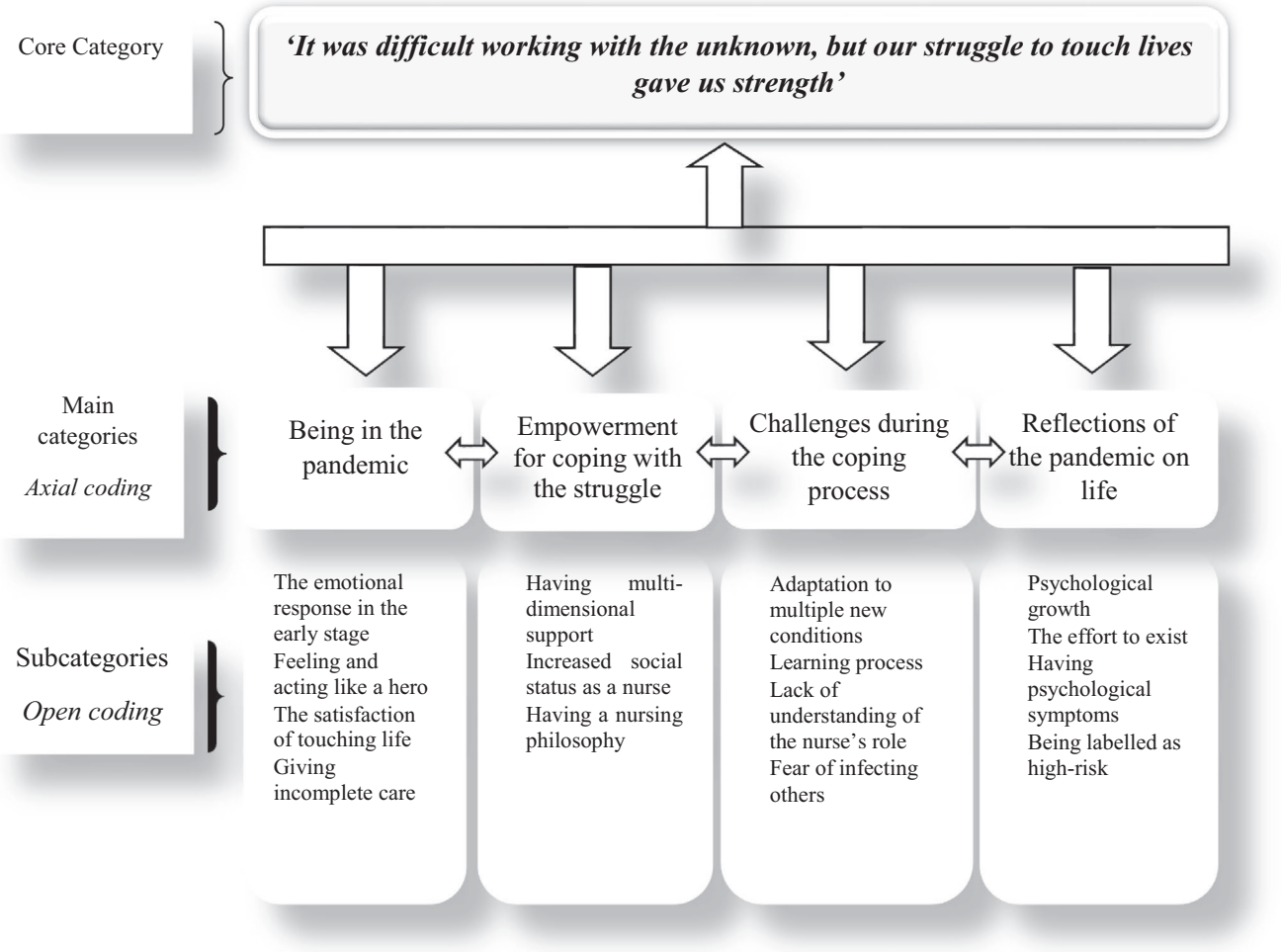


FIGURE 1 The conceptual model of the core category, main categories and subcategories.

Interviews were subsequently transcribed verbatim by the authors (MO, ADD).

3 | ETHICAL CONSIDERATIONS

All participants were informed about the aim of the study and the content of the interviews; all provided written consent to participate. The present study was approved by the regional ethics committee at Health Sciences University Antalya Education and Research Hospital in Turkey (Approval Number: 9/21).

their relationship and similarities. In the final step, selective coding was conducted to integrate all the emergent categories into a single category as the central phenomenon, which is defined as a core category. This core category needed to account for most variation, and most other categories were related to it. This process, which is known as theoretical coding, involves associating the core categories with other categories, ensuring that they continue until theoretical saturation is reached.

3.2 | Rigour

This study considered the (T)rustworthiness, (A)uditability, (C)redibility and (T)ransferability (TACT) framework to achieve rigour. Trustworthiness provides the understanding and interpretation of findings and creates confidence in the quality of study/data. Trustworthiness was achieved by reflexivity, which means avoiding biases about researchers' experience of the phenomenon of interest (Daniel, 2019). The authors in the present study made an effort to bracket hypotheses, preconceptions and the theoretical reference framework. As another way to achieve trustworthiness, data were analysed using a hierarchical, systematic approach recommended by Strauss and Corbin (1998), which involved a constant comparative method. Auditability was provided by the participants' validation. Participants were asked to check transcripts and approve or reject the interpretations of the researcher. Credibility was achieved by synthesising the categories most representative of the data. Interviews were transcribed verbatim and presented directly as a quotation. All the authors reviewed the data carefully and participated in the entire analysis process. Transferability was provided through in-depth individual interviews that were conducted by updating the interview questions based on the interviews. To ensure content validity, a combination of purposive and theoretical sampling allowed participants to talk freely during interviews and share comprehensive descriptions of their experiences. To further promote transferability, the characteristics of the participants were the president. The present study represents one of very few qualitative studies on the experiences of nurses working in pandemic units in middle-income countries. The characteristics of the nurses include diversity in education level, age and length of clinical experience, which assured a range of responses.

4 | RESULTS

One core category was generated: 'It was difficult to work in the unknown, but our struggle to touch lives gave us strength', along with four main categories and fifteen subcategories (Figure 1). The core category incorporated the fact that all participants experienced difficulties with the unknown, yet also felt strengthened through their struggle to have a positive impact on patients' lives. The nurses described different emotional responses, but they felt part of a heroic struggle. They had many resources to empower them to cope with the struggle but also faced challenges during the coping process. The nurses working in the pandemic felt that it had affected them, in terms of the meaning of their lives, psychological symptoms and voluntary social isolation.

4.1 | Main category: Being in the pandemic

This main category captured the participants' satisfaction at having a positive impact on patients' lives and feeling heroic, while also experiencing incomplete care and a range of negative emotional responses.

4.1.1 | The emotional response in the early stage

The nurses highlighted that they experienced a range of negative emotions, including anxiety, fear, shock and stress, when they learned that they would be working at a pandemic clinic, due to prevailing media portrayal of COVID-19. Some participants felt that their clinical experience was insufficient and were concerned about their qualifications suited to working at pandemic clinics:

> 'When I learned that I would work in a pandemic clinic, I felt fear, anxiety, panic and uncertainty. However, I have seen a much more beautiful ambiance than I had hoped and feared. I realised that my fears were unnecessary'.
>
> *(Interviewee B).*

4.1.2 | Feeling and acting like a hero

The participants observed that nurses were healthcare professionals who spent most of their time with the patient. Therefore, they saw themselves at the forefront in the struggle with COVID-19 and felt like soldiers or heroes fighting against the pandemic. They described this professional satisfaction and motivation in terms of nursing as a sacred profession:

> 'There is a war against the disease, and we struggle with the pandemic like a soldier at the frontline. I think this disease will never end if we do not fulfil our duty. It brings a very beautiful, spiritual satisfaction to be in the pandemic. I realised that we have a very sacred profession as a nurse'.
>
> *(Interviewee A).*

4.1.3 | Providing incomplete care

Some participants underscored as they perceived their nursing care as inadequate, due to the need for protective equipment and the

restrictions placed on the wards. It was difficult to provide care without touching the patient, and some nurses reported feeling insufficient psychological aspects of care, such as less communication due to limited time in the patient's room caused by contagion fears. This resulted in an ethical dilemma, and they were not comfortable with the resultant reduced job satisfaction.

> 'I realised how important touch is to patient care. I missed providing care without any limitation between my patient and me. It feels like something has been interrupted, and my care is limited'.
>
> *(Interviewee E).*

4.2 | Main category: Empowerment for coping with the struggle

This main category describes how nurses have been empowered by multi-dimensional support (psychological support, equipment support and informational support), increasing the value accorded to the nursing profession by society and their own nursing philosophy.

4.2.1 | Having multi-dimensional support from the environment

Many nurses reported receiving multi-dimensional support from their social environment, institutions and colleagues, and this support made a significant contribution to managing the coping process. Several participants mentioned institutional support as a facilitating factor, with initiatives to support nurse immunity, such as vitamin and ozone therapy, personal protective equipment (PPE) support, informational support, lengthening intervals between shifts and choosing a shift. The 'buddy' and psychological support for nurses have also been reported to make nurses feel valued:

> 'We work in better conditions than our previous units. Feeling that we are valued and thought of and seeing that our processes are being facilitated have motivated us. I feel that our needs are fully met'.
>
> (Interviewee H).

Participants reported that they received support primarily from their nursing colleagues at the pandemic clinic. Most of the nurses experienced good communication and found a spirit of learning together, supporting each other and fighting together against the pandemic. Some nurses noted that professional solidarity facilitated their adaptation to the clinic, especially for nurses who started to work later at pandemic units:

> 'Although we came from different clinics, we all knew that this was a team job and we had to support each other. We held on to each other more and we worked in solidarity. We all learned together. This helped me cope'.
>
> *(Interviewee K).*

4.2.2 | Increased social status as a nurse

Some nurses highlighted that they received satisfaction from being valued as they were deserved by society. They stated that sharing positive thoughts about nurses on social media and being applauded by society at a certain time each evening gave them strength:

> 'My only wish was always to see nurses valued all over the world one day. I think this has been the main advantage of COVID-19. I think it was understood that the nurses are members of the team and how important their care is'.
>
> *(Interviewee G).*

4.2.3 | Having a nursing philosophy

Most participants emphasised that they love their profession and that this profession is required in fighting the disease at pandemic clinics. They expressed they had benefitted in terms of professional and life experience from their work at the pandemic clinics:

> 'Nursing is a sacred profession. I always think that our profession has a spiritual dimension. Patients need us during this period. For this reason, I think we should do our best'.
>
> *(Interviewee A).*

4.3 | Main category: Challenges during the coping process

4.3.1 | Adapting to multiple new conditions

Most nurses underlined that working at new clinics with new working conditions was initially difficult to cope with. It took time to develop team spirit because the nurses came from different clinics and had to adapt to changes in treatments and practices. Some participants stated that the changes made in treatment practices created anxiety about the reliability of information, causing concern that they might be acting incorrectly. They also reported an increased workload, caused particularly by the use of personnel protective equipment.

> 'Especially in the first days, the lack of order in the unit and the uncertainty concerned me. Every health care professional and the other workers came from different units and hospitals. Even the staff did not

know where the equipment was. It would have been possible for someone who knew this clinic to facilitate the process'.

(Interviewee F).

4.3.2 | Learning process

Most of the participants described a sense of uncertainty as an important factor that negatively affected coping processes. Many participants reported that insufficient information about the disease exacerbated the difficulties; they highlighted social media as a source of individual information but they were anxious about the reliability of this information. Participants emphasised the importance of learning from experience, which made them feel more secure, and this sense of trust gave them competence and self-confidence:

'Earlier, the uncertainty scared us. However, we learned by observing that we could prevent contamination with adequate protection in the process, and these relieved us'.

(Interviewee L).

4.3.3 | Lack of understanding of the nurse's role as a team member

Most of the participants said that they felt worthless and less motivated because they were not included in decision-making processes in the pandemic clinic. Despite the increased visibility of the nursing profession in society, they felt demoralised by a sense of 'doctors first, then nurse and other healthcare workers' in society:

'I think we didn't get the economic value we deserve. We struggled against the pandemic, but the money started to be distributed from the top, and we felt that we were seen as assistant health care professionals, compared to doctors'.

(Interviewee I).

4.3.4 | Fear of infecting others

Most participants emphasised that their fear of spreading the infection was a factor that made it difficult to cope with the pandemic. In particular, living with family members increased this anxiety, but some participants stated that, although they lived alone, they felt afraid of infecting people they did not know. They tried, therefore, to control as many factors as possible and voluntarily isolated, due to their anxiety of infecting others:

'I feel like a bomb ready to explode. It looks like the virus will infect wherever I touch. I have always needed to control everything. This really exhausts me'.

(Interviewee F).

4.4 | Main Category: Effects of the pandemic on life

This category captured the effects of the pandemic on life in terms of psychological growth, the effort to exist, having psychological symptoms and being labelled as high risk.

4.4.1 | Psychological growth

Most nurses highlighted that the meaning they placed on their lives has changed and cited effects such as understanding the meaning and value of everything. They stated that they can look at the bigger picture and do not get overwhelmed by details and have gained a positive perspective on life:

'I used to look at life from a narrower frame. My perspective on life has changed. Now, I try to get satisfaction from life. In fact, this is a positive contribution from the pandemic'.

(Interviewee B).

4.4.2 | The effort to exist

The participants underlined that the fight for life at the pandemic clinic has caused them to put their patients at the centre of their own lives. To combat this, they engaged in leisure activities that would feed their inner world and reduce psychological fatigue caused by the hospital and patients. These self-coping activities included reading books, chatting with family and friends to relieve stress, obtaining support and trying new things:

'In this process, I chose to be alone and feed my inner world. The days when I did not work in the hospital, I turned to artistic hobbies for myself and to feel good. This made me feel great'.

(Interviewee N).

4.4.3 | Having psychological symptoms

Some nurses explained that they experienced psychological symptoms, including mental breakdown, stagnation in their social life, unwillingness to do anything, reluctance, despair, anxiety about the

future and negativity. They also stated that they were obsessed with controlling the virus:

> 'I started not enjoying most things. I am not caring for myself. I feel desperate because I feel I do not know when it will end'.
>
> *(Interviewee C).*

4.4.4 | Being labelled as high risk

Some participants highlighted that their friends or acquaintances who knew that they worked in the pandemic clinic saw them as high risk, and the resulting feeling of exclusion affected them negatively:

'My friends, my earlier colleagues and apartment friends, who know I am working at pandemic units, approached me in fear. They thought of me as a virus and made me feel it. This made me very sad'. (Interviewee D).

5 | DISCUSSION

The core category developed from a common experience of difficulties due to the unknown as well as the strength from the struggle to impact patients' lives. The rapid spread of the disease, which emerged in Wuhan, China, in December 2019, had a global impact and subsequently brought uncertainties about many aspects of the disease, including understanding of the risk, transmissibility, pathogenicity and treatment (Huang & rong Liu, 2020).

The nurses highlighted various emotional responses, mostly negative, to working in clinics in the early days of the pandemic. Nurses need to adapt to working in an unfamiliar setting or care system and suffer high levels of stress, fear, anxiety and concern for patients and family members (Chew et al., 2020; Sun et al., 2020; Xiao et al., 2020). All these factors may lead to their stress, with additional implications for their well-being (Huang & rong Liu, 2020; Mo et al., 2020; Sun et al., 2020; Xiao et al., 2020). Psychological interventions are therefore important at an early stage to establish early support systems and to facilitate the adaptation process for nurses (Sun et al., 2020).

In contrast to the mostly negative emotional responses in the early stages, nurses emphasised that they gained satisfaction from impacting patients' lives and felt like heroes. Jiang et al. (2020) stated that in the fight against COVID-19, nurses served the sick in the spirit of humanity. A spirit of professional dedication is described as a key factor in overcoming the difficulties of COVID-19 outbreaks (Liu et al., 2020).

The participants highlighted that they felt they were providing incomplete care, due to the lack of physical contact allowed with patients. It is recommended that nurses who care for COVID-19 patients work with PPE, including gowns, masks, goggles, face shields and gloves (Adams & Walls, 2020). Social distancing and using PPE may lead to restrictions, decreased communication and interaction with the patient, and less engagement in active therapeutic processes during care. However, caring is known as the fifth nursing metaparadigm (Noel, 2010), and nurses need to be informed about how to provide psychological care under these conditions.

The nurses stated that they received multi-dimensional support from their environment, which empowered them to cope with the struggle. The amount of resources may positively correlate with the number of wellness behaviours (Shechter et al., 2020), and various resources for social support were cited in the study. Social support plays a critical role for nurses in combating epidemics and is accepted as serving an intermediary role in psychological rehabilitation (Sun et al., 2020{Liu, 2020 #6). Organisational supports, such as enough personnel, sufficient quantities of PPE, reasonable working hours and psychological support systems, were cited as key factors in the present study. Research shows that concerns about shortages of staff and PPE, and lack of organisational support resulted in work stress for nurses (Joob & Wiwanitkit, 2020; Kim, 2018). In addition to work stress, working conditions, such as excessive workload, are associated with psychological symptoms (Elbay et al., 2020). Therefore, management should prioritise the safety of nurses and meet their basic needs. Nurses also stated that being valued by society as a professional motivates and strengthens their resolve. Thus, it appears likely that greater recognition from society will empower nurses. All individual and government efforts to professionalise nursing and improve its status should be directed at empowering nurses, not only for the sake of the nursing profession, but also for the health of the society.

Nurses highlighted that their learning process was hampered by a lack of reliable resources and knowledge about the disease. Nurses were learning about COVID-19, its prevention and the mechanisms by which it was transmitted, as a personal coping strategy to alleviate stress (Cai et al., 2020). Despite an increase of evidence-based practice in nursing in recent years, nursing practice in Turkey is still based on experience, intuition, traditional approaches and untested theories (Öztürk Copur et al., 2015). Çağlar et al. (2020) reported that nursing students lacked sufficient information about research and were unable to access data sources; therefore, support was needed for nurses to read and use research in their clinical practice.

The nurses stated that they struggled to cope with their stress. Nurses' self-coping strategies included psychological and life adjustments, altruistic acts, team support and rational cognition (Sun et al., 2020). Nurses engaged in different types of self-coping behaviours, such as physical activity/exercise, waking up and being positive every day, faith-based religion or spirituality, yoga and meditation (Jun et al., 2020; Shechter et al., 2020). Supporting nurses' individual coping methods and providing diverse and flexible coping resources may help nurses work more effectively in pandemic units.

5.1 | Strengths and limitations

There were potential limitations to the present investigation. First, mainly female nurses participated in the study. Second, the study was conducted at a single healthcare centre. The results of the present study may not be generalisable to other organisations that have

conditions such as a heavy workload and a lack of PPE. This is because organisational support was described as an empowerment factor of the coping process. However, this investigation represents one of very few qualitative studies on the experiences of nurses coping with working in the COVID-19 wards of middle-income countries. The characteristics of the nurses are diverse in education level, age and length of clinical experience, which assured a range of responses.

6 | CONCLUSION

Nurses have fought at the forefront of the pandemic, and it is obvious that they experienced a negative emotional response in the earlier stages. However, they gained satisfaction from their direct effect on people's lives, feeling that nursing is sacred and valued by society, and comprehensive support has facilitated the process. Nurses had difficulty in managing their fear of infecting others, being labelled high risk, adapting to many new elements, the learning process, psychological symptoms and a lack of understanding of their role as team members. Working in pandemic units had some positive effects on their lives, such as psychological growth and re-evaluating the important elements of their lives.

7 | RELEVANCE TO CLINICAL PRACTICE

Comprehensive support should be provided to safeguard the well-being of nurses, and good preparation and efficiency promoted to manage crises. Nurses' psychological well-being can be strengthened by supporting the professionalisation of nursing and improving their social status.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

ETHICAL APPROVAL INFORMATION

The present study was approved by the regional ethics committee at Health Sciences University Antalya Education and Research Hospital in Antalya, Turkey (Approval Number: 9/21).

AUTHOR CONTRIBUTIONS

Study design: A. Deliktas Demirci, M. Oruc, K. Kabukcuoglu; statistical design of the study: A. Deliktas Demirci; data analysis: A. Deliktas Demirci, M. Oruc; assistance in manuscript writing: A. Deliktas Demirci, K. Kabukcuoglu, M. Oruc; data collection: M. Oruc; and supervision: K. Kabukcuoglu.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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